State of Illinois
Illinois Department of Public Health

RENEWAL APPLICATION FOR SUBACUTE CARE LICENSE

☐ $500 Application Fee Attached

☐ $100 for each Subacute care bed

Total $ _____

Subacute Care ID Number: _____

- DEPARTMENT USE ONLY-

Pursuant to Section 265 of the Alternative Health Care Delivery Act [210 ILCS 3] and the rules of the Illinois Department of Public Health entitled "Subacute Care Hospital Demonstration Program Code" (77 Ill. Adm. Code 270)

1. ☐ Hospital ☐ Skilled Nursing Home

2. NAME/ADDRESS OF APPLICANT

Name _____

Address _____

City _____ State _____ Zip Code _____ County _____

Telephone Number (Including Area Code) _____

3. LOCATION OF SUBACUTE UNIT

Name _____

Address _____

City _____ County _____ State _____ Zip Code _____

4. Number of Subacute Beds _____

5. Name and address of the Illinois Registered Agent or other individual(s) authorized to receive Service of Process for the facility.

Name(s) of Registered Agent(s)	Address

IMPORTANT NOTICE

THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER 210 ILCS 3. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THIS HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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6. List the name(s) and title(s) of person(s) under whose management or supervision the Subacute care beds will be operated:

Name	Title

7. VERIFICATION

I (we) swear or affirm that this application and accompanying documents are true and complete. I (we) further certify that I (we) have knowledge of and understand the action required to comply with the Act and licensing requirements.

Signed _____ Signed _____

Title _____ Title _____

Signed and Sworn (or attested) to before me this _____ day of _____ 20 _____

_____
Notary Public

My commission expires _____ 20 _____

SUBMIT APPLICATION AND FEE TO:

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION HEALTH CARE FACILITIES AND PROGRAMS
525 WEST JEFFERSON STREET, 4th Floor
SPRINGFIELD, ILLINOIS 62761