DHHS Public Health Licensure Unit
PO Box 94669
Lincoln NE 64669-4669
402-471-3484
DHHS.acutecarefacilities@nebraska.gov

# Health Clinic Initial Licensure APPLICATION

Health Clinic licenses expire 2/28 of each year

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

## Section 1: TYPE of HEALTH CLINIC

Type of HEALTH CLINIC: Choose ONE.

- ☐ Public Health Clinic
- ☐ Ambulatory Surgical Center
- ☐ ESRD facility providing hemodialysis services
- ☐ Labor & Delivery Services (and not licensed as any other facility type)
- ☐ Facility providing 10 or more abortions per calendar week
- ☐ Rural Health Clinic (wanting to be licensed as a Health Clinic)
- ☐ Other (please specify below)

## Section 2: APPLICATION TYPE

1. Choose ONE:

- ☐ Initial License
- ☐ Change of Location
- ☐ Change of Ownership

## Section 3: PROVIDER INFORMATION

1. The preferred name/position of person to receive official notices from the Department:

2. Facility DBA name (if applicable):

3. Legal name and physical address of facility:

4. Generic e-mail address for official notices from Department:

5. Administrator Name:

6. Facility phone number:

7 Facility fax number:

8. Date you would prefer to begin services:

9. **ASC's ONLY:** Number of operating/procedure rooms:

- ☐ ONE
- ☐ 2 to 3
- ☐ 4 or more

10. Is the facility planning on being accredited OR is the facility currently accredited?

- ☐ Y
- ☐ N

If YES, which Accrediting Organization is the facility utilizing:

- ☐ Accreditation Association for Ambulatory Health Care (AAAHC)
- ☐ American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
- ☐ American Osteopathic Association/Healthcare Facilities Accreditation Program (HFAP)
- ☐ Institute for Medical Quality (IMQ)
- ☐ The Compliance Team (TCT)
- ☐ National Dialysis Accrediting Commission (NDAC)

Facility Name:

## Section 4: OWNERSHIP INFORMATION

1. Please enter the legal name and mailing address of the **OWNER** of the facility below:

A) If a CORPORATION, LIMITED LIABILITY COMPANY or GOVERNMENTAL, enter the company name and mailing address:

B) If an INDIVIDUAL, enter the owner's personal name and mailing address:

2. What is the facility's ownership type? ☐ Governmental Individual/Sole ☐ Limited Liability Company ☐ Proprietorship ☐ Corporation

3. What is the facility's Federal Employer Identification Number:

4. Is the facility? Check **ONE**: ☐ Non-profit ☐ For-profit

5. If identified as a CORPORATION - List the names of the CORPORATE OFFICERS:
(As specified on the Secretary of State website - i.e, President, Vice President, Secretary, Treasurer):

6. If identified as a GOVERNMENTAL UNIT - List the name of the head of the Governmental unit having jurisdiction over the facility:

7. If identified as a LIMITED LIABILITY COMPANY - List the members of that company.

## Section 5: REQUIRED SIGNATURES

**Neb. Rev. Stat. Section 71-433 REQUIRES the application to be signed by:** (Please refer to your responses to Section 3 above):

1. **INDIVIDUAL/SOLE PROPRIETORSHIP:** the individual owner
2. **LIMITED LIABILITY COMPANY:** two of the members of that company
3. **CORPORATION:** two of the officers of the CORPORATION
4. **GOVERNMENTAL:** the head of the governmental unit having jurisdiction over the facility or a person with written authorization to sign (if this is applicable, please include written documentation indicating the authorization with this renewal form)

## Section 6: ACCEPTANCE/SIGNATURES OF THE OWNER(S) AS THE LICENSEE

**I/we agree to comply with the rules and regulations issued by the Department of Health & Human Services, Title 175 Chapter 7 licensure regulations for Health Clinics. I/we accept responsibility for compliance with these regulations. I/we certify to the best of my/our knowledge that the information and statements on or attached to this application are true and correct, and hereby apply for a license:**

Printed name/title of authorized person(s) as identified in Sections 3 and 4:

**SIGNATURE:** **DATE:**

Printed name/title of authorized person(s) as identified in Sections 3 and 4 (IF APPLICABLE):

**SIGNATURE:** **DATE:**

## ----------Section 7: SUBMIT THE FOLLOWING WITH YOUR APPLICATION----------

The following information is required to be submitted and received by our office before your application can be processed:

1. **FEE(s):**
   (A) For **PUBLIC HEALTH CLINICS,** the fee is: $400
   (B) For other **HEALTH CLINICS EXCEPT Ambulatory Surgical Centers**, the fee is: $600
   (C) For **AMBULATORY SURGICAL CENTERS,** the fee depends on the number of operating/procedure rooms:
      a. 1 operating/procedure room $1250
      b. 2 to 3 operating/procedure rooms $1350
      c. 4 or more operating/procedure rooms $1450

Please make the check payable to **DHHS Licensure Unit** and **MAIL** it with your initial licensure documents to the address on the top of this renewal form.

2. **OCCUPANCY CERTIFICATE/PERMIT.** This must come from the State Fire Marshal's office or delegated authority and be dated within the past 18 months. Please make sure the NAME, FACILITY TYPE and ADDRESS on the Certificate match the name, address and type of the facility or it will not be accepted.

3. A **LIST OF PERSONS IN CONTROL** of the facility

4. A **COPY OF REGISTRATION AS A FOREIGN CORPORATION** filed with the Nebraska Secretary of State Office, if applicable.

5. A **FLOOR PLAN or SCHEMATIC DRAWING** of the facility identifying all operating/procedure rooms, handwashing stations, treatment rooms, medication storage rooms, entrances and exits.

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Name and contact information of person to contact if the Department has questions about this application

E-mail

Phone