PUBLIC HEALTH DIVISION
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
healthoregon.org/hflc

End-Stage Renal Dialysis Facility License Application Form

Type of Action			
New Facility*	◯ Y	◯ N	
License Renewal* **(due 12/1)**	◯ Y	◯ N	License #:
Accredited?	◯ Y	◯ N	If yes, what Accrediting Agency?
Station Increase/Decrease?	◯ Y	◯ N	
* Fee Payment Required (See back of this form for amount).			

Facility Information		
Facility Legal Name:		
Facility DBA Name (if applicable):		
Facility Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Facility Mailing Address (if different from above):		
Facility E-Mail:		
Name of Administrator & Phone:		
Administrator Email:		
Emergency Contact Person & Phone:		
Emergency Contact E-Mail:		

Days and Hours of Operation:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
First shift starts:							
Last shift ends:							
Number of Stations:			Number of Home Training Rooms:				

Owner Information			
Ownership Category: (If partnership or corporation, list each person having 5% or more interest on an additional page)			
◯ Individual	◯ State	◯ Health District	◯ Partnership
◯ City	◯ County	◯ Church	◯ Corporation or LLC
Ownership Type: For Profit ◯ Non-Profit ◯ (If non-profit, list all board members on a separate page)			Tax ID#:
Name of Owner(s):			
Address, City, State and ZIP of Owner(s):			

Type of Action			
☐	**License Renewal**		
☐	**Facility Change:** What type of Facility change is requested?		
☐	Station Increase:	☐	Station Decrease:
☐	Change of Information		
☐	Name Change	☐	Services to be Added
☐	Address Change	☐	Services to be Removed
☐	Change of Administrator	☐	Change of Ownership

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

Current Modalities/Services (check all that apply)			
☐ In-center Hemodialysis (HD)	☐ In-center Peritoneal Dialysis (PD)	☐ In-center Nocturnal HD	☐ Home HD Training and Support
☐ HD in LTC	☐ Home PD Training and Support	☐ PD in LTC	☐ Dialyzer Reuse
☐ Other, please specify:			
Effective date of requested change:			

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.

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

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

Fee Schedule		
$2,000.00	New Facility	Fee is required when initial application is submitted.
$2,000.00	Yearly Renewal	Submit fee with this application 30 days prior to license expiration.
$2,000.00	Change of Ownership	Submit the fee with this application.

Application Process	
Is your application complete?	
☐	**Payment calculated.** Note: There is no fee required for station increase/decreases, name changes or address changes. Change of ownership required a new license and payment of the full license fee.
☐	**Payment enclosed.**

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

HFLC Office Use Only					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 619 Initial QC 620 Renewal						