New Jersey Department of Health
Office of Certificate of Need and Healthcare Facility Licensure
PO Box 358
Trenton, NJ 08625-0358

APPLICATION FOR NEW OR AMENDED ACUTE CARE FACILITY LICENSE

LICENSURE AND CONSTRUCTION REQUIREMENTS

LICENSURE REQUIREMENTS

General

Licensure by the Department of Health, Office of Certificate of Need and Healthcare Facility Licensure is mandatory **PRIOR TO** commencement of new or expanded services. To be licensed as an operator of a health care service in New Jersey, all of the applicable licensing requirements for that service must be met. This includes both physical plant and operational requirements. To obtain the licensing standards for the proposed service and/or additional information regarding the licensure process, please call:

609-292-6552	Team A: for facilities located in Bergen, Hudson, Mercer, Morris, Passaic, Somerset, Sussex and Warren Counties
609-633-9042	Team B: for facilities located in Burlington, Gloucester, Hunterdon, Middlesex, Monmouth and Ocean Counties
609-292-7228	Team C: for facilities located in Atlantic, Camden, Cape May, Cumberland, Essex, Salem and Union Counties

Application Filing

Forty-five (45) days prior to your planned opening, ***one original and two copies*** of a completed license application form, license application fee, biennial inspection fee (if applicable), floor plan (if applicable), and all out-of-state track record reports shall be submitted to the Department of Health, Office of Certificate of Need and Healthcare Facility Licensure, PO Box 358, Trenton, NJ 08625-0358. A schedule of fees for licensure and inspection is attached. The licensing/inspection fee shall be in the form of a certified check or money order made payable to *"Treasurer, State of New Jersey."*

Track Record Requirements

Please be advised that in making a determination as to the applicant's capacity to operate a health care facility/service, the Department will consider the applicant's prior operating history, both in New Jersey and in other states. Any evidence of licensure violations representing a serious risk of harm to patients, or any record of criminal convictions representing a risk of harm to the safety or welfare of patients may result in denial of the applicant's application for licensure. All health care facilities owned, operated or managed by the applicant and any principals of the applicant entity which are similar or related to the service which is the subject of the application must be disclosed. For the purposes of this application, similarity or relatedness of any two services is determined by the inclusion of two services together in one of the following categories:

(1) The acute care category, which includes hospital services such as medical/surgical, pediatric, obstetric, cardiac, psychiatric, and intensive care/critical care; comprehensive rehabilitation; surgical services; magnetic resonance imaging and computerized tomography, lithotripsy; renal dialysis; and birth centers.

(2) The ambulatory care and other category, which includes primary care, home health care, family planning, drug counseling, abortion, ambulatory surgery, and outpatient rehabilitation.

(3) The substance abuse treatment category, which includes residential alcohol treatment, residential drug treatment, and outpatient drug treatment.

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LICENSURE AND CONSTRUCTION REQUIREMENTS (Continued)

Track record reports from out-of-state agencies responsible for licensing these health care facilities must be submitted WITH YOUR LICENSE APPLICATION. Out-of-state track record reports are not required for diagnostic health care facilities/services (e.g., magnetic resonance imaging). The license application will be returned if all required out-of-state track record reports are not provided at the time the license application is filed. Each out-of-state track record report must indicate the history of compliance with standards in the state for the 12 months preceding application submission, as well as a description of any non-compliance, penalties imposed, duration of non-compliance and corrective actions taken.

Operational Survey

Forty-five (45) days prior to your planned opening, contact the Ambulatory/Medicare Inspections Unit (ambulatory care facilities), the Hospital Inspections Unit (hospitals) at (609) 292-9900 or the Division of Addiction Services Inspections Program (residential substance abuse treatment) at (609) 292-0961 to arrange for an operational survey. The licensing standards for the proposed service shall be reviewed for compliance **PRIOR TO** a request for an operational survey. At the time of the operational survey, all written policies and procedures, contracts, plans approved and stamped by the Department of Community Affairs (if applicable), copy of the certificate of occupancy and transfer agreements required by licensure standards must be complete and available to the surveyor.

Functional Review

The Department highly recommends that prospective applicants contact the Department to schedule a functional review to discuss their proposed project included but not limited to physical plant plans, policies and procedures, licensing protocols and applicable rules and regulations. Please schedule the review in accordance with the county in which the facility is located. It is also highly recommended that this functional review occur prior to the submission of any construction plans to the Department of Community Affairs.

CONSTRUCTION REQUIREMENTS

If new construction and/or renovations **ARE** required, architectural plans must be submitted to the Department of Community Affairs, Division of Codes and Standards, Health Care Plan Review, 101 South Broad Street, PO Box 815, Trenton, NJ 08625-0815 (Telephone 609-633-8151, FAX 609-633-8229). You may not proceed with any construction or renovations until you have received final construction plans approval. Upon completion of construction and/or renovations, written notification and a copy of the certificate of occupancy must be submitted to the Department of Community Affairs.

If new construction and/or renovations **ARE NOT** required, a floor plan of the facility must be submitted with your license application. This plan shall indicate the dimensions and use of each room, door swing direction, corridor widths, exit locations, and locations of all toilets and sinks. You must also note whether the bathrooms and premises are handicapped accessible, in accordance with the latest ADA requirements. You must also submit documentation that the existing unit complies with applicable fire signaling systems and egress requirements and note locations of pull stations, emergency fixtures, and fire extinguisher locations on the plan.

ISSUANCE OF LICENSE

A license will be issued by the Office of Certificate of Need and Healthcare Facility Licensure upon receipt of a letter of approval from the Department of Community Affairs for construction or renovation, compliance with all regulatory requirements based on the operational survey, copy of the certificate of occupancy and receipt and approval of the application for licensure. You MAY NOT proceed with initiation of new or expanded services until you have received occupancy approval from the Office of Certificate of Need and Healthcare Facility Licensure.

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IMPORTANT: Complete and forward an original and two (2) copies to the above address. Please retain a copy for your records.

FOR STATE USE ONLY

Team	☐Approval ☐Denial	Amount Received License Application Fee $ _____ Biennial Inspection Fee $ _____ TOTAL $ _____
Facility ID No.	Date Received ____ / ____ / ____	
Reviewer Signature		Date

Type of Application

- ☐ New Facility - CN # _____
- ☐ New Facility - CN Exempt (N.J.S.A. 26:2H-7a)
- ☐ Amendment Facility ID No. _____

Type of Amendment

- ☐ Bed/Service Addition
- ☐ Bed/Service Reduction
- ☐ Transfer of Ownership (Licensed facilities as provided for at N.J.S.A. 26:2H-7a and N.J.A.C. 8:33-3.3(b) only)
- ☐ Relocation
- ☐ Change in Name of Operating Entity
- ☐ Change in Name of Facility

Official Name of Facility *	Operating Entity/Operator *
Site Address County	Street Address
City State Zip Code	City State Zip Code
Telephone Number ( )	Fax Number ( ) / Telephone Number ( )
Name of Facility Administrator/Director/CEO	Name of Management Company, If Applicable (Submit copy of management agreement.)
Title	Address
Name of Contact Person	City State Zip Code
Telephone Number ( )	Telephone Number ( )
Name of Emergency Contact Person	Name of Management Company Contact Person
Emergency Telephone Number	Title

** The official name of facility and operating entity will appear on the license. Please provide complete and accurate information. Please complete the application as to the name, address and telephone number for both the facility and operator even when the information is the same. As used in this application, "operator" or "operating entity" refers to the person or entity which is the holder of the facility license (i.e., licensee) and which has the ultimate responsibility for the provision of health care services.*

APPLICATION FOR NEW OR AMENDED ACUTE CARE FACILITY LICENSE, CONTINUED

Name of Facility

SECTION I - INPATIENT FACILITIES

Type of Facility (Check one)

☐General Acute Care Hospital ☐Psychiatric Hospital ☐Residential Substance Abuse Treatment Facility
☐Comprehensive Rehabilitation Hospital ☐Special Hospital ☐Pediatric Community Transitional Home Facility

Beds and Services	New Facility Proposed Capacity/ Services	Current Licensed Capacity/ Services	Total Change (+) or (-)	Revised Capacity/ Services
Medical/Surgical Beds				
OB/GYN Beds ☐LDRP				
Pediatric Beds				
Adult ICU/CCU Beds				
Pediatric ICU Beds				
Psychiatric - Adult Acute				
- Adult Closed Acute				
- Adult Intermediate/Specialized				
- Child/Adolescent Acute				
- Child/Adolescent Intermediate				
Alcohol Detoxification Beds (Hospital Based)				
Comprehensive Rehabilitation Beds				
Burn Unit				
TOTAL BEDS				
Neonatal Bassinets - Intensive				
- Intermediate				
Operating Rooms - Inpatient (Excl. Cardiac)				
- Same Day Surgery				
- Mixed-Use				
- Cardiac Surgery-Adult				
- Cardiac Surgery-Pediatric				
Cystoscopy Rooms				
Cardiac Catheterization Labs - Adult				
- Pediatric				
- Low Risk				
Transplantation Services - Bone Marrow				
- Heart				
- Kidney				
- Liver				
- Lung				
- Pancreas				
Renal Services - Acute Hemodialysis				
- Chronic Hemodialysis Stations				
- Chronic Peritoneal				
- CAPD/Home Training				
Linear Accelerator				
Cobalt Units				
Magnetic Resonance Imaging Unit - Open				
- Closed				
- Fixed				
- Mobile				
Computerized Axial Tomography - Fixed				
- Mobile				
Pediatric Community Transitional Home (PCTH) Beds				
Sleep Lab(s)				
Other (specify):				

APPLICATION FOR NEW OR AMENDED ACUTE CARE FACILITY LICENSE, CONTINUED

Name of Facility

SECTION I - INPATIENT FACILITIES, CONTINUED

Beds and Services	New Facility Proposed Capacity/ Services	Current Licensed Capacity/ Services	Total Change (+) or (-)	Revised Capacity/ Services
Lithotripter - Fixed				
- Mobile				
- Transportable				
Positron Emission Tomography - Fixed				
- Portable				
- CT Unit				
Hyperbaric Chamber				
Gamma Knife				
Designations - CPC-Basic				
- CPC-Intermediate				
- CPC-Intensive				
- Regional Perinatal Center				
- Children's Hospital				
- Level I Trauma				
- Level II Trauma				
Hospital-Based Off-Site Ambulatory Care Facility *				
Residential Substance Abuse Treatment Beds - Extended Care Adult				
- Extended Care Adult Female				
- Extended Care Adult Male				
- Extended Care Juvenile				
- Extended Care Juvenile Female				
- Extended Care Juvenile Male				
- Halfway House Adult				
- Halfway House Adult Female				
- Halfway House Adult Male				
- Halfway House Juvenile				
- Halfway House Juvenile Female				
- Halfway House Juvenile Male				
- Long Term Adult				
- Long-Term Adult Female				
- Long-Term Adult Male				
- Long-Term Juvenile				
- Long-Term Juvenile Female				
- Long-Term Juvenile Male				
- Short-Term Adult				
- Short-Term Adult Female				
- Short-Term Adult Male				
- Short-Term Juvenile				
- Short-Term Juvenile Female				
- Short-Term Juvenile Male				
- Non-Hosp. Based Detox. Adult				
- Non-Hosp. Based Detox. Adult Female				
- Non-Hosp. Based Detox. Adult Male				
- Non-Hosp. Based Detox. Juvenile				
- Non-Hosp. Based Detox. Juvenile Female				
- Non-Hosp. Based Detox. Juvenile Male				
Long Term Care Beds **				
Sub-Acute Beds **				
Adult Day Health Care Slots **				

* In addition to the application to amend the hospital's license, a separate license application, with applicable fee, must be submitted for each ambulatory care facility, as well as documentation of compliance with N.J.A.C. 8:43G-2.11.

** For record keeping purposes only, license is issued by Long Term Care Licensing Program.

APPLICATION FOR NEW OR AMENDED ACUTE CARE FACILITY LICENSE, CONTINUED

Name of Facility

SECTION II - AMBULATORY CARE FACILITY

Services Provided	New Facility Proposed Capacity/ Services	Current Licensed Capacity/ Services	Total Change (+) or (-)	Revised Capacity/ Services
Ambulatory Surgery Operating Rooms				
Birth Center				
Community Based Primary Care				
Community Based Primary Care Satellite				
Comprehensive Outpatient Rehabilitation				
Computerized Axial Tomography - Fixed				
- Mobile				
Drug Abuse Treatment (Outpatient)				
Drug Abuse Treatment (Methadone Maintenance)				
Lithotripter - Fixed				
- Mobile *				
- Transportable				
Family Planning				
Family Planning Satellite				
Home Health Agency **				
Home Health Agency Branch Office **				
Hospice				
Hospice Branch Office				
Hyperbaric Chamber				
Magnetic Resonance Imaging - Open				
- Closed				
- Mobile *				
- Portable				
Renal - Chronic Hemodialysis Stations				
- Chronic Peritoneal				
- CAPD/Home Training				
Linear Accelerator				
Positron Emission Tomography - Fixed				
- Portable				
- CT Unit (Comb.)				
Sleep Lab(s)				
Other Services (specify):				

* Identify name of manufacturer, serial number, and all locations served by mobile MRI/Lithotripter/PET Scanner.

** Identify Home Health Agency service area:

SECTION III - OPERATING ENTITY

Type of Operating Entity

☐ Sole Proprietorship ☐ Limited Liability Company ☐ Corporation - For Profit *
☐ General Partnership ☐ Professional Association ☐ Corporation - Nonprofit *
☐ Limited Partnership ☐ Government Agency **(Attach list of the names and addresses of board of directors/trustees)**

* NOTE: If the corporate entity is a wholly-owned subsidiary, please identify the parent corporation:

Name and Title of Individual or Current Registered Agent Upon Whom Orders May be Served (Must be NJ Resident)

Residence Address City State Zip Code

Name of Facility

SECTION III - OPERATING ENTITY, CONTINUED

PRINCIPALS IN OPERATING ENTITY

Attach a list of the names and addresses of partners/stockholders and identify 100% of the ownership, except that for publicly held corporations, identify each principal who has a 10% or greater interest in the corporation. Applicants for transfer of ownership shall provide information for the PROPOSED operator.

1. Have any of the principals of the operating entity ever applied, directly or indirectly, for health care facility approval in New Jersey, or any other state, which was denied or revoked?

☐Yes ☐No

If Yes, indicate whom and give details (attach additional sheets if necessary):

2. Do any of the principals of the operating entity have an ownership, operational or management interest in any other licensed health care facility in New Jersey, or any other state?

☐Yes ☐No

If Yes, explain the nature of the interest and give name and address of each facility:

3. Have any principals of the operating entity ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect? Have any of these ever been indicted for the same charge?

☐Yes ☐No

If Yes, explain in detail (attach additional sheets if necessary):

4. Have any principals of the operating entity ever been indicted for or convicted of a felony crime?

☐Yes ☐No

If Yes, explain in detail (attach additional sheets if necessary):

APPLICATION FOR NEW OR AMENDED ACUTE CARE FACILITY LICENSE, CONTINUED

Name of Facility

AFFILIATED HEALTH CARE FACILITIES

Identify the name, address and Medicare Provider Number of all health care facilities, both in New Jersey and in any other state, which are owned, operated or managed by the applicant, any principals or any corporate entity related to the applicant (e.g. parent or subsidiary) which is similar or related to the service which is the subject of the application. If licensed out-of-state facilities are listed, submit track record reports for the preceding 12 months from the respective state agencies responsible for licensing those facilities. Attach additional sheets as necessary.

Name and Address of Facility	Medicare Provider Number

CERTIFICATION

I, _____ of full age, hereby certify that I am employed with _____ in the capacity of _____ and am duly authorized to make the representations contained within this application for licensure on behalf of the applicant and to bind the applicant thereto; that the facility has been and will be operated in accordance with all applicable laws, rules and regulations, both state and federal; and that all information supplied in this application, including any and all attachments, are true, accurate and correct to the best of my knowledge. I am aware that if any of the information contained in this application, including any and all attachments, are willfully false or misleading, I and the applicant may be subject to civil and/or criminal penalties in accordance with applicable laws and/or other licensure enforcement activity, including, but not limited to facility loss of license in accordance with N.J.A.C. 8:43E.

Name of Operator or Authorized Representative ☐Mr. ☐Ms.	Title
Signature	Date

FOR TRANSFER OF OWNERSHIP

Name of Proposed Operator or Authorized Representative ☐Mr. ☐Ms.	Title
Signature	Date
Name of Current Operator or Authorized Representative ☐Mr. ☐Ms.	Title
Signature	Date

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