STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, NH 03301
TDD Access: Relay NH 1-800-735-2964
Agency Phone: 603-271-9039

APPLICATION FOR RESIDENTIAL, HEALTH CARE LICENSE OR SPECIAL HEALTH CARE SERVICES

EXISTING FACILITY LICENSE #: _____
CURRENT FACILITY LICENSE EXPIRATION DATE, IF APPLICABLE: _____

THIS APPLICATION SHALL BE FILLED OUT IN ACCORDANCE WITH RSA 151:4. A SEPARATE APPLICATION MUST BE SUBMITTED FOR EACH LICENSURE CATEGORY. **PLEASE BE SURE TO COMPLETE THE ENTIRE APPLICATION**. IF A SECTION DOES NOT APPLY TO YOUR FACILITY, MARK NOT APPLICABLE (N/A). FAILURE TO COMPLETE THE APPLICATION WILL RESULT IN A DELAY IN THE LICENSURE PROCESS. SEND THE ENTIRE COMPLETED FORM TO THE ADDRESS ABOVE. IF YOU NEED TO REVIEW YOUR LICENSING RULES, THEY CAN BE FOUND ONLINE AT: https://www.dhhs.nh.gov/administrative-rules-health-facilities

Check all applicable items:

☐ License renewal:
☐ *New owner:
☐ **Change in address:
☐ *New facility:
☐ **Change in # of beds:
☐ Other (please explain):
☐ ***Change in classification:

* Requires processing as a new application.
** Requires Local Approval Forms
***Requires both

LICENSEE (Legal Owner of Facility): _____TELEPHONE #: (___)_____

NAME OF FACILITY (DBA): _____ TELEPHONE #: (___)_____

FAX #: (___)_____

STREET ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____

MAILING ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____

ADMINISTRATOR:_____

MEDICAL DIRECTOR (IF APPLICABLE):_____

FACILITY E-MAIL ADDRESS (REQUIRED):_____

IF APPLICABLE:
NUMBER OF BEDS: PRESENTLY LICENSED:_____ TOTAL # TO BE LICENSED:_____

NUMBER OF HCBC CFI OR STATE PLACED INDIVIDUALS IN HOME (Complete for He-P 804, He-P 805 and He-P 814):_____

NUMBER OF ESRD STATIONS (Completed for He-P 811 licensees only):_____

BRANCH OFFICE LOCATIONS (Complete if applies under He-P 809.07, 819.07, 822.07 & 823.07 only):

_____

_____

OWNERSHIP

a. Type of ownership: ☐ Association ☐ Partnership ☐ Corporation ☐ LLC ☐ Individual ☐ Other (explain

b. List name and address of each person having an ownership interest (directly or indirectly) of greater than 5% in the facility.

c. If the licensee is organized as an association or corporation, list the name of the association or corporation and the name, address, and title of each officer.

d. If the licensee is a partnership, list the name and address of each partner.

e. Is this a certified facility? **(Facilities with deem status under RSA 151)** ☐ YES ☐ NO
Only applies to He-P 802, 803, 809, 811, 812, 815, & 823

If you are already a certified facility, is this an increase in services? If YES, please call 1-800-852-3345 ext. 9049

f. Are you planning on being a certified facility? If YES, please call 1-800-852-3345 ext. 9049

FEES:

Hospitals (General, CAH, Psychiatric, Rehabilitation) (802)	$25 per licensed bed
Free Standing Emergency Rooms (802)	$500
Nursing Homes (803)	$25 per licensed bed
Residential and Supported Residential Care Homes (804 & 805)	$15 per licensed bed (NO CHARGE FOR HCBC OR NH STATE PLACED RESIDENTS)
Non-Emergency Walk-In Care Centers (806)	$500
Residential Treatment and Rehabilitation Facilities (807)	$25 per licensed bed
Home Health Care Providers (809)	$250
Birthing Centers (810)	$150
End Stage Renal Disease Dialysis Centers (811)	$500
Ambulatory Surgical Centers (812)	$500
Intermediate Care Facilities for Individuals with Intellectual Disabilities(ICF/IID)(815)	$25 per licensed bed
Educational Health Centers (816)	$500
Adult Day Care Centers (818)	$200
Case Management Agencies (819)	$150
Home Care Service Provider Agencies (822)	Less than ten clients $25; Ten or more clients $250
Home Hospice Care Providers (823)	$250
Hospice Houses (824)	$25 per licensed bed
Substance Use Disorder Residential Treatment Facilities (826)	$25 per licensed bed
Freestanding Megavoltage Radiation Therapy Facility (827)	$500
Psychiatric Residential Treatment Programs (830)	$25 per licensed bed

A check or money order (payable to: TREASURER, **STATE OF NEW HAMPSHIRE)** must be attached to this application.

Applications submitted by those facilities exempt under RSA 151:4 I (a), (b) & (c) are not required to pay the license fee.

ADDITIONAL APPLICATION REQUIREMENTS: NOTE THAT NOT ALL APPLICATION REQUIREMENTS ARE LISTED HERE PLEASE REFER TO THE APPROPRIATE RULE TO DETERMINE OTHER ITEMS THAT NEED TO BE SUBMITTED.

1. Renewal applications must be submitted at least 120 days prior to expiration of the current license. **(Yearly)**

2. Include qualifications, including a resume with education and experience, and copies of all applicable licenses and certifications, a copy of the non-conviction attestation as described in rule, and the results of the BEAS registry check from the bureau of elderly and adult services for the administrator and medical director **(if applicable)**. **(Initial Application Only, unless changing Administrator or Medical Director)**

3. Include information relative to whether the facility has been granted any waivers, exemptions, or variances to the rules by the Department of Health and Human Services and/or the State Fire Marshal. **(Yearly)**

4. Include a floor plan indicating the location of all rooms, # of beds in each bedroom, and fire exits. **(Initial Application Only – NOT FOR He-P 809, 819, 820 & 823)**

5. Include NH Secretary of State Authority to do business in the State of NH and/or tradename registration **(Initial Application Only)**

6. Include written local approvals from the health officer, the building official, the zoning officer, and the fire chief. For a building under construction, the written approvals required shall be submitted at the time of the application based on the local official's review of the building plans and again upon completion of the construction project. **(Initial Application Only for ALL categories)**

7 Include documentation that the water supply has been tested in accordance with RSA 485 and Env-Dw 702.02 and 704.02 (formerly Env-Ws 313.01 and 314.01) or if a public water supply is used, a copy of a water bill. **(Initial Application Only – NOT FOR He-P 809. 819, 820 & 823)**

8. Include documentation that **every 3 years** the water supply has been tested for bacteria and nitrates and determined to be at acceptable levels, in accordance with Env-Dw 702.02 (formerly Env-Ws 313.01) for bacteria and Env-Dw 704.02 (formerly Env-Ws 314.01) for nitrates. **(NOT FOR He-P809. 819, 820 & 823)**

9. Include a list of all employees who have previously been granted waivers for criminal background check results from the Department of Health and Human Services. **(Yearly and on initial application if change of ownership or category)**

10. Include the results of a criminal records check to include results for the state of New Hampshire for the applicant(s), the licensee (owner even if entity) if different than the applicant, the administrator, medical director and, if applicable, each household member 17 years of age or older who resides at the facility. **(Initial Application Only)**

FACILITY SERVICE DESCRIPTION: Complete even on renewal

The following information will be used to determine which licensure category your facility will be placed in.

I. Provide a detailed description of the services and programs you wish to provide.

*II. Describe the facility's health care you wish to provide to residents.

*III. Identify who will provide the health care listed in II.

*To be completed if applying for beds. **SIGNATURES:** This application must be signed by:

1. The owner if a private facility;
2. Two officers if a corporation;
3. Two authorized individuals if an association or partnership; or
4. The head of the government agency if a government unit.

I affirm that I am familiar with the requirements of RSA 151 and the rules adopted thereunder and that the premises are in full compliance. I understand that providing false information shall be grounds for denial, suspension, or revocation of the license and the imposition of a fine.

DATE: _____ SIGNED: _____
(NAME AND TITLE)

DATE: _____ SIGNED: _____
(NAME AND TITLE)

For all facilities to be newly licensed as an ambulatory surgical center (He-P 812), hospital (He-P 802), birthing center (He-P 810), walk in care center (He-P 806), dialysis center (He-P 811), or special health care service (He-P 802 and He-P 827) located within a 15 mile radius of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. section 485.610 (b) and (c):

I affirm that I have complied with 151:4-a and a determination is on file with the department that finds the proposed health care facility shall be allowed to apply for licensure.

DATE: _____ SIGNED: _____
(NAME AND TITLE)

DATE: _____ SIGNED: _____
(NAME AND TITLE)

HFA OFFICE USE ONLY

CHECK NUMBER: _____ AMOUNT: _____
APPLICATION COMPLETE: _____ NOT COMPLETE: _____
(Describe in comments)

NEW ☐ RENEWAL ☐ CHANGE ☐

QUALIFICATIONS OF ADMINISTRATOR	Required	☐	Not Required	☐	Received	☐
COPY OF ADMINISTRATOR LICENSE	Required	☐	Not Required	☐	Received	☐
LIST OF EMPLOYEES WITH WAIVERS	Required	☐	Not Required	☐	Received	☐
WATER TEST (INITIAL OR 3YR)	Required	☐	Not Required	☐	Received	☐
FLOOR PLAN*	Required	☐	Not Required	☐	Received	☐
SECRETARY OF STATE INFORMATION	Required	☐	Not Required	☐	Received	☐
LOCAL APPROVAL	Required	☐	Not Required	☐	Received	☐
LSC INSPECTION	Required	☐	Not Required	☐	Received	☐
LSC PLAN OF CORRECTION	Required	☐	Not Required	☐	Received	☐
LICENSURE INSPECTION	Required	☐	Not Required	☐	Received	☐
PLAN OF CORRECTION	Required	☐	Not Required	☐	Received	☐
COMPLIED WITH RSA 151:4-a	Required	☐	Not Required	☐	Received	☐

FEDERAL FACILITY (EXEMPT FROM INSPECTION) YES ☐ NO ☐

LICENSURE CATEGORY:

☐ 02 Hospitals (General, CAH, Psychiatric, Rehabilitation)
☐ 03 Nursing Homes
☐ 04 Residential Care Home Facility
☐ 05 Supported Residential Health Care Facility
☐ 06 Non-Emergency Walk-in Care
☐ 07 Residential Treatment & Rehabilitation Facility
☐ 09 Home Health Care Provider
☐ 10 Birthing Center
☐ 11 End Stage Renal Disease Dialysis
☐ 12 Ambulatory Surgical Center
☐ 14 Community Residence
☐ 15 ICF/IID
☐ 16 Educational Health Services
☐ 18 Adult Day Care
☐ 19 Case Management
☐ 22 Home Care Service Provider
☐ 23 Home Hospice Care Provider
☐ 24 Hospice House
☐ 26 Substance Use Disorder Res Treatment Facility
☐ 27 Freestanding Megavoltage Radiation Therapy
☐ 30 Psychiatric Residential Treatment

REVIEWED BY: _____
(NAME & TITLE) (DATE)

ISSUE ANNUAL LICENSE: YES _____ NO _____

LICENSE CERTIFICATE DATES: FROM _____ TO _____

NUMBER OF PATIENTS/STATIONS/BEDS: _____

NOTES:

COMMENTS ON CERTIFICATE: