Pre-License Filing

THIS FORM WAS REVISED IN FEBRUARY 2024
- PLEASE READ CAREFULLY -

THIS FILING IS REQUIRED FOR ALL HEALTH CARE FACILITIES THAT MUST SUBMIT TO ARCHITECTURAL REVIEW AND MUST BE SUBMITTED AND APPROVED BEFORE PLANS ARE SUBMITTED

— PLEASE READ CAREFULLY -

Regulations affecting the application for licensure can be found by clicking the Rules tab or link on the applications page.

The following information must be submitted:

1. A completed Pre-License Filing form.

2. A copy of the local zoning approval for the proposed project.

3. A copy of the Articles of Incorporation, Articles of Organization, LLC Agreement, Partnership Agreement, or Statement of Sole Proprietorship under which the facility will operate. Corporations, Limited Partnerships, and Limited Liability Companies must provide a copy of their Certificate of Existence (for domestic entities) or Certificate of Registration (for foreign entities) from the Alabama Secretary of State as proof of authority to transact business in the state of Alabama.

4. A facility diagram illustrating planned licensed beds and room numbers. Please provide floor plans on letter sized paper, if possible.

5. All facilities except Abortion Centers, regular Assisted Living Facilities, Independent Clinical Laboratories, and Independent Physiological Laboratories are required to obtain approval for the proposed project from the Alabama State Health Planning and Development Agency (SHPDA). A copy of said documentation issued by SHPDA must be provided.

   There is no fee for a Pre-License Filing.

ADDITIONAL INFORMATION
PRE-LICENSE FILING

Item 1, Entity. The entity is the individual, partnership, corporation or other legal entity that will be the governing authority of the facility and to whom the license may be granted. The name entered in this section must be identical to the name reflected on the documents submitted with this Pre-License Filing. (See Item 3 on Page 1). If the facility is to be operated by another entity pursuant to a lease agreement, the lessee should be listed as the Entity, and a copy of the lease agreement must be submitted with the application. **NOTE – The Entity must be the operator of the facility, the entity that makes employment decisions concerning the facility's administrator, determines patient care issues, makes payment for the facility's financial obligations, etc.**

Freestanding Emergency Departments must list the parent hospital as the Entity.

The Department does not recognize fictitious business names (d/b/a's) as such or require their disclosure. Businesses are not required to register a d/b/a or trade name with the Alabama Secretary of State. If a d/b/a is included as part of the Entity's legal name in Item 1, the d/b/a will be reflected on the license. If the d/b/a will be utilized as the facility name, it should be entered in Item 7.

Item 6, Bed/Station Capacity. Total number of beds or stations that the facility will operate. This number cannot exceed the number of beds or stations listed on the Certificate of Need.
This item does not apply to Freestanding Emergency Departments.

Item 7, Facility Name. The information provided on this line will be entered in the Department's Provider Services Directory, and the facility will be referred to by this name. This same name should be reflected on all of the facility's advertisements, letterhead, signage and certification information. The name must be unique to the facility - that is, it may not be the same as the name of any other licensed facility in Alabama, nor may it be so similar to the name of any other licensed facility that, in the judgment of Department staff, it could create any confusion in the mind of the public.

Governing authorities operating more than one facility may give the facilities they operate similar, but not identical, names. The facility name may be abbreviated if the abbreviation is also used on all advertisements, letterhead, signage and certification information.

Item 9, Facility Mailing Address. The facility's mailing address or post office box must be within the same postal service area as its street address.

Please note: it is a violation of state law to provide healthcare facility services before you are granted an appropriate license from this agency. If you have any questions about your filing, please call (334) 206-5175.

(Rev. 04/2021)

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH - DIVISION OF PROVIDER SERVICES
P.O. BOX 303017 (MAILING ADDRESS)
MONTGOMERY, ALABAMA 36130-3017
THE RSA TOWER, SUITE 710, 201 MONROE STREET, MONTGOMERY, AL 36104
(PHYSICAL LOCATION)

PRE-LICENSE FILING

1._____
Entity
(see instructions on page 2)

2._____
Entity Address

3._____
City State Zip Code

4._____
Entity Telephone Number

5._____
Facility Administrator (If known)

6._____
Facility Bed/Station Capacity
(see instructions on page 2)

7._____
Name of the Facility
(see instructions on page 2)

8._____
Facility Physical Address

9._____
Facility Mailing Address
(see instructions on page 2)

10._____
City Zip Code County

11. Select facility type:□

Abortion/Reproductive Health Center □ Ambulatory Surgical Treatment Pediatric □ Eye □ Assisted Living Facility: Group (3-16 beds) □ Congregate (17 + beds) □ Specialty Care Assisted Living Facility: Group (4-16 beds) □ Congregate (17 + beds) □	Birthing Center Cerebral Palsy Treatment □ End Stage Renal Disease □ Hospice: In-Home □ In-Patient □ Hospital: General □ Specialized □ Freestanding Emergency Dept □ Specify specialization: _____ _____	Independent Clinical Laboratory □ Independent Physiological Laboratory □ Nursing Home: Skilled Nursing Facility□ Nursing Facility □ ICF/MR □ Rehabilitation Center □ Sleep Disorders Center □

12. Entity Information

a. Entity is a (check one):

Individual	□	Nonprofit Corporation	□	City	□
Partnership	□	Hospital Authority	□	County	□
Corporation	O	State	□	Joint City County	□
Limited Liability Company	□	Other: _____ Specify			□

b. List all the Entity's board members and officers (attach additional paper if necessary).

_____ _____

_____ _____

c. List the name(s) of any person or business entity that has 5% or more ownership interest in the Entity (attach additional paper if necessary). Attach a schematic depicting the organizational structure of the Entity and its governing body.

_____ _____

_____ _____

d. Does this Entity or any of its owners listed in item "c" operate any other health care facility in Alabama or in any other state? YES a NO a If yes, attach a list including the type(s) of facility(s), name(s), address(es), and owner(s).

e. Have any of the facilities listed in item "d" had any adverse licensure action taken against them or been subject to exclusion from the Medicare or Medicaid Reimbursement Programs?
YES ☐ NO ☐ If yes, attach an explanation.

f. Have the Entity, officers or principals ever been convicted of a crime? YES ☐ NO ☐
If yes, attach an explanation.

g. Have the Entity, officers or principals ever been found guilty of abusing another individual?
YES ☐ NO ☐ If yes, attach an explanation.

h. Have the Entity, officers or principals ever had adverse action taken against a professional license held by any of them, such as a license as a nursing home administrator, attorney, nurse, or physician? YES ☐ NO ☐ If yes, attach an explanation.

i. Has the Entity, or any of its officers or principals, ever had a license application denied by this or any other state? YES ☐ NO ☐ If yes, attach an explanation.

13. Has the facility **administrator** listed in item "5" of this filing:

a. ever been convicted of a crime? YES ☐ NO ☐

b. ever been found guilty of abusing another individual? YES ☐ NO ☐

c. ever had adverse action taken against any professional license held by him/her, such as a license as a nursing home administrator, attorney, nurse, or physician? YES ☐ NO ☐

d. ever been excluded from participation in any Medicare or Medicaid Reimbursement Program?
YES ☐ NO ☐

If a, b, c, or d are yes, attach an explanation for each affirmative answer.

14. Provide the name, phone number, and email address of a knowledgeable person who can provide additional information about this filing. **PLEASE TYPE OR PRINT CLEARLY.**

Name _____

Phone _____ Email _____