Extended Stay Center Application

[Click Here For ESC Administrative Rules]

Type of Action		
New facility* license: ☐		
License renewal*: ☐ **(due December 1 before the annual renewal)**	License #:	
Change request: ☐ **(Select all that apply)**	☐Name ☐Address ☐Ownership ☐Room increase/ ☐decrease* Other (specify)	Effective date of change: Additional information about the requested change (please attach additional pages as needed:

*Fee payment required (see page 2 for amount).

Facility Information – For change-only applications, complete the Facility Name and any changes selected above		
Facility Legal Name:		
Facility Doing Business As (DBA) Name (if applicable):		
Facility physical address, city, state & zip:		
Phone:	Fax:	County:
Facility mailing address (if different from above):		
Facility email:		
Administrator name:	Administrator phone:	
Administrator email:		
Name of facility manager:		
Emergency contact name:	Emergency contact phone:	
Days and hours of operation:		
Number of recovery beds:		
Name of affiliated Ambulatory Surgery Center:		
Name of ASC's Accrediting Organization (if applicable):		

How many operating rooms does the ASC have?		
Yes	**No**	
☐	☐	Is the ASC physically contiguous with the ESC (OAR 333-076-0820(7)(b)?
☐	☐	Is the ASC certified by the Centers for Medicare and Medicaid Services (CMS) as participating in the ASC Quality Reporting Program, administered by CMS?
☐	☐	Does the ESC have an agreement with a local hospital for the transfer of patients?
☐	☐	Has the ASC had any condition-level deficiencies cited in a survey or complaint investigation in the previous 24 consecutive months?
☐	☐	Is the ESC affiliated with only one ASC?
☐	☐	Facilities Planning and Safety Final Project Approval enclosed

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 or LLC ☐
Ownership Type: For-Profit ☐	Non-Profit ☐	Tax ID#:	
Name of Owner(s):			
Address, City, State & ZIP of Owner(s):			
Phone:	Fax:	County:	

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. In accordance with Oregon Administrative Rule Chapter 333, Division 076, the ASC affiliated with this ESC application is accredited, and all accrediting survey and inspection reports, and written evidence of all corrective action and progress reports related to accrediting surveys shall be provided to the Health Care Regulation and Quality Improvement Section.

_____ _____

Administrator's Signature **Print Name**

_____ _____

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

The person who filled out this application form	
Name:	Email:
Title:	Phone:

Fee Schedule: Initial, renewal, and room increases (No fee is required for procedure room decreases.)	
$20,000.00	New license
$4,100.00	License renewal

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

HCRQI Office Use Only
Renewal Licensure/change: Approved:_____ Denied:_____ Withdrawn:_____ Initials:_____ Date:_____
CASH OFFICE: QC 791 initial / QC 792 renewal

Questions about this application? Phone: 971-673-0540 **Email:** mailbox.hclc@odhsoha.oregon.gov