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/oos/bhfa/rules.htm

Check all applicable items:

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

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

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
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
Residential Rehabilitation Substance Use Disorder Facilities (826)	$25 per licensed bed
Freestanding Megavoltage Radiation Therapy Facility (827)	$500
Acute 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:

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, for the administrator and medical director **(if applicable)**. **(Yearly)**

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). **(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-P 809. 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 from the NH Department of Safety for the applicant(s), the licensee (owner even if entity) if different than the applicant, the administrator, 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;
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:

I certify that I have notified the public of the intent to file this application with a description of the facility to be licensed by publishing a notice in a newspaper of general circulation covering the area where the facility is to be located in at least 2 separate issues of the newspaper no less than 10 business days prior to the filing of this application.

DATE: _____ SIGNED: _____
(NAME AND TITLE)

DATE: _____ SIGNED: _____
(NAME AND TITLE)

For all facilities to be newly licensed and to be located within a radius of 15 miles of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. section 485.610 (b) and (c): If not sure if you are within 15 miles of a critical access hospital please call the office number on front of application.

I certify that the facility is to be located within a radius of 15 miles of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. 485.610 (b) and (c), and that I have given written notice of the intent to file this application with a description of the facility to be licensed to the chief executive officer of the hospital by registered mail no less than 10 business days prior to the filing of this application.

DATE: _____ SIGNED: _____
(NAME AND TITLE)

DATE: _____ SIGNED: _____
(NAME AND TITLE)

Signature required for only facilities to be licensed under the listed categories

I understand that, in accordance with RSA 151:4, III(a)(7), this facility cannot be licensed pursuant to He-P 802, 806, 810, 811, 812, 816, 823, or 824 if it is within a radius of 15 miles of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. 485.610 (b) and (c), until the Commissioner makes a determination that the proposed new facility will not have a material adverse impact on the essential health care services provided in the service area of the critical access hospital. I also understand that if the Commissioner is not able to make such a determination, the license will not be issued.

DATE: _____ SIGNED: _____
(NAME AND TITLE)

DATE: _____ SIGNED: _____
(NAME AND TITLE)

BHFA 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	☐
WITHIN 15 MILES OF CAH LETTERS SENT	Required	☐	Not Required	☐	Received	☐
PUBLICATIONS IN NEWSPAPERS	Required	☐	Not Required	☐	Received	☐

FEDERAL FACILITY (EXEMPT FROM INSPECTION) YES ☐ NO ☐

LICENSURE CATEGORY:

☐ 02 Hospitals (CAH, Rehabilitation, Psychiatric and FSER)
☐ 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/MR
☐ 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 Residential Treatment – Substance Use
☐ 27 Freestanding Megavoltage Radiation Therapy
☐ 30 Acute 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:

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, New Hampshire 03301-3857
TDD Access: Relay NH 1-800-735-2964
Agency Phone Number: 800-852-3345, Extension 9039 or 603-271-9039

The facility listed below is requesting through the Department of Health and Human Services the following action:

- ☐ Initial Licensing
- ☐ A change in current licensing category
- ☐ Renovation of Existing Building
- ☐ New Construction and/or Addition to Existing Building
- ☐ An increase in current licensed beds / ESRD stations/ or Adult Day Clients

Please note: All applicants must have this form filled out by the local officials, even if they do not see clients at their place of business. This is to confirm that the local authorities are aware that a business is operating at the identified location and that the business complies with all local ordinances.

Local authorities please complete and sign each section.

FACILITY/ESTABLISHMENT NAME: _____
STREET ADDRESS: _____
OWNER'S NAME: _____
ADMINISTRATORS NAME: _____
TELEPHONE NUMBER: _____
PROPOSED TYPE OF FACILITY: _____

HEALTH OFFICER

I HEREBY CERTIFY THAT _____
COMPLIES WITH ALL APPLICABLE HEALTH, SEWAGE AND WATER REGULATIONS FOR THE CITY/TOWN OF _____.

I HEREBY CERTIFY THAT _____ DOES NOT REQUIRE HEALTH, SEWAGE AND WATER APPROVAL OF THIS FACILITY/ESTABLISHMENT.

NUMBER OF BEDS/CLIENTS: _____ NUMBER OF ESRD* STATIONS: _____ N/A: _____

DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF HEALTH OFFICIAL)

BUILDING REGULATIONS

I HEREBY CERTIFY THAT _____
COMPLIES WITH ALL APPLICABLE BUILDING REGULATIONS FOR THE CITY/TOWN OF _____.

I HEREBY CERTIFY THAT _____ DOES NOT HAVE LOCAL BUILDING CODES OR REGULATIONS.

NUMBER OF BEDS/CLIENTS: _____ NUMBER OF ESRD* STATIONS: _____ N/A: _____

DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF BUILDING OFFICIAL)

ZONING REGULATIONS

I HEREBY CERTIFY THAT _____
COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF
_____.

I HEREBY CERTIFY THAT _____ DOES
NOT HAVE LOCAL ZONING REGULATIONS.

NUMBER OF BEDS/CLIENTS: _____ NUMBER OF ESRD* STATIONS: _____ N/A: _____

DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF ZONING OFFICIAL)

FIRE REGULATIONS

THIS CITY/TOWN USES THE FOLLOWING FIRE CODES: (EXAMPLE NFPA 101 (2003 EDITION)
CHAPTER _____.)

_____
_____
_____

☐ I HEREBY CERTIFY THAT _____ FD HAS INSPECTED _____
ON _____ AND OBSERVED THE FOLLOWING VIOLATIONS:

_____
_____
_____

☐ I HEREBY CERTIFY THAT _____ FD HAS INSPECTED _____
ON _____ AND FIND THAT ON THE DATE OF INSPECTION NO VIOLATIONS OF THE FIRE CODE ADOPTED BY THE STATE FIRE MARSHAL AND/OR LOCAL MUNICIPAL CODES WERE OBSERVED.

☐ I HEREBY CERTIFY THAT _____ FD HAS INSPECTED _____
ON _____ AND ALL PREVIOUSLY VIOLATIONS NOTED HAVE BEEN CORRECTED.

NUMBER OF BEDS/CLIENTS: _____ NUMBER OF ESRD* STATIONS: _____ N/A: _____

DATE: _____ SIGNATURE: _____
(FIRE CHIEF OR DESIGNEE)

* ESRD = End Stage Renal Dialysis

COMMENTS: