

Dept. of Human Services Health Care Licensure and Certification
SPECIAL INPATIENT CARE FACILITY APPLICATION FORM

Phone: 971-673-0540 Fax: 971-673-0556

QC-441 Initial

QC-444 Renewal/Chow

License # _____

If you need this document in an alternate format please contact this office.

Facility Category (Choose One)		Type of Action	
<input type="checkbox"/> Alcohol Treatment Center <input type="checkbox"/> Christian Science Sanatorium <input type="checkbox"/> Infirmary for the Homeless <input type="checkbox"/> College Infirmaries <input type="checkbox"/> Freestanding Hospice <input type="checkbox"/> Rehabilitation Center <input type="checkbox"/> Critical Access Hospital		<input type="checkbox"/> *Initial License <input type="checkbox"/> *License Renewal <input type="checkbox"/> *Ownership Change <input type="checkbox"/> *Bed Increase/Decrease <input type="checkbox"/> New Facility <input type="checkbox"/> Name/Address Change	
*Note: Fee payment required. Fee schedule is listed on page 2 of this form. Make checks payable to DHS and mail to Public Health Division, Fiscal Services, PO Box 14260, Portland, OR 97293. There is no fee required for bed decreases, name changes or address changes.			
NOTE: If this is an initial license application, the initial license fee will be collected after the facility/agency has been approved for licensure.			
FACILITY NAME		Effective Date of Ownership Change	
Facility Address		Fiscal Year Ending Date	
MAILING ADDRESS			
CITY	STATE	ZIP CODE	COUNTY PHONE NO.
E-mail Address :		FAX NO.	
Name of Owner(s): Use Additional sheet if necessary:			Phone No.
Street Address of Owner (Not P.O. Box)		City	State Zip Code
Oregon State Corporation No.	REGISTERED AGENT	ASSUMED BUSINESS NAME	
Name of Administrator		Is the building owned by licensee?	
Ownership Category:		Ownership Type	Current Bed Capacity
<input type="checkbox"/> Individual <input type="checkbox"/> County <input type="checkbox"/> Church <input type="checkbox"/> Corporation	<input type="checkbox"/> State <input type="checkbox"/> City <input type="checkbox"/> Health Dist. <input type="checkbox"/> Partnership	<input type="checkbox"/> Profit <input type="checkbox"/> Non-profit	Is this a new bed capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>I declare, under penalties of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct and complete. I will notify Health Care Licensure and Certification of any changes in this information within 30-days of any such change.</i>			
Signature of Administrator			Date
Name & Title (printed or typed)			

If partnership or corporation, list name(s) and list each person having 5% or more interest (attach separate page if necessary)

Name & Title	Tax ID #	Address	Phone No.	Percent

<i>FEE SCHEDULE</i>	Total No. of Beds	Fee:		
	0 – 25	\$ 750.00		
	26 – 49	1,000.00		
	59 – 99	1,900.00		
	100 – 199	2,900.00		
	200 or more	3,400.00		

HCLC Office Use Only

Initial Licensure:

- Approved**
 Denied
 Withdrawn

If approved, effective date of initial licensure:

Surveyor Signature	Date:
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Section Manager Signature	Date:
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