LOUISIANA DEPARTMENT OF HEALTH

HOME & COMMUNITY BASED SERVICE PROVIDER
Facility Need Review Application

Check one: ☐ ***FNR Initial Application*** ***Or*** ☐ ***Change of Ownership***

Check all services for which you are applying: ☐ ***MIHC*** ☐ ***PCA*** ☐ ***SIL*** ☐ ***Respite (□ center-based AND/OR □ in-home)***

☐ ***Mailed $200 FNR Fee to DHH Licensing Payment, PO Box 734350, Dallas, TX 75373-4350***

CHECK / MONEY ORDER # _____

☐ ***FNR Supporting Documentation is attached to this FNR application***

I. FACILITY (DBA) NAME _____

GEOGRAPHIC ADDRESS (if applicable) _____

CITY / STATE / ZIP _____

ENTITY/CORPORATE NAME _____

CURRENT MAILING ADDRESS _____ ***City/State/Zip Code:*** _____

ENTITY PHONE NUMBER _____

II. APPLICANT'S DESIGNATED REPRESENTATIVE _____

DESIGNATED REPRESENTATIVE'S: *Telephone number (____)* _____
Email address _____

III. SERVICE AREA (Refer to FNR Rule/Regulation): _____

IV. ATTESTATION:

It is my responsibility to notify the Louisiana Department of Health, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge.

I acknowledge that Facility Need Review approval and licensure does not guarantee any form of reimbursement, including Medicaid. Documentation of the information above is available upon request by the Louisiana Department of Health.

I acknowledge that I have read the facility need review rule and will comply with the provisions therein.

_____
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

_____ _____
AUTHORIZED REPRESENTATIVE SIGNATURE ***DATE***

This Section to be completed by Health Standards Section Program Manager

APPLICATION # _____

DATE APPLICATION, DOCUMENTATION, AND FEE RECEIVED: ____/____/_____

FNR RECEIVED by (initials): _____

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-0453 • http://new.dhh.louisiana.gov/