MONTANA 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
OUT PATIENT FACILITY LICENSE APPLICATION

Indicate type of outpatient services being licensed:

CENTER FOR PRIMARY CARE _____ CENTER FOR SURGICAL SERVICES _____

Facility Name: _____

Facility Address: _____ PO Box: _____

City _____ Zip _____ County _____

Facility Telephone Number: _____ FAX: _____

Facility E-mail/Web page Address: _____

Floor Plan is: ☐ New Construction ☐ Existing Structure ☐ Addition ☐ Remodeled

Operating Organization: ☐ State ☐ Individual ☐ Partnership ☐ Church ☐ Corporation ☐ Association

Name of Applicant: _____

Applicant Address: _____

City _____ State/Zip _____

Applicant (or contact) e-mail address: _____

Administrator of Facility: _____

Owner (If different from Applicant): _____

Owner Address: _____ City _____ State/Zip _____

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

_____

_____

_____

_____

- If a partnership, firm or association, list every member thereof.
- If a corporation, list the name and address thereof and the names of its officers.

NAME ***ADDRESS***

(Please attach additional sheets as needed.)

Please list the Outpatient Services that will be provided:

List name, type of profession and license number of <u>all</u> licensed professionals employed by your Facility:

NAME	**LICENSE TYPE**	**LICENSE NO.**

(Please attach additional sheets as needed.)

I certify that all information submitted to DPHHS is true and correct. This license application for an Outpatient Facility is hereby submitted under the provision of Section 50-5-101 through 50-5-208.

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.

For additional information see the following Web Pages:

https://dphhs.mt.gov/

&

https://dphhs.mt.gov/qad/Licensure