



**STATE OF CONNECTICUT**  
 DEPARTMENT OF PUBLIC HEALTH  
 FACILITY LICENSE & INVESTIGATIONS SECTION

**LICENSURE APPLICATION**

[ ] INITIAL                      [ ] RENEWAL

**NOTE: A separate application must be completed for each licensed level of care which is located at a different address. One (1) application may be submitted for multiple levels of care provided each level of care has the same name and the same licensee and is located at the same address.**

In accordance with Section 19a-491 and/or Section 19a-506 of the Connecticut General Statutes, application is hereby made for a license to operate the following (please check the appropriate box/boxes that apply):

- |                                                                |                                                                           |
|----------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Assisted Living Services Agency       | <input type="checkbox"/> Infirmary Operated by an Educational Institution |
| <input type="checkbox"/> Children’s Hospital                   | <input type="checkbox"/> Maternity Home                                   |
| <input type="checkbox"/> Chronic and Convalescent Nursing Home | <input type="checkbox"/> Maternity Hospital                               |
| <input type="checkbox"/> Chronic Disease Hospital              | <input type="checkbox"/> Outpatient Clinic                                |
| <input type="checkbox"/> Family Planning Clinic                | <input type="checkbox"/> Outpatient Dialysis Unit                         |
| <input type="checkbox"/> General Hospital                      | <input type="checkbox"/> Outpatient Surgical Facility                     |
| <input type="checkbox"/> Home Health Care Agency               | <input type="checkbox"/> Residential Care Home                            |
| <input type="checkbox"/> Homemaker-Home Health Aide Agency     | <input type="checkbox"/> Rest Home with Nursing Supervision               |
| <input type="checkbox"/> Hospice                               | <input type="checkbox"/> Well Child Clinic                                |
| <input type="checkbox"/> Hospital for Mentally Ill Persons     | <input type="checkbox"/> Mental Health Day Treatment                      |
| <input type="checkbox"/> Mental Health Psychiatric OutPat.     | <input type="checkbox"/> Mental Health Community Residence                |
| <input type="checkbox"/> Mental Health Intermediate Tmt.       | <input type="checkbox"/> Mental Health Residential Living                 |
| <input type="checkbox"/> Substance Abuse & Dependence          |                                                                           |

Please respond to all of the following questions:

1. \_\_\_\_\_  
 Facility “d/b/a” (doing business as) Name

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Business Address	City	State	Zip Code	Telephone
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Mailing Address (if applicable)	City	State	Zip Code
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Phone: (860) 509-7444  
 Telephone Device for the Deaf (860) 509-719  
 410 Capitol Avenue - MS # 12HFL  
 P.O. Box 340308 Hartford, CT 06134



*An Equal Opportunity Employer*



9. Respond to the specific question that reflects the ownership structure of the licensee. **The Licensee is the legal entity which will be issued the license to operate.**
  - A. If the Licensee is a **general partnership, limited partnership or limited liability company**, complete Form 1 (attached).
  - B. If the Licensee is a **trust**, complete Form 2 (attached) for the Licensee.
    - i. Attach a list including the name, address and telephone number of all trustees.
  - C. If the Licensee is a **corporation (profit or non-profit)**, complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.
    - i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.
    - ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.
10. Attach a current copy of the facility’s Certificate of malpractice and public liability insurance. (Note: Information Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.). Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities are exempt from the malpractice requirement.
11. Attach evidence of current compliance with the worker’s compensation insurance coverage requirements in the form of one of the following:
  - A. a certificate of self-insurance issued by a worker’s compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or
  - B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or
  - C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker’s compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)
12. Ownership of Real Property
 

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Name

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Business Address	City	State	Zip Code	Telephone
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13. Annual Fire Marshal’s Certificate of Inspection Form (attached) must be completed by the Local Fire Marshal. **NOTE: Hospitals must have a separate Fire Marshal’s Certificate of Inspection completed for each building on the hospital’s campus and each satellite listed on the hospital’s license. Additional forms may be copied if necessary. Each completed Fire Marshal’s Certificate of Inspection that is submitted must have an original signature. (Not applicable for ALSA’s, Homemaker Home Health and Home Health Agencies).**

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**FOR OFFICE USE ONLY**

CHECK # \_\_\_\_\_ AMOUNT \$ \_\_\_\_\_

DATE RECEIVED \_\_\_\_\_ INITIALS \_\_\_\_\_

\*\*\*\*\*

14. Affidavit of Owner:

I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

Check one as applicable:

- Individual/Sole Proprietor
- General/Managing Partner
- President of Corporation
- Secretary of Corporation
- Municipal Officer
- Trustee

State of Connecticut )

County of \_\_\_\_\_ ) ss \_\_\_\_\_ 20\_\_\_\_\_

Personally appeared before me the above named \_\_\_\_\_ and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

- \_\_\_\_\_  
Notary Public [ ]
- Justice of the Peace [ ]
- Town Clerk [ ]
- Commissioner of the Superior Court [ ]

My Commission Expires:  
(If Notary Public)



**STATE OF CONNECTICUT**  
**DEPARTMENT OF PUBLIC HEALTH**  
**FACILITY LICENSING & INVESTIGATIONS SECTION**

**FORM 1**

**FACILITY/AGENCY NAME:** \_\_\_\_\_

**Form 1 must be completed if the facility/agency is owned/operated by, or the Real Property Owner is, a partnership or a limited liability company. Please copy additional sheets if necessary.**

For each partner or manager with a 10% or greater ownership interest in the Licensee/Real Property Owner, provide the information requested below. **Please complete a separate form for each legal entity listed below that is not an individual.**

This information is for:  Licensee \_\_\_\_\_  
 Real Property Owner \_\_\_\_\_

1. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Please indicate the category which best describes this entity:  
 Manager                     General Partner                     Limited Partner  
 Partner's/Manager's percentage of ownership: \_\_\_\_\_

2. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Please indicate the category which best describes this entity:  
 Manager                     General Partner                     Limited Partner  
 Partner's/Manager's percentage of ownership: \_\_\_\_\_

3. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Please indicate the category which best describes this entity:  
 Manager                     General Partner                     Limited Partner  
 Partner's/Manager's percentage of ownership: \_\_\_\_\_

4. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Please indicate the category which best describes this entity:  
 Manager                     General Partner                     Limited Partner  
 Partner's/Manager's percentage of ownership: \_\_\_\_\_  
 Manager                     General Partner                     Limited Partner



**STATE OF CONNECTICUT**  
**DEPARTMENT OF PUBLIC HEALTH**  
**FACILITY LICENSING & INVESTIGATIONS SECTION**

**FORM 2**

**FACILITY/AGENCY NAME:** \_\_\_\_\_

**Form 2 must be completed if the facility/agency or Real Property Owner is owned/operated by a trust. Please copy additional sheets if necessary.**

For each beneficiary having an ownership interest of 10% or more in the trust, provide the information requested below:

This information is for:  Licensee \_\_\_\_\_  
 Real Property Owner \_\_\_\_\_

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Beneficiary's percentage of ownership: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Beneficiary's percentage of ownership: \_\_\_\_\_
3. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Beneficiary's percentage of ownership: \_\_\_\_\_
4. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Beneficiary's percentage of ownership: \_\_\_\_\_
5. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Beneficiary's percentage of ownership: \_\_\_\_\_
6. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Beneficiary's percentage of ownership: \_\_\_\_\_



**STATE OF CONNECTICUT**  
**DEPARTMENT OF PUBLIC HEALTH**  
**FACILITY LICENSING & INVESTIGATIONS SECTION**

Attachment 3

**FORM 3**

**FACILITY/AGENCY NAME:** \_\_\_\_\_

**Form 3 must be completed if the facility/agency or Real Property Owner is owned/operated by a corporation (profit or non-profit). Please copy additional sheets if necessary.**

For each stockholder with a 10% or greater ownership interest in the Licensee, provide the information requested below. If no owner owns 10% or more of the total shares, please indicate the two largest stockholders. **Please complete a separate form for each legal entity listed below that is not an individual.**

This information is for:  Licensee \_\_\_\_\_  
 Real Property Owner \_\_\_\_\_

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Stockholder's percentage of ownership: \_\_\_\_\_  
Stockholder's occupation with the owner: \_\_\_\_\_
  
2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Stockholder's percentage of ownership: \_\_\_\_\_  
Stockholder's occupation with the owner: \_\_\_\_\_
  
3. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Stockholder's percentage of ownership: \_\_\_\_\_  
Stockholder's occupation with the owner: \_\_\_\_\_
  
4. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Stockholder's percentage of ownership: \_\_\_\_\_  
Stockholder's occupation with the owner: \_\_\_\_\_

Department of Public Safety  
Division of Fire, Emergency & Building Services  
Office of State Fire Marshal



STATE OF CONNECTICUT

On (date) \_\_\_\_\_, the (Town/City) \_\_\_\_\_ Office of the Fire Marshal conducted at inspection of (name of facility) \_\_\_\_\_ located at (address) \_\_\_\_\_ in the City/Town of \_\_\_\_\_ to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as a (new/existing) \_\_\_\_\_ (occupancy classification) \_\_\_\_\_ as classified by the *CONNECTICUT FIRE SAFETY CODE*. As a result of this inspection, the following conditions were found:

- I. At the time of inspection, no code violations were identified. **Certificate of approval recommended.**
- II. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (See attached information) **Certificate of approval recommended.**
- III. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted. (See attached information) **Certificate of approval NOT recommended.**
- IV. Based on the extreme hazard to public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our Town/City Attorney for the purpose of closing or restricting usage of this facility by the public. (See attached information) **Certificate of approval NOT recommended.**

\_\_\_\_\_  
Fire Marshal

\_\_\_\_\_  
Date

City or Town: \_\_\_\_\_



**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
FACILITY LICENSING & INVESTIGATIONS SECTION**

**LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED**

GENERAL HOSPITALS, CHRONIC DISEASE HOSPITALS, CHILDREN’S HOSPITALS, HOSPICE, MATERNITY HOSPITALS AND HOSPITALS FOR MENTALLY ILL PERSONS

Please respond to all of the following:

1. \_\_\_\_\_  
Facility “d/b/a” (doing business as) Name
  
- \_\_\_\_\_

Business Address	City	State	Zip Code	Telephone
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2. \_\_\_\_\_  
Chief Administrative Officer/Administrator
  
3. \_\_\_\_\_  
Chief of Medical Staff (Your name needs to appear as it is shown on your Professional License).
  
4. \_\_\_\_\_  
Director of Nursing Services (Your name needs to appear as it is shown on your Professional License).
  
5. Complete the following additional forms (attached):
  - A. Hospital Satellite Information Form (if applicable)
  - B. Deemed Status Application (if applicable)

Signature of Administrator	Date Signed
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**STATE OF CONNECTICUT**  
**DEPARTMENT OF PUBLIC HEALTH**  
**FACILITY LICENSING & INVESTIGATIONS SECTION**

**DEEMED STATUS APPLICATION**

**GENERAL HOSPITAL, CHRONIC DISEASE HOSPITAL, CHILDREN'S HOSPITAL, MATERNITY HOSPITAL AND  
HOSPITAL FOR MENTALLY ILL PERSONS**

In accordance with Section 19a-493 of the Connecticut General Statutes and Section 19-13-D1a of the regulations of Connecticut State Agencies, application is hereby made to be licensable without additional inspection or investigation:

1. \_\_\_\_\_  
Facility "d/b/a" (doing business as) Name

\_\_\_\_\_

Business Address	City	State	Zip Code	Telephone
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2. Most recent JCAHO Accreditation Survey: \_\_\_\_\_  
Date Survey Number

Length of Accreditation: \_\_\_\_\_ (years)

3. Is the hospital scheduled to be surveyed by JCAHO during the licensure period?  
 YES  NO Date: \_\_\_\_\_

4. Has the hospital been denied a license or renewal within the last three (3) years?  
 YES  NO Date: \_\_\_\_\_

5. Has the hospital been found to be out of compliance with condition(s) of participation in programs established by Titles V, XVIII, XIX and XX of the Social Security Act within the last three (3) years?  
 YES  NO Date: \_\_\_\_\_

6. Date of Last Licensure Inspection: \_\_\_\_\_

7. Has the hospital experienced a change in chief executive officer since the last licensure application?  
 YES  NO

\_\_\_\_\_  
Signature of President of Hospital

\_\_\_\_\_  
Date Signed



**STATE OF CONNECTICUT  
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FACILITY LICENSING & INVESTIGATIONS SECTION**

**HOSPITAL SATELLITE INFORMATION FORM**

Name of Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

**PROGRAM/SERVICE LOCATIONS**

**Please complete the below requested information for each satellite service location (e.g., outpatient clinic, or other licensable entity) which is operated under the jurisdiction of the hospital's license. Attach additional forms if necessary.**

**Please Note: Blood collection and blood drawing stations need not be listed as they hold separate licenses.**

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Type of Service: \_\_\_\_\_  
Please choose one:  On-campus  Off-Campus  
Please choose one:  Outpatient  Residential  Both

2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Type of Service: \_\_\_\_\_  
Please choose one:  On-campus  Off-Campus  
Please choose one:  Outpatient  Residential  Both

3. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Type of Service: \_\_\_\_\_  
Please choose one:  On-campus  Off-Campus  
Please choose one:  Outpatient  Residential  Both

4. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Type of Service: \_\_\_\_\_  
Please choose one:  On-campus  Off-Campus  
Please choose one:  Outpatient  Residential  Both

5. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Type of Service: \_\_\_\_\_  
Please choose one:  On-campus  Off-Campus  
Please choose one:  Outpatient  Residential  Both

6. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Type of Service: \_\_\_\_\_  
Please choose one:  On-campus  Off-Campus  
Please choose one:  Outpatient  Residential  Both

7. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Type of Service: \_\_\_\_\_  
Please choose one:  On-campus  Off-Campus  
Please choose one:  Outpatient  Residential  Both