PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
APPLICATION FORM

ARKANSAS HEALTH SERVICES PERMIT COMMISSION

ARKANSAS HEALTH SERVICES PERMIT AGENCY
906 BROADWAY, SUITE 200
LITTLE ROCK, AR 72201
(501) 661-2509

INSTRUCTIONS FOR COMPLETION OF PERMIT OF APPROVAL APPLICATION FORM

General Instructions

In accordance with adopted policies pursuant to Arkansas Act 593 of 1987, as amended, all parties desiring to obtain a Permit of Approval are required to provide the requested information on this application form. Failure to supply adequate information may result in a delay in the review, a return of the application, or a denial of the application. Please refer to the Health Services Permit Commission's Policies and Procedures for Permit of Approval for details of the scope of coverage, projects subject to review, and specific procedures for processing applications.

1. **Please review the Commission's adopted Psychiatric Residential Treatment Facility bed need standards and criteria before starting the application process.**

2. **The Agency recommends that each applicant meet with a staff member of the Health Services Permit Agency (by appointment) for a pre-submission conference.**

3. **Each question must be addressed fully. Contact the staff before a response of "not applicable" is made in order to insure that it is an appropriate response.**

4. **One (1) original and one (1) copy of the completed application along with the appropriate fee must be submitted to the Health Services Permit Agency in accordance with the established batching schedule. The original must be signed in blue ink. Please do not send applications in binders or folders.**

I. I. GENERAL INFORMATION

A. ***Current Facility*** *(*Applies to replacement or additions only*)*

Name of Facility:_____

Address:_____

City: _____Zip Code: _____

County:_____ Phone: _____

Fax: _____ Email: _____

B. Proposed Facility *(Applies to replacement or new facilities.)*

Name of Facility:_____

Address:_____

City: _____Zip Code: _____

County:_____ Phone: _____

C. Identification of applicant

Name of Applicant:_____

Address:_____

City: _____Zip Code: _____

Phone: _____ Fax _____

Email _____

Application Contact Person: *(This person will be contacted regarding questions about this application.)*

Name: _____

Title: _____

Corporation/Company _____

Address: _____

City: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

Project Contact Person: (*This person will be contacted regarding progress or questions about the project if a POA is awarded)*

Name: _____

Corporation:_____

Title: _____

Address: _____

City: _____Zip Code: _____

Phone: _____Fax:_____

Email: _____

3. **Facility Administrator: _____**

4. **Ownership of Facility (Check One):**

(a) Individual Owner ____ (b) Partnership ____
(c) Corporation_____
For-Profit _____ Non-Profit _____

Please list names of all partners: _____

_____

_____

Do any of the owners or partners own another PRTF in Arkansas or in another State? Yes ____ No ____ If yes, list name and location of each facility.
_____
_____
_____

5. **Parent Organization (if any): _____**

   Address _____

   City _____Zip Code _____

   Phone: _____ Fax: _____

   Email: _____

Does this organization currently own a PRTF facility in Arkansas or out of state? Yes _____ No _____ If yes, list name and location of each PRTF.
_____
_____
_____

D. Project:

1. **General Information (All applicants please complete this)**

   Number of beds proposed _____

   Gross square feet to be constructed _____

   Proposed per square foot construction cost _____

   Estimated Project Cost _____

   First year projected annual operating cost: _____

   Estimated project initiation date: _____

   Estimated project completion date: _____

   Has an option been obtained for the site? Yes ____ No _____

   a. **For new construction, provide a letter from the Planning Commission stating that the property is properly zoned.**

   b. **For new construction, provide documentation of land ownership or documentation that an option has been obtained for the site.**

C. Project Description

1. **Describe the proposed construction/project. Please include the site selected for the proposed facility with a description of the setting in which the facility will be located. State whether the area is residential or commercial. Please include a map as an attachment showing the location of the proposed or existing facility. Use additional pages if necessary.**
2. **Please give your organization's/staff's experience in providing psychiatric services to the population in need. Include a statement on the staff's licensing certification and qualifications. In addition, describe the organization's credentialing and privileging procedures.**

3. **Describe the program of treatment including:**
   a) **access to inpatient, outpatient and follow-up services;**

   b) **if school age children will be treated describe how educational services will be provided;**

   c) **describe how parents and/or significant others will be involved in the treatment;**

   d) **explain whether these services will be provided directly or through a contract, and**

   e) **provide a written quality assurance plan showing how quality and appropriateness of care is assessed, reviewed, and improved.**

4. **Please list admission and discharge criteria.**

5. **Explain what ages the project will serve. If the facility will serve both children and adolescents, please explain how the needs of the two groups will be addressed.**

6. **Please attach any linkage agreements with**

- **Hospitals with Psychiatric Units that serve the age population of your proposal**
- **Community Mental Health Centers**
- **Local Schools, etc.**

7. **Do you plan on participating in Medicaid? Yes ____ No ____**
   If yes, please estimate the percent of patients and revenue that will be Medicaid.

8. **POA Transfer**
   <u>Complete this section only if you are applying</u> <u>for a POA Transfer</u>

CURRENT POA HOLDER

Name of POA Holder:_____

Address:_____

City: _____Zip Code: _____

County:_____ Phone: _____

Number of beds authorized by the Permit of Approval____

- **POA transfers are required by law to provide proof of at least $2,500 of assets to be transferred with the Permit. Please list the assets and value of assets to be transferred with this Permit.**

- **Will you need an extension on the time frames of the original POA? Yes_____ No_____**
If yes, state and justify the amount of time needed.

II. REVIEW CRITERIA

CRITERION #1 "Whether the proposed project is needed"

A. Standard of Need

1) **Explain how the proposed project complies with the adopted standard of need.**
   a. **Number of beds available in the area _____.**
   b. **Number of beds requested in this application _____.**

2). **Review Priorities. Applicants will be approved in the following ranked order:**

a.Existing PRTFs wishing to expand and replace an older facility.

b.Applicants for new PRTFs in sections of the State that are more than one and a half hours travel time from existing PRTFs.

c. Applicants for new PRTFs.

d.Existing PRTFs that are transferring beds

3) Please explain how your project relates to the Review priorities.

B. Transfer of Beds

1. **Net need in area from which the beds are being transferred. _____**
2. **Number of beds being transferred. _____**
3. **Net need in area to which beds are being transferred. _____**

C. Community Need - explain how the proposal will benefit the community and network with existing community services.

D. Other - expert assessments of need, surveys, or other indications of the need for the proposed project.

CRITERION #2 "Whether the proposed project can be adequately staffed and operated when complete"

A. Personnel - list by type/discipline the number of staff needed for the proposed project.

B. Explain your plan for recruiting and retaining staff.

CRITERION #3 "Whether the proposed project is economically feasible"

A. Cost Estimates for Project

1. Financing and other Cash Requirements

Loans Fees	**$_____**
Bond Issue Cost	**$_____**
Legal Fees, Printing, etc.	**$_____**

Financial Feasibility Study	**$_____**
Consultant Fees	**$_____**
Permits (Building, Utilities, etc.)	**$_____**
Capitalized Interest During Construction	**$_____**
Debt Service Reserve Fund	**$_____**
Lease Space	**$ _____**
Other (Specify)	**$_____**
2. Physical Plant Costs	**$_____**
Construction Costs	**$_____**
Renovation Cost	**$ _____**
Fixed Equipment	**$ _____**
Site Acquisition Costs	**$_____**
Architect's Fee	**$_____**
Engineering Fees	**$_____**
Contingency Factor (Cost Overrun)	**$_____**
Total Capital Expenditure	**$_____**

B. Please indicate the sources of capital funds:

Source	**Amount**	**Percent**
Commercial Loans	**$_____**	**_____**
Government Grants or Loans (Please Specify)	**$_____**	**_____**
Retained Earnings	**$_____**	**_____**
Other Debt Financing	**$_____**	**_____**
Other _____	**$_____**	**_____**
Total	**$_____**	**100%**

<u>You are required to attach *original* letters of commitment or agreements that indicate the above financing can be obtained.</u>

1. **A recent (not more than 90 days old) pre-approved loan for Total Capital and Working Capital Start-up Cost.**

2. **All existing facility applicants must submit audited financial statements for the last two years. In the absence of audited financial statements, provide documentation for the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant.**

3. **For individual investors or partners, a recent (not more than 90 days old) proof of bank deposit or line of credit for the amount needed for the project.**

D. What are the terms of debt financing?

1. **Rate of Interest _____**
2. **Term of Debt (years) _____**
3. **Annual Debt Service _____**
4. **Total Debt Service _____**
5. **Total Annual Depreciation cost for facility _____**

E. Has an option been obtained for the site? Yes ___ No ___.

F. Has the proposed facility site location been approved by the licensing Agency? Yes_____ No_____

G. Has the proposed facility site location been approved by local zoning Commission. Yes _____ No _____

H. A three (3) year pro forma budget is required as an attachment to the application.

CRITERION #4. "Whether the project will foster cost containment through improved efficiency and productivity."

A. How will this project help contain the costs of healthcare in the local health services community and save State and Federal money?

II. CERTIFICATION

This form completed by: _____
Name Phone

_____
Corporation

_____
Title

_____
Address

_____
City State Zip

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

_____ _____
Date Signature

_____
Title