OREGON HEALTH AUTHORITY

AMBULATORY SURGICAL CENTERS

License Application Form
Health Care Regulation and Quality Improvement

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

Type of Action

New Facility ☐ License Renewal ☐ Name/Address Change ☐ Ownership Change ☐ Other ☐ (Specify) _____ Effective Date of Change: _____	License # _____ Provider # (if applicable) _____ Accredited? ☐Y / ☐N Accrediting Agency? _____ Deemed? ☐Y / ☐N Add/Remove Services ☐ Procedure Room Increase/Decrease* ☐

* Fee Payment Required (See back of this form for amount). There is no fee required for procedure room decreases, name or address changes.

Facility Information

Profit ☐	Non-Profit ☐	Facility E-Mail:
Facility Legal Name:		
Facility DBA Name (if applicable):		
Facility Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Facility Mailing Address (if different from above):		
Fiscal Year Ending Date (MM/DD) :		
Name of Administrator & Phone:		
Administrator Email:		
Name of Facility Mgr.:		
Emergency Contact Person & Phone:		
Days and Hours of Operation:	Number of Procedure Rooms*:	

Owner Information

(If partnership or corporation, list each person having 5% or more interest on an additional page)

Ownership Category (Choose One):			
Individual ☐	State ☐	Health District ☐	Partnership ☐
City ☐	County ☐	Church ☐	Corporation ☐
Ownership Type: For Profit ☐ Non Profit ☐			Tax ID#:
Name of Owner(s):			
Address, City, State & ZIP of Owner(s):			
Phone:	Fax:		County:

Description of Service

Please mark the services provided with an (X), if there has been a change, indicate (A) if adding or (D) if deleting services.

Please enter (X) for Services Provided or A (Add) or D (Delete)	Service		Please enter (X) for Services Provided or A (Add) or D (Delete)	Service
	Cardiovascular			Ophthalmology
	Foot			Oral
	General			Orthopedic
	Neurological			Otolaryngology
	Obstetrics/Gynecology			Plastic
	Thoracic			Urology
	Other Specify: _____			

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 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 ASC provide to the Health Care Regulations and Quality Improvement Section all accrediting survey and inspection reports, and written evidence of all correction actions and progress reports related to accrediting surveys.

_____ _____

Administrator's Signature ***Print Name***

_____ _____

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

Fee Schedule

***Per OAR 441.020(14)(b), Procedure Rooms are defined as a room where surgery or invasive procedures are performed.**

$1750.00*	CMS Certified & High Complexity Non-certified Ambulatory Surgical Centers with more than two procedure rooms*
$1250.00*	CMS Certified & High Complexity Non-certified Ambulatory Surgical Centers with no more than two procedure rooms*
$1000.00*	Moderate Complexity Non-certified Ambulatory Surgical Centers

*** Yearly Renewal Due By December 1st**

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

HCRQI Office Use Only

Effective date of initial licensure: _____ Initials: _____ Date: _____

Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____

Initials: _____ Date: _____

CASH OFFICE: QC **797** initial/QC **798** renewal **50320 50430**