

## Ambulatory Surgical Center Application Form

Type of Action	
New Facility* <input type="checkbox"/> License Renewal* <input type="checkbox"/> <b>(due 12/1)</b> Name/Address Change <input type="checkbox"/> Ownership Change <input type="checkbox"/> Other <input type="checkbox"/> (Specify) _____ Effective Date of Change: _____	License # _____ Accredited? Y / N Accrediting Agency? _____ Add/Remove Services <input type="checkbox"/> <i>(If yes, please complete section IV)</i> Procedure Room Increase/Decrease* <input type="checkbox"/>

\*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		
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):		
Name of Administrator & Phone:		
Administrator Email:		
Name of Facility Manager:		
Emergency Contact Person & Phone:		
Days and Hours of Operation:	Number of Procedure Rooms:	

Owner Information <small>(If partnership or corporation, list each person having 5% or more interest on an additional page)</small>			
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.

X	A	D	Service	X	A	D	Service
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ophthalmology
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Otolaryngology
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obstetrics/Gynecology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plastic
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urology
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:				

*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	
\$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

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

**Make check payable to: Oregon Health Authority**  
**Mail payment and application to: HFLC**  
**PO Box 14260**  
**Portland, OR 97293**

**Questions about this application? Phone: 971-673-0540 Email: [mailbox.hcl@state.or.us](mailto:mailbox.hcl@state.or.us)**

**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