Reset Form

APPLICATION FOR SMALL HOUSE HEALTH FACILITY APPROVAL

State Form 56334 (7-17)
Indiana State Department of Health – IC 16-28-2.5-7

A. Location of Facility

Name of Facility		
Street Address *(number and street)*		P.O. Box
City	County	ZIP Code + 4
Telephone Number	Fax Number	

B. Licensee Information

Licensee *(Company / Owner of the Facility)*		
Street Address *(number and street)*		P.O. Box
City	County	ZIP Code + 4

C. Building Information

☐ Proposed New Construction ☐ Alteration of Existing Building

☐ Existing Licensed Health Facility ☐ Other _____

D. Number of Beds Requested

I am requesting approval for the following number of small house health facility beds:	Number of Beds

E. Authorized Representative for Application

Communications regarding this application will be sent to the licensee's authorized representative.

Name of Authorized Representative	Title	
Street Address *(number and street)*		P.O. Box
City	County	ZIP Code + 4
Telephone Number	Fax Number	Date *(month, day, year)*
E-mail Address		