

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
Quality Assurance Division-Licensure Bureau

2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953
FAX: (406) 444-1742

APPLICATION FOR MONTANA STATE HEALTH CARE FACILITY/SERVICE LICENSE
END STAGE RENAL DIALYSIS APPLICATION

Initial Application Renewal Application Change of Ownership

Number of Bays _____

Facility Name: _____

Facility Address: _____ PO Box: _____

City: _____ Zip: _____ County: _____

Facility Telephone Number: _____ FAX: _____

Facility E-mail/Web page Address: _____

Administrator of Facility: _____

Administrator Contact information: _____

Phone number: _____ Email Address: _____

Mailing Address (if different than the facility): _____

Floor Plan is: New Construction Existing Structure Addition Remodeled

Operating Organization

Information on ownership, contract, or lease agreement if operated by a person other than the owner:

- If a partnership, firm or association, list below every member thereof:
- If a corporation, list below the names and address thereof and the names of its officers:
- If a State Affiliated Organization, list below:

NAME

ADDRESS

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
Quality Assurance Division-Licensure Bureau

List name and License number of all health care professionals employed by your agency.

NAME

LICENSE NUMBER

I certify that all information submitted to DPHHS is true and correct. This license application to operate an Infirmary is hereby submitted under the provisions of MCA 50-5-101-50-5-231.

SIGNED: _____

DATE: _____

TITLE: _____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

Enclose a check, money order or draft made payable to the Department of Public Health & Human Services to cover the license fee. The fee is determined as follows:

(a) facilities with 20 or less = \$20.00

(b) facilities with 21 beds or more = \$1.00 per bed.

This fee will be deposited in the State Treasury and is non-refundable.