

PLAN REVIEW APPLICATION

1. NEW PLAN REVIEW RESUBMITTAL

ASSOCIATED EXISTING PROJECT: P0 _____

EXISTING PROJECT NAME & ZIP CODE: _____

2. REVIEW TYPE:  **DHH LICENSE REVIEW**

3. Project Name: _____

Street Address: _____

Suite or Space No: _____

City: _____ Within city limits? Yes No

State: LA Zip: _____ - _____ Parish: _____

STATE OWNED STATE LICENSED STATE LEASED MUNICIPAL PROJECT

PRIVATE PROJECT FEDERALLY OWNED FEDERALLY FUNDED

- Complete the following --- if the Building has more than one story?

Number of Stories: _____ Project is on which floor(s)? _____

Is this a high-rise building? Yes No

A high rise is defined as a building with 7 stories or more or 75 ft high or taller.

Estimated Cost of Project: \$ _____

Project Description: _____

4. REVIEW TYPE: (Choose the requested DHH Licensing Category)

HOSPITAL

- General Hospital
- Psychiatric Hospital
- Rehabilitation Hospital

- AMBULATORY SURGICAL CENTER
- ABORTION CLINIC
- END STAGE RENAL DISEASE FACILITY (ESRD – Dialysis Center)
- RURAL HEALTH CLINIC
- PEDIATRIC DAY HEALTH CARE
- INPATIENT HOSPICE FACILITY
- NURSING HOME
- ADULT DAY HEALTH CARE

ADULT RESIDENTIAL CARE SERVICES

(LEVELS 1-4)

- Level 1 - Personal Care Home
- Level 2 - Shelter Care
- Level 3 - Assisted Living
- Level 4 - ARCP

- INTERMEDIATE CARE FACILITIES (ICF/DD)
- CENTER BASED RESPITE CARE (HCBS)
- THERAPEUTIC GROUP HOME
- PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)
- ADULT DAY CARE (HCBS)
- ABUSE/ADDICTION TREATMENT FACILITY/BHS Provider

BEHAVIORAL HEALTH – Outpatient / Mental Health Clinic

- Opioid Addiction Treatment
- Children / Adolescent Program
- Treatment / Detoxification
- Outpatient Counseling / Mental Health options
- Intensive Outpatient Treatment

BEHAVIORAL HEALTH – Inpatient / Residential (24HR Facility)

- Primary Residential Treatment
- Inpatient Detoxification
- Inpatient Primary Treatment
- Community-Based Program
- Therapeutic Community (Large Term Residential)

OTHER

Please Specify: _____

Number of Sheets of Drawings for Review: _____

5. OCCUPANCY CLASSIFICATION(s)

- ASSEMBLY _____ square feet
 - 50 TO 299 OCCUPANTS 300 TO 499 OCCUPANTS
 - 500 TO 999 OCCUPANTS 1,000 OCCUPANTS OR MORE
 - Group A-1 Group A-2 Group A-3 Group A-4 Group A-5

- INSTITUTIONAL _____ square feet
 - Group I-1 (Group Care)
 - Group I-2 (Health Care)
 - HOSPITAL LIMITED CARE FACILITY NURSING HOME
 - Group I-3 (Detention/Correction)
 - CONDITION 1 CONDITION 2 CONDITION 3 CONDITION 4
 - Group I-4 (Day-Care)
 - Number of Children over 2-1/2 years of age: _____
 - Number of Children 2-1/2 years of age or less: _____
 - Number of Adults (if Adult Day Care): _____

- BUSINESS _____ square feet
- MERCANTILE _____ square feet
 - Class A (>30,000 sq. ft.)
 - Class B (Between 3,000 and 30,000 sq. ft.)
 - Class C (<3,000 sq. ft.)
- EDUCATIONAL OR DAY-CARE _____ square feet
 - School/Classroom
 - Day Care
 - Number of Children over 2-1/2 years of age: _____
 - Number of Children 2-1/2 years of age or less: _____
 - Number of Adults (if Adult Day Care): _____

- RESIDENTIAL _____ square feet
 - Group R-1 (Hotel/Motel - Primarily Transient)
 - Group R-2 (Apartments- Primarily Permanent)
 - Group R-3 (Small Miscellaneous)
 - Group R-4 (Small Residential Care for <16 Occupants)
 - Number of Occupants: _____

- FACTORY / INDUSTRIAL _____ square feet
 - Group F-1 (Moderate Hazard)
 - Group F-2 (Low Hazard)
 - High Hazard
 - GROUP H-1 DETONATION HAZARD
 - GROUP H-2 DEFLAGRATION HAZARD

- STORAGE _____ square feet
 - GROUP S-1 (Moderate Hazard) → Identify the materials to be stored: _____
 - GROUP S-2 (Low Hazard) → _____

- (CONT) FACTORY / INDUSTRIAL*

 - High Hazard
 - GROUP H-3 COMBUSTIBLE HAZARD
 - GROUP H-4 HEALTH HAZARD
 - GROUP H-5 HAZARDOUS PRODUCTION MATERIALS

- HIGH HAZARD
 - GROUP H-1 DETONATION HAZARD
 - GROUP H-2 DEFLAGRATION HAZARD
 - GROUP H-3 COMBUSTIBLE HAZARD
 - GROUP H-4 HEALTH HAZARD
 - GROUP H-5 HAZARDOUS PRODUCTION MATERIALS

UTILITY / MISCELLANEOUS _____ square feet

Provide a Description of Use: _____



TOTAL SQUARE FEET OF THE AREA UNDER REVIEW: _____ SQ FT

8. ADDITIONAL FEATURES

(Select ALL applicable fire protection or occupancy features that are associated with this project)

- Sprinkler System – 13
- Sprinkler System – 13 D
- Sprinkler System – 13 R
- Kitchen Hood Fire Suppression System
- Boiler(s)
- Clean Agent
- Covered Mall Building
- Underground Building
- Stage or Platform
- Aircraft Related
- Owned and Operated By a Religious Entity
- Fire Alarm System
- Special Locking System(s)
- Paint Booth
- Casino/Gaming Area
- Atrium
- Motor-Vehicle Related
- Special Amusement
- Hazardous Materials
- University / College
- Emergency Shelter
- Generator (Required)
- Generator (Non-Required)
- Ambulatory Health Care

9. CONSTRUCTION TYPE

- V-B / V(000)
(NON-RATED WOOD)
- III-A / III(211)
(COMBINATION WOOD/STEEL/CONC)
- I-A / I(332)
(3 HOUR RATED STEEL/CONC)
- V-A / V(111)
(FIRE-RATED WOOD)
- II-B / II(000)
(NON-RATED STEEL/CONC)
- I-A / I(442)
(4 HOUR RATED STEEL/CONC)
- IV-HT / IV(2HH)
(HEAVY TIMBER)
- II-A / II(111)
(1 HOUR RATED STEEL/CONC)
- Not Provided / Unknown
- III-B / III(200)
(COMBINATION WOOD/STEEL/CONC)
- I-B / II(222)
(2 HOUR RATED STEEL/CONC)

10. APPLICANT(S) (P.O.R. / OWNER / TENANT / CONTRACTOR / ADDITIONAL CONTACT)

PROFESSIONAL OF RECORD

P.O.R is a Louisiana Licensed Engineer Louisiana License Number: _____

Architect Louisiana License Number: _____

LAST NAME FIRST NAME MIDDLE NAME SUFFIX

NAME OF FIRM PHONE FAX EMAIL

STREET ADDRESS

ZIP Code PARISH/COUNTY CITY STATE

OWNER

LAST NAME _____		FIRST NAME _____		MIDDLE NAME _____	SUFFIX _____
NAME OF FIRM _____		PHONE _____	FAX _____	EMAIL _____	
STREET ADDRESS _____					
ZIP Code _____	PARISH/COUNTY _____		CITY _____	STATE _____	

TENANT

LAST NAME _____		FIRST NAME _____		MIDDLE NAME _____	SUFFIX _____
NAME OF FIRM _____		PHONE _____	FAX _____	EMAIL _____	
STREET ADDRESS _____					
ZIP Code _____	PARISH/COUNTY _____		CITY _____	STATE _____	

CONTRACTOR

LAST NAME _____		FIRST NAME _____		MIDDLE NAME _____	SUFFIX _____
NAME OF FIRM _____		PHONE _____	FAX _____	EMAIL _____	
STREET ADDRESS _____					
ZIP Code _____	PARISH/COUNTY _____		CITY _____	STATE _____	

ADDITIONAL CONTACT

LAST NAME _____		FIRST NAME _____		MIDDLE NAME _____	SUFFIX _____
NAME OF FIRM _____		PHONE _____	FAX _____	EMAIL _____	
STREET ADDRESS _____					
ZIP Code _____	PARISH/COUNTY _____		CITY _____	STATE _____	

11. DOCUMENTS PROVIDED FOR REVIEW

- Correspondence Plans Shop Drawings Specifications Photographs

12. REVIEW FEE & PAYMENT (See the FEE SCHEDULE on the following pages to determine the required fee)

Any facility requiring a plan review prior to licensure by DHH shall submit the following information TO THIS OFFICE:

- a. Completed application for plan review. NOTE: "DHH Licensed Project" will be reviewed as a "System Type", separate from the new construction or renovation review;
- b. The appropriate plan review fees - payable to the Department of Public Safety (see below);
- c. Drawings, specifications, and functional program requirements of the proposed facility;
- d. The information indicated in the "Health Care Facility License and/or Certification Plan Review Checklist" located in the "Health Care Licensing Plan Review" section on our website (LASFM.org).

- Money orders, cashier's checks, certified checks, and company checks are accepted. Personal checks accepted – must include LA driver's license number on check.

Review Fee Schedule

In accordance with R.S. 40:2017.11, fees for review of plans, there shall be a charge of five dollars per page for all plans or specifications for hospitals, ambulatory surgical centers, nursing homes, and group or community homes or other residential living options which are submitted for review to the Department of Public Safety and Corrections, Office of State Fire Marshal, or its designee pursuant to rules promulgated in accordance with the Administrative Procedure Act. There shall be a minimum charge of twenty-five dollars and a maximum charge of three hundred dollars, plus postage and handling fee often dollars. Such costs shall be paid prior to review by the owner of the project for which the review is requested.

Occupancy	Number of Sheets	Minimum Fee	Maximum Fee
<p>HOSPITALS, AMBULATORY SURGICAL CENTERS, NURSING HOMES, GROUP OR COMMUNITY HOMES, OTHER RESIDENTIAL LIVING OPTIONS</p> <p>(See attached “Health Care Facility License and/or Certification Plan Review Checklist”)</p> <p>Groups I-1, I-2, I-3, I-4, R-1, R-2, R-3, R-4</p>	0 - 5	\$35.00	\$35.00
	6 and up	\$40.00	+ \$5 for each additional sheet, not to exceed \$310.00