PUBLIC HEALTH DIVISION
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program

Oregon Health Authority

Hospital License Application Form

New Hospital? ◯ Y ◯ N

Existing Hospital License # _____

Accredited? ◯ Y ◯ N If yes, what Accrediting Agency?

(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 Nurse Staffing Committee	Direct Care Co-Chair	Nurse Manager Co-Chair
Name:		
Title:		
Email:		
Phone:		

HOSPITAL CLASSIFICATION (choose one)

☐ General Hospital	☐ Mental or Psychiatric Hospital
☐ Low Occupancy Acute Care Hospital (25 beds or fewer)	

LICENSED BED CAPACITY

Total on-campus inpatient beds: ____
Total psychiatric satellite inpatient beds: ____

SERVICES:	☐ Maternity	☐ Surgical	☐ Emergency

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 the main hospital building and is more than 250 yards from any exterior wall of the hospital's main building as measured by radial distance (i.e.,"as the crow flies").		
Hospital operates on-campus buildings	◯ **Y** ◯ **N**	**Total # operated: ____**
Attach a list of all on-campus buildings to this application. For each building, please include the following: service name, address (including suite number) and description of services provided. An on-campus building is any building that is within 250 yards of any exterior wall of the hospital's main building.		

TYPE OF ACTION

☐	**License Renewal**

☐	**Hospital Change:** *What type of hospital change is requested?*	
☐	Inpatient Bed Count Increase to _____ beds	☐ Inpatient Bed Count Decrease to _____ beds
☐	Change of Information	
	☐ Name Change	☐ Services to be Added
	☐ Address Change	☐ Services to be Removed
	☐ Change of Administrator	☐ Add or change on-campus building
☐	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)*

Person who filled out this license application:

_____
Print Name

_____ _____
Email *Phone Number*

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 buildings 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	☐ Include a map depicting the location for all new satellite locations.
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 _____		

I declare, under penalty of perjury, that I have examined this satellite information form and that to the best of my knowledge and belief, this building has a radial distance of more than 250 yards from any exterior wall of the main hospital building. 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)*