Hospital License Application Form

New Hospital?	☐Y	☐N	

Existing Hospital?	☐Y	☐N	License # _____	CMS Provider # _____
Accredited?	☐Y	☐N	If yes, what Accrediting Agency?	
Deemed?	☐Y	☐N		

(See page 3 of this form for required fees.)

HOSPITAL INFORMATION

Hospital Legal Name:		
Hospital DBA Name (if applicable):		
Hospital Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Hospital Mailing Address (if different from above):		
Hospital E-Mail:		
Fiscal Year Ending Date (MM/DD) :		
Name of Administrator & Phone:		
Administrator Email:		
Emergency Contact Person & Phone:		

HOSPITAL CLASSIFICATION (choose one)

☐ General Hospital	☐ Mental or Psychiatric Hospital
☐ Low Occupancy Acute Care Hospital	

LICENSED BED CAPACITY

Hospital Licensed Inpatient Bed Capacity: ____
Psychiatric Satellite Licensed Inpatient Bed Capacity: ____

SERVICES:	☐ Maternity	☐ Surgical	☐ Emergency	☐ Respite	☐ Other:

OWNER INFORMATION

Ownership Category (If Partnership, Corporation or LLC, list each person having 5% or more interest on a separate page.)			
☐ Church	☐ State	☐ Health District	☐ Partnership
☐ City	☐ County	☐ Individual	☐ Corporation or LLC

Ownership: (If non-profit, list all board members on a separate page.)		Tax ID#:
Name of Owner(s):		
Address, City, State & ZIP of Owner(s):		
Phone:	Fax:	County:

Hospital operates off-campus satellite location(s)	☐ **Y** ☐ **N**	**Total # of satellites operated: _____**
Complete a “Satellite Information” template for <u>each</u> satellite operated by the hospital (see page 4 of this application). A "satellite location" is any location that is geographically separate from the hospital and is more than 250 yards from the hospital's main emergency department (ED) doors as measured by radial distance (i.e.,"as the crow flies").		
Hospital operates on-campus, provider-based location(s)	☐ **Y** ☐ **N**	**Total # operated: _____**
Attach a list of all on-campus, provider-based locations to this application. For each location, please include the following: name, address (including suite number) and description of services provided. An on-campus, provider-based location is any location that is within 250 yards of the hospital's main emergency department (ED) doors.		

TYPE OF ACTION

☐	**License Renewal**

☐	**Hospital Change:** *What type of hospital change is requested?*	
☐	Inpatient Bed Count Increase	☐ Inpatient Bed Count Decrease
☐	Change of Information	
	☐ Name Change	☐ Services to be Added
	☐ Address Change	☐ Services to be Removed
	☐ Change of Administrator	☐ Add or change on-campus, provider-based location
☐	Change of Ownership	
☐	Other. Please specify	
	Effective date of requested change _____	

☐	Satellite change (See page 4)

I declare, under penalty 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 Regulation and Quality Improvement, in writing, of any changes in this information within 30 days of any such change. Oregon Administrative Rule Chapter 333, Divisions 500-535 requires that all accredited hospitals provide to the Health Care Regulation and Quality Improvement Section all accrediting survey and inspection reports, and written evidence of all corrective actions and progress reports related to accrediting surveys.*

_____ _____

Administrator’s Signature *Print Name*

_____ _____

Print Title *Date (mm/dd/year)*

FEE SCHEDULE

$1,250.00	01 – 25 Beds	$6,525.00	100 – 199 Beds	$750.00 Per Satellite Location
$1,850.00	26 – 49 Beds	$8,500.00	200 – 499 Beds	
$3,800.00	50 – 99 Beds	$12,070.00	500 or more Beds	

APPLICATION PROCESS

License Renewal Due By December 1st

Is your application complete?

- ☐ **Payment calculated.**

  Note: There is no fee required for bed decreases, name changes or address changes.
  Change of ownership requires a new license and payment of the full license fee.

- ☐ **Satellite Information template attached for <u>each</u> satellite operated by the hospital, if any.**

- ☐ **List of on-campus, provider-based locations attached.**

- ☐ **Payment enclosed.**

  Make check payable to: Oregon Health Authority
  Mail payment to: Health Care Regulation and Quality Improvement
  P.O. Box 14260
  Portland, OR
  97293-0260

Questions?

Contact us by email at: mailbox.hclc@state.or.us, or by phone at: 971-673-0540

HCRQI Office Use Only			**Approved/Denied by**		**Entered by**	
☐ Initial Licensure	☐ Approved	☐ Denied	Initials: _____	Date:_____	Initials: _____	Date:_____
☐ License Renewal	☐ Approved	☐ Denied	Initials: _____	Date:_____	Initials: _____	Date:_____
☐ Change	☐ Approved	☐ Denied	Initials: _____	Date:_____	Initials: _____	Date: _____

CASH OFFICE: QC **442** Initial QC **445** Renewal **50202** **51035**

SATELLITE INFORMATION

Satellite Name:	
Satellite Street Address:	
Phone:	Hours of Operation:

Type:
- ☐ Outpatient Satellite
- ☐ Psychiatric Satellite
- ☐ Emergency Medical Services Satellite (also known as “Off-campus Emergency Departments”)

Describe type and scope of services provided. If multiple suites at this location that are not separately licensed, list suite #s and services provided in each suite.

TYPE OF ACTION

New Satellite?	☐Y ☐N
Existing Satellite?	☐Y ☐N License # _____

Satellite Change: *What type of satellite change is requested?*

☐	Satellite Closure	☐	Addition of Services to Satellite
☐	Satellite Relocation	☐	Removal of Services from Satellite
☐	Other. Please specify		
	Effective date of requested change _____		