

**MEDICAL ASSISTANCE FACILITY
Checklist for State Licensure**

FACILITY NAME: _____

CITY: _____

CONTACT PERSON: _____

PHONE: _____ EMAIL: _____

Please mail or E-mail the following items to Healthcare Licensing and Surveys:

CHECK OFF	ITEM
	1. A completed license application form and required fee.
	2. Proof of a fidelity bond of no less than \$2500 augmented in relation to the number of employees.
	3. Verification of Department of Family Services central registry check on self and/or manager, and all employees hired.
	4. Copy of personnel policy and procedure to include the frequency of evaluations and ensuring the confidentiality of central registry information checks.
	5. Copy of organizational chart that reflects the administrative control and lines of authority for the delegation of responsibility from management down to the patient care level.
	6. Copy of policy and procedures for quality improvement.
	7. Copy of policy and procedures on employee health, including communicable disease information.
	8. Copy of policy and procedures on advance directives.
	9. Agreement with one or more hospitals who participate in Medicare/Medicaid to provide services which the facility itself is unable to provide.

	10. Copies of policy and procedures on infection control.
	11. Medical staff must consist of at least one physician. Provide name and professional license number.
	12. Copy of policy and procedure on fire safety plan.
	13. Evidence of full-time, part-time, or consulting radiologist.
	14. Copy of CLIA certificate for laboratory.

FOR HEALTHCARE LICENSING AND SURVEYS USE ONLY**Date:****Surveyor Assigned to Review:****Surveyor Recommendation Review Summary/Comments:****Date****Surveyor Signature:****State Survey Agency Director/Administrator (or designee) Comments:****Additional Information Needed:** ☐ **Approved:** ☐ **Denied:** ☐**Date:****Signature:**