

# STATE OF COLORADO

Bill Ritter, Jr., Governor  
James B. Martin, Executive Director

Dedicated to protecting and improving the health and environment of the people of Colorado

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Located in Glendale, Colorado

<http://www.cdphe.state.co.us>



Colorado Department  
of Public Health  
and Environment

## LETTER OF INTENT REQUEST FOR A HEALTH FACILITY/AGENCY LICENSE APPLICATION AND/OR CERTIFICATION\* PACKET

**Notice to Requestor and/or Applicant:** Completion of this "Letter of Intent" in no way obligates the requestor or applicant to open a health facility/agency or to modify a facility/agency license. The form *does* allow the Division to track the number of proposed facilities, efficiently handle application requests and changes and to eliminate unnecessary mailings of information packets. Please complete the following form to the best of your knowledge. If a question is not applicable or is unknown at the time of request, please write "N/A" or "Unknown" where appropriate. When completed, fax form to **303-753-6214** attention LOI, send via email to [HFLOI@cdphe.state.co.us](mailto:HFLOI@cdphe.state.co.us) or mail to: LOI, CDPHE/Health Facilities #A-2, 4300 Cherry Creek Dr. So., Denver, CO 80246. Your packet will be mailed shortly. Thank you for your inquiry.

### TYPE OF APPLICATION REQUESTED (Check all that apply)

Add/Change Secured Unit/Assisted Living	Change of Certification Type*	Change of Stock	
Add/Change Secured Unit/Long Term Care	Change of Licensed Facility/Agency Name	Closure of Facility/Agency	
Change of Administrator/Assisted Living	Change of Licensure Type**	Initial Certification*	
Change of Beds (No Construction)	Change of Location/Address	Initial License	
Change of Beds (With Construction, see below for additional information)	Change of Ownership	Other	

\*Certification is the Federal process that verifies a health care facility/agency is able to meet the standards of care required for Medicare/Medicaid reimbursement.

\*\*For a complete list of facility/agency types, please refer to [www.healthfacilities.info](http://www.healthfacilities.info).

Current Facility/Agency Type: \_\_\_\_\_

**Proposed** Facility/Agency Type based on types of services offered: \_\_\_\_\_

(see [http://www.cdphe.state.co.us/hf/static/lic\\_cert.htm](http://www.cdphe.state.co.us/hf/static/lic_cert.htm) for a list of licensed facility/agency types, see

<http://www.cdphe.state.co.us/regulations/healthfacilities/index.html> for a list of facilities and corresponding regulations)

For any construction on the following facility/agency types:

**Acute Treatment Units, Ambulatory Surgical Centers, Assisted Living Residence, Birth Centers, Community Clinics and Community Clinic Emergency Centers, Community Residential Homes For Persons With Developmental Disabilities, Convalescent Centers, Dialysis Treatment Clinics, General Hospitals, Hospice, Hospital Units, Intermediate Care Facility For Persons With Developmental Disabilities, Long Term Care Facilities, Maternity Hospitals, Psychiatric Hospitals, Rehabilitation Centers** please refer to <http://www.cdphe.state.co.us/hf/LSCrequirements/> for additional information under the Architectural Requirements and Plan Review. You will need to choose the pertinent facility/agency type for additional instructions.

Applicant or Requestor's Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Applicant or Requestor's Title/Agency: \_\_\_\_\_

Mailing Address for Application: \_\_\_\_\_

Attn: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Do you wish to receive your application/certification packet via Email, if available? Yes No

If yes, please provide the appropriate Email address: \_\_\_\_\_

Current Facility/Agency Name as licensed by the Division: \_\_\_\_\_

**Proposed** Facility/Agency Name as it is to be licensed: \_\_\_\_\_

*(Please note, facility/agency names must be approved by the Division prior to registration with the Secretary of State's Office)*

**Proposed** Opening Date \_\_\_\_\_ **Proposed** Closing Date \_\_\_\_\_ **Proposed** Date of Change: \_\_\_\_\_

Current Owner of the Business:  
\_\_\_\_\_

**Proposed** Owner of the Business:  
\_\_\_\_\_

Current Facility/Agency Location: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Proposed** Facility/Agency Location: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Current # of Private Pay Beds: \_\_\_\_\_ Current # of Medicare Beds: \_\_\_\_\_ Current # of Medicaid Beds: \_\_\_\_\_

**Proposed** # of Private Pay Beds: \_\_\_\_\_ **Proposed** # of Medicare Beds: \_\_\_\_\_ **Proposed** # of Medicaid Beds: \_\_\_\_\_

Current # of Secured Unit Beds: \_\_\_\_\_ ALR LTC **Proposed** # of Secured Unit Beds \_\_\_\_\_ ALR LTC

**Proposed** list of services to be offered/performed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Comments/Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The following items are to be completed by CDPHE/HF personnel. Do not write below this line.

**Health Facilities and Emergency Medical Services Division (303) 692-2800 or direct LICENSING questions to the Licensure Hotline at (303) 692-2836 between the hours of 2 and 4 PM Weekdays.**

Date Application/Info Mailed: \_\_\_/\_\_\_/\_\_\_ Attestation Mailed: \_\_\_/\_\_\_/\_\_\_ By: \_\_\_\_\_ Entered: \_\_\_/\_\_\_/\_\_\_ By: \_\_\_\_\_

Packet Code(s): \_\_\_\_\_