Office of Health Systems Development
Center for Health Systems Policy and Planning
Rhode Island Department of Health
Three Capitol Hill, Room 410
Providence, RI 02908-5097
Phone: (401) 222-2788
Website:Office of Health Systems Development

Initial Licensure Application Instructions

Please submit **an electronic copy as a single pdf file that is *EDITABLE*** [to: Paula.Pullano@health.ri.gov with a copy (Cc) to: Jim.Suah@health.ri.gov] of the completed application to the Office of Health Systems Development, Rhode Island Department of Health, Three Capitol Hill, Room 410, Providence, Rhode Island 02908. Upon submission, the application will be reviewed for acceptability, and the applicant will be notified of any deficiencies if the application has been found not acceptable in form. All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788.

Regulatory Requirements: Completion and submission of this application is a prerequisite to licensure of a new health care facility. This application should be completed after a thorough review of Title 23, Chapter 17 of the General Laws of Rhode Island, as amended, and the Rules and Regulations for the specific license being sought (see below):

- ❑ Rules and Regulation for Licensing of Kidney Disease Treatment Center (216-RICR-40-10-12);
- ❑ Rules and Regulation for Licensing of Organized Ambulatory Care Facility (216-RICR-40-10-3);
- ❑ Rules and Regulation for Licensing of Birth Center (216-RICR-40-10-8);
- ❑ Rules and Regulation for Licensing Home Nursing Care Providers and Home Care Providers (216-RICR- 40-10-17);
- ❑ Rules and Regulation for Licensing of Freestanding Ambulatory Surgical Centers (216-RICR-40-10-5);
- ❑ Rules and Regulation for Licensure of Physician Ambulatory Surgery Centers and Podiatry Ambulatory Surgery Centers (216-RICR-40-10-13);
  (Applies only to Multi-Practice Physician Ambulatory Surgery Centers and Multi-Practice Podiatry Ambulatory Surgery Centers)
- ❑ R.I. Gen. Laws § 23-17-2 (17) and (18)

Additional Questions: Please note that RIDOH reserves its right to request additional information and pose additional questions as part of the application.

Format: Full responses to each question must be provided and references to other responses shall not be accepted as a complete response. **The electronic submission must include electronic links ("hyperlinks")** to the applicable tab when responding to questions where attachments have been provided as a response within the application. Applications should not include the instruction pages nor appendices not applicable to the application proposal. The application should be completed in a typewritten format. A table of contents must be included to identify the specific location of responses to questions. When resubmitting an application, please include the date of resubmission on the cover page with an updated attestation page signed and dated by the President or Chief Executive Officer and Notary Public.

Timeframe: Regulations recognize a ninety-day review time frame once an application is accepted for review.

Legal Fees: In addition to the application fee, please be advised that you may be charged for Department's costs for legal services performed with regards to the review of the application [pursuant to RIGL 23-1-53].

Application Fee: The application must be accompanied by an appropriate fee, in the form of a check made out to the "General Treasurer of Rhode Island" in the amount of (0.002 times the Total Revenue projected for the first full fiscal year (Appendix A # 4)), $1,500 minimum to $50,000 maximum. **The fee is non-refundable**. **Applications without fees will not be reviewed for acceptability.**

All checks are to be mailed to: Rhode Island Department of Health, Three Capitol Hill, Suite 410, Office of Health Systems Development, Providence, Rhode Island, 02908, with a follow up confirmation email to: Paula.Pullano@health.ri.gov

INITIAL LICENSURE APPLICATION
Version 7.2026

Legal Name of Applicant:
Name of Proposed Facility:
Date Application Submitted (MM/DD/YYYY):
Date Application Resubmitted (MM/DD/YYYY):
Amount of Fee:

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788

Please have the appropriate individual attest to the following:

"I hereby certify under penalty of perjury that the information contained in this application is complete, accurate, and true."

_____
signed and dated by the President or Chief Executive Officer

_____
signed and dated by Notary Public

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1. Requested Facility License (select only 1 per application):

	Kidney Disease Treatment Centers (216-RICR-40-10-12)
	Organized Ambulatory Care Facility (216-RICR-40-10-3)
	(Outpatient) Birth Center (216-RICR-40-10-8)
	Home Nursing Care Providers and Home Care Providers (216-RICR-40-10-17)
	Freestanding Ambulatory Surgical Centers (216-RICR-40-10-5)
	Physician Ambulatory Surgery Centers and Podiatry Ambulatory Surgery Centers (216-RICR-40-10-13) (Applies only to: Multi-Practice Physician Ambulatory Surgery Centers and Multi- Practice Podiatry Ambulatory Surgery Centers)
	R.I. Gen. Laws § 23-17-2 (17) and (18)

2. Please provide an Executive Summary describing the nature and scope of the application which should at least include the following: (1) identification of all parties and their track record and experience, (2) the types of services to be offered, (3) operational information about the proposed facility (hours of operation, whether the site if leased or owned, geographic area to be served, estimated date of when service will start being offered, if approved), (4) whether the applicant will seek professional accreditation from a nationally recognized accrediting agency (e.g. CHAP, TJC, etc.).

3. Legal name and address of the applicant (i.e., the proposed licensee):

Name:	Telephone:
Address:	Zip Code:

4. Information of the President or Chief Executive Officer of the applicant:

Name:	Telephone:
Address:	Zip Code:
E-Mail:	Fax:

5. Information for the person to contact regarding this application (only if different from the President/CEO in Question 4):

Name:	Telephone:
Address:	Zip Code:
E-Mail:	Fax:

6. Applicant's legal status: ___ Sole Proprietorship ___ Partnership

___ Corporation ___ Limited Liability Corporation

Applicant's tax status: ___ For-Profit ___ Not-For-Profit

7. Please attach a job description for the facility administrator's position:

8. Will the facility be operated under or assisted by a management, a consultant, or other like agreement? Yes___ No ___

❑ If the response to Question 8 is "Yes", please provide copies of that agreement.

9. Will the facility offer healthcare services provided under contract with an outside party? Yes___ No ___

❑ If response to Question 9 is "Yes", please identify and describe those services to be contracted out.

10. For all plans for new construction or the renovation, alteration, extension, modification or conversion of an existing facility, the plans must be reviewed by a licensed architect acceptable to the Director. Please provide a copy of the architect's signed certification stating that the plans comply with the construction requirements outlined in the applicable rules and regulations.

❑ In the event of non-conformance with any construction requirements for which the facility seeks variance(s), please include details of the non-conformance for which the variance(s) is sought and alternate provisions made, as well as detailing the basis upon which the request is made.

11. Please demonstrate that the facility, as proposed, will be in full compliance with all applicable rules and regulations and not require any variances (apart from any variance(s) requested for the physical facility as outlined in Question 10).

❑ If the facility finds that a literal enforcement of the provisions of any rule and regulation will result in unnecessary hardship to the applicant and that such variance(s) will not be contrary to the public interest, public health and/or health and safety of patients, please include details of the non-conformance for which the variance(s) is sought and alternate provisions made, as well as detailing the basis upon which the request is made.

12. Please provide an organizational chart identifying all "parent" legal entities with direct or indirect ownership in or control of the applicant, all "sister" legal entities also owned or controlled by the parent(s), and all "subsidiary" legal entities owned or controlled by the applicant.

13. For all entities identified in response to Question 12, please provide a brief narrative clearly explaining the relationship of these entities, the percent ownership the principals have in each (if applicable), and the role of each and every legal entity that will have control over the applicant.

14. Does the entity seeking licensure plan to participate in Medicare or Medicaid (Titles XVIII or XIX of the Social Security Act)?

MEDICARE: Yes___ No___ MEDICAID: Yes___ No___

❑ If the response to Question 14, for either Medicare and/or Medicaid is 'No', please explain.

15. If the proposed owner, operator or director of the proposed health care facility owned, operated or directed a healthcare facility (both within and outside Rhode Island) within the past three years, please demonstrate the record of that person(s) with respect to access of traditionally underserved populations to its health care facilities.

16. Please provide a copy of proposed charity care policies and procedures and charity care application form.

17. Please identify the proposed immediate and long-term plans of the applicant to ensure adequate and appropriate access to the program and health care services to be provided by the proposed health care facility to traditionally underserved populations.

18. Will the facility provide healthcare services (for which it is seeking licensure) to patients/clients without discrimination, including their ability to pay for services? Yes___ No___

❑ If the response to Question 18 is "No", please explain.

19. Please address the following:
- How will the applicant ensure full and open communication with their patients' primary care providers for the purposes of coordination of care.

20. Please identify and describe all instances **involving the applicant and/or its affiliates** and the status or disposition of each of the following within the past 3 years:

A. Citations, enforcement actions, violations, charges, investigations, or similar types of actions involving the applicant and/or its affiliates (including but not limited to actions or civil proceedings brought forward by any governmental agency, accrediting agency, or similar type of an agency.)

21. Please provide a detailed description of the applicant's financial capability to establish and operate the proposed facility in accordance with the Rules and Regulations.

22. Please provide legally binding evidence of site control (e.g., deed, lease, option, etc.)

sufficient to enable the applicant to have use and possession of the subject property.

23. Please provide pictures and schematics of the proposed facility in sufficient detail to show use and dimensions of the space.

24. Please provide each of the following documents applicable to the applicant's legal status:

- ❑ Certificate and Articles of Incorporation and By-Laws (for corporations)
- ❑ Certificate of Partnership and Partnership Agreement (for partnerships)
- ❑ Certificate of Organization and Operating Agreement (for limited liability corporations)

25. If the applicant or one of its parent companies (or ultimate parent) or affiliates is not a publicly traded corporation, please provide the audited financial statements for the most recent three years, if applicable.

26. If the applicant or one of its parent companies (or ultimate parent) is a publicly traded corporation, please provide copies of its most recent SEC 10K filing.

27. Select and complete the Appendices applicable to this application:

(Applications should not include appendices not applicable to the proposal)

Appendix	Check off:	Required for:
A		Financing mix, Capital Cost, Personnel, Payor Source and Operation Expenses
B		Compliance Report
C		Disclosure of Ownership and Control Interest
D		Ownership Information

Appendix A

1. Please indicate the financing mix for the capital cost of this proposal, if applicable. **NOTE:** the Health Services Council's policy requires a minimum 20 percent equity investment.

Source	Amount	Percent	Interest Rate	Terms (Yrs.)
Equity*	$	%		
Debt	$	%	%	
Lease	$	%	%	
TOTAL	**$**	**100%**		

* Equity means non-debt funds contributed towards the capital cost related to a change in owner or change in operator of a healthcare facility which funds are free and clear of any repayment or liens against the assets of the proposed owner and/or licensee and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged.

2. A) Please identify the total number of FTEs (full-time equivalents) and the associated payroll expense (with fringe benefits) required to staff this proposal.

	RAMP UP YEAR 20____		**FIRST FULL FISCAL YEAR 20____**		**SECOND FULL FISCAL YEAR 20____**	
Personnel	**Number of FTEs**	**Payroll W/Fringes**	**Number of FTEs**	**Payroll W/Fringes**	**Number of FTEs**	**Payroll W/Fringes**
Medical Director	#	$	#	$	#	$
Physicians	#	$	#	$	#	$
Administrator	#	$	#	$	#	$
Director of Nursing	#	$	#	$	#	$
APRNs	#	$	#	$	#	$
CNPs	#	$	#	$	#	$
PAs	#	$	#	$	#	$
RNs	#	$	#	$	#	$
LPNs	#	$	#	$	#	$
Nursing Aides	#	$	#	$	#	$
PTs	#	$	#	$	#	$
OTs	#	$	#	$	#	$
Speech Therapists	#	$	#	$	#	$
Clerical	#	$	#	$	#	$
Housekeeping	#	$	#	$	#	$
Other: (_____)	#	$	#	$	#	$
Other: (_____)	#	$	#	$	#	$
TOTAL:	**#**	**$**	**#**	**$**	**#**	**$**

Appendix A (cont.)

2. B) Please describe the plan for the recruitment and training of personnel and the proposed businesses plan

2. C) Please Provide a business plan for the proposed new facility that demonstrates operational and financial viability in order to establish and sustain the facility.
The business plan must include a detailed projection of operating expenses and demonstrate sufficient available funding (including personal funds) to cover the facility's working capital for operating needs (total expense). The total amount of available funding should be equal to or greater than the total projected expenses for the first six months of the **First Full Fiscal Year,** as identified in **Appendix A, Question 3. If not please explain.**

2. D) Please provide a job description for the position, demonstrating compliance with Section 17.5.3(B) of the HNCP and HCP Rules and Regulations.

Appendix A (cont.)

3. Please complete the following projected income statements for the first three years after implementation. Round all amounts to the nearest dollar.

PRO-FORMA FOR PROPOSED FACILITY				
	Ramp up Year 20___	**First Full Fiscal Year 20___**	**Second Full Fiscal Year 20___**	**Third Full Fiscal Year 20___**
REVENUES:				
Net Patient Revenue	$	$	$	$
Other: (_____)	$	$	$	$
Total Revenue	$	$	$	$
EXPENSES:	$	$	$	$
Payroll w/Fringes	$	$	$	$
Bad Debt	$	$	$	$
Supplies	$	$	$	$
Office Expenses	$	$	$	$
Utilities	$	$	$	$
Insurance	$	$	$	$
Interest	$	$	$	$
Depreciation/Amortization	$	$	$	$
Leasehold / Rent Expenses	$	$	$	$
Other: (_____)	$	$	$	$
Other: (_____)	$	$	$	$
Total Expenses	$	$	$	$
OPERATING PROFIT:	**$**	**$**	**$**	**$**

Number of Patients/Clients:	#	#	#	#
Number of Visits/Procedures:	#	#	#	#

4. All applicants must complete the table below for the Projected First Three Operating Years, by payor source. Please provide both the amounts and percentages for each payor source category.

(All Applicants)

	Projected First Three Operating Years (if approved)					
PAYOR SOURCE	**FY:_____**		**FY:_____**		**FY: 20____**	
	#	**%**	**$**	**%**	**#**	**%**
Medicare	#	%	$	%	#	%
Medicaid	#	%	$	%	#	%
Private Insurance	#	%	$	%	#	%
Workers' Comp.	#	%	$	%	#	%
Self-Pay	#	%	$	%	#	%
Tricare	#	%	$	%	#	%
Other: ( )	#	%	$	%	#	%
TOTAL:	**#**	**%**	**$**	**%**	**#**	**%**
Charity Care*	#	%	$0	0%	#	%

***** Charity care does not include bad debt and is based on costs (not charges).

(TO BE COMPLETED BY THE APPROPRIATE STATE AGENCY)

Appendix B

Rhode Island Department of Health
Office of Health Systems Development

Compliance Report

*(Legal Name of Applicant)*_____ has applied for licensure as a healthcare facility in Rhode Island. As part of the regulatory requirements to determine the character, competence and other quality related information of the applicant, the Office of Health Systems Development is requesting the following information regarding the health care facilities operated by or affiliated with the applicant, as listed on the attached sheet.

Please answer the following questions.

1. Are the agencies/facilities currently licensed and in substantial compliance with all applicable codes, rules and regulations? Yes__ No__

If the answer to #1 is "NO", please identify the facility(ies) and briefly explain the licensure status.

2. Has there been any enforcement actions against these agencies/facilities in the past three years? Yes__ No__

If the answer to #2 is "YES", please identify the facility(ies) and include any information relevant to those enforcement actions (reason for action, stipulation, fine, etc.). In addition, please furnish a brief description of the outcome of the most recent survey, including any deficiencies cited. Additional pages may be attached, if needed.

Reviewer's Name: _____ Title: _____
Department: _____ State: _____
Telephone_____ E-mail _____
Reviewer's Signature: _____ Date: _____

If you have any questions, please contact Paula Pullano at (401) 222-2788 or e-mail, Paula.Pullano@health.ri.gov. Please return the completed form within 15 days to Paula.Pullano@health.ri.gov or to the address below:

Rhode Island Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 410
Providence, Rhode Island 02908

Appendix B (cont.)

Applicant, please provide the following information identifying each facility to the appropriate state agency as an attachment to the letter in the table below, use additional pages if necessary. Please make sure to identify yourself in the cover letter by filling in the blank for 'Name of Applicant'.

State	Facility Name, Address and Contact Information	License Number

Appendix C

Disclosure of Ownership and Control Interest

All applicants must complete this Appendix

Please answer the following questions by checking either 'Yes' or 'No'. If any of the questions are answered 'Yes', please list the names and addresses of individuals or corporations.

1. Will there be any individuals (or organizations) having a direct (or indirect) ownership or control interest of 5 percent or more in the applicant, that have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX of the Social Security Act? Yes___ No___

2. Will there be any directors, officers, agents, or managers of the applicant (or facility) who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX of the Social Security Act? Yes___ No___

3. Are there (or will there be) any individuals employed by the applicant (or facility) in a managerial, accounting, auditing, or similar capacity who were employed by the applicant's fiscal intermediary within the past 12 months (Title XVIII providers only)? Yes___ No___

4. Will there be any individuals (or organizations) having direct (or indirect) ownership interests, separately (or in combination), of 5 percent or more in the applicant (or facility)? (Indirect ownership interest is ownership in any entity higher in a pyramid than the applicant) Yes___ No___ (Note, if the applicant is a subsidiary of a "parent" corporation, the response is 'Yes')

5. Will there be any individuals (or organizations) having ownership interest (equal to at least 5 percent of the facility's assets) in a mortgage or other obligation secured by the facility? Yes___ No___

6. Will there be any individuals (or organizations) that have an ownership or control interest of 5 percent or more in a subcontractor in which the applicant (or facility) has a direct or indirect ownership interest of 5 percent or more. (Also, please identify those subcontractors.) Yes___ No___

7. Will there be any individuals (or organizations) having a direct (or indirect) ownership or control interest of 5 percent or more in the applicant (or facility), who have been direct (or indirect) owners or employees of a health care facility against which sanctions (of any kind) were imposed by any governmental agency? Yes___ No___

8. Will there be any directors, officers, agents, or managing employees of the applicant (or facility) who have been direct (or indirect) owners or employees of a health care facility against which any sanctions were imposed by any governmental agency? Yes___ No___

Appendix D

Ownership Information

All applicants must complete this Appendix

1. List all officers, members of the board of directors, and trustees of the applicant and/or ultimate parent entity. For each individual, provide their business address, principal occupation, position with respect to the applicant and/or ultimate parent entity, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.

2. For each individual listed in response to Question 1 above, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, F) any professional accreditation (e.g. TJC, CHAP, etc.), and G) complete Appendix B 'Compliance Report' and submit it to the appropriate state agency (not applicable for Rhode Island facilities).

3. If any individual listed in response to Question 1 above has any business relationship with the applicant, including but not limited to: supply company, mortgage company, or other lending institution, insurance or professional services, please identify each such individual and the nature of each relationship.

4. Have any individuals listed in response to Question 1 above been convicted of any state or federal criminal violation within the past 20 years? Yes___ No___.

   € If response to Question 4 is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

5. Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 12 of the application. For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, F) any professional accreditation (e.g. TJC, CHAP, etc.), and G) complete Appendix B 'Compliance Report' and submit it to the appropriate state agency (not applicable for Rhode Island facilities).

6. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 5 above during the last 5 years had bankruptcies and/or were placed in receiverships? Yes___ No___

   € If response to Question 6 is 'Yes', please identify the facility and its current status.

7. Have any officers, directors, trustees, members, managing or general partners, or other senior management of the applicant and/or its affiliates ever been convicted of or placed on probation

for any criminal offense by any state, local, or federal government? Yes___No____

ξ If yes, provide the name of the individual, the nature of the offense, the date and jurisdiction of the conviction or probation, and any other relevant details.