



**STATE OF MAINE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF LICENSING AND REGULATORY SERVICES**

**Medical Facilities Unit – Acute Care  
Ambulatory Surgical Center**

<b>SECTION 1: Agency Information</b>			
Agency Name:			
Doing Business As:			
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: (     )		Fax No.: (     )	
Email Address:			

<b>SECTION 2: Fees</b>	
<b>APPLICATION FOR AMBULATORY SURGICAL CENTER</b>	
<p>License Type:</p> <p><input type="checkbox"/> Initial Application</p> <p style="margin-left: 20px;"> <input type="checkbox"/> 0 – 10 Total Full-Time Equivalent Employees (fee \$350)  <input type="checkbox"/> 10 – 25 Total Full-Time Equivalent Employees (fee \$425)  <input type="checkbox"/> 26 or over Total Full-Time Equivalent Employees (fee \$500) </p> <p><b>Total Fee Enclosed for Initial Application .....</b> \$ _____</p> <p><input type="checkbox"/> Renewal Application</p> <p style="margin-left: 20px;"> <input type="checkbox"/> 0 – 10 Total Full-Time Equivalent Employees (fee \$350)  <input type="checkbox"/> 11 – 25 Total Full-Time Equivalent Employees (fee \$425)  <input type="checkbox"/> 26 or over Total Full-Time Equivalent Employees (fee \$500) </p> <p>License Renewal Period (dates): _____ to _____</p> <p><b>Total Fee Enclosed for Renewal Application .....</b> \$ _____</p>	
<p><b>Make checks or money orders payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time.</b></p> <p style="text-align: right;"><b>Total Checks/Money Orders enclosed =</b> \$ _____</p>	

*For questions regarding this program and/or application, please contact the following:*

Department of Health and Human Services  
Licensing and Regulatory Services  
Medical Facilities – Acute Care Program  
41 Anthony Ave; 11 State House Station  
Augusta, ME 04333-0011

Tel: (207) 287-9300    Fax: (207) 287-2671    Toll Free: 1-800-791-4080    TTY users call Maine relay 711  
Email: [DLRS.MedFacilities@maine.gov](mailto:DLRS.MedFacilities@maine.gov)

<b>Office Use Only:</b>				
Check# _____	MO # _____	Amount \$ _____	Initials: _____	License# _____

**SECTION 3: Ownership Information** (Use additional sheets, if necessary)

**Type of Entity:**

- Sole Proprietorship (complete section A)                       Corporation (complete section C)  
 Partnership (complete section B)                                       Not-for-Profit (complete section D)  
 Other: \_\_\_\_\_

**A. Sole Proprietorship**

Owner Name:

Mailing Address:

City:

State:

Zip:

County:

Telephone No.: (        )

ID# (Owner SSN or EIN#):

**B. Partnership**

List the names and addresses of partners or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5% or more in the disclosing entity. Indirect ownership interest is ownership interest in an entity that has an ownership in any entity higher in a pyramid than the disclosing entity.

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____

**C. Corporation**

List the names, address and titles of the Officers and Directors.

Officer Name	Title	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

Director Name	Title	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

**D. Not-for-Profit**

List the name and address of the President of the Board of Directors or the appropriate Municipal Government Representative.

Name

Address

\_\_\_\_\_  
\_\_\_\_\_

**SECTION 4: Facility Information** (Use additional sheets, if necessary)

Name of Person in Charge:

Title:

Home Address:

City:

State:

Zip:

County:

Home Telephone No.: ( )

Office Telephone No.: ( )

**Location of all facilities (sub-units) utilized by the Ambulatory Surgical Center Facility:**

Name of Owner of Building  
Telephone Number

Address

	Name of Owner of Building Telephone Number	Address
1.	_____ _____	_____ _____
2.	_____ _____	_____ _____
3.	_____ _____	_____ _____

**Operating Status:**

What is the Fiscal Year End date for this facility: \_\_\_\_\_

This Ambulatory Surgical Center is Medicare Certified:  Yes  No

Date that this Ambulatory Surgical Center was opened: \_\_\_\_\_

Number of Operating Rooms : \_\_\_\_\_ Class of Operating Room(s):  A  B  C

**Accreditation:** Please select all Accreditation Organizations that this Ambulatory Surgical Center is accredited by.

Joint Commission  CHAPS  AAAHC  Other: \_\_\_\_\_

**Full-Time Equivalent Staff:** All employees of the Ambulatory Surgical Center, including administrative, business, clerical and direct service providers, must be included in the calculation of this figure. A full-time equivalent employee is one or more individuals who is/are employed on the basis of at least 37 ½ hours per week for the hospice agency. Both individuals directly employed and those contracted by the agency shall be counted in the calculation of the agency's full-time equivalency figure.

How many full-time equivalent staff are employed by the facility? \_\_\_\_\_

**SECTION 5: Submission**

Submit your completed application with the following:

- A check or money order made payable to "Treasurer, State of Maine"
- A copy of any and all leases, if the building(s) used is leased.
- Letter(s) from the appropriate Municipal Official(s) that demonstrates compliance with all Local Ordinances relative to zoning and building code regulations. Applicable for Initial applicants or if you have moved since your last renewal.
- A list of all procedures performed at this Ambulatory Surgical Facility.

**SECTION 6: Declaration**

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, \_\_\_\_\_, being duly authorized to assume responsibility for the conduct of the agency herein described, do hereby apply for a license to operate the agency and do agree to assume responsibility that the facility will comply with all current regulations of the Department of Health and Human Services, as authorized by Title 22, MRSA §2141-2148, and MRSA §42.

\_\_\_\_\_

**Print name of Administrator**

\_\_\_\_\_

**Signature of Administrator**

\_\_\_\_\_

**Date**