End-Stage Renal Dialysis (ESRD) Facility License Application

Click Here For ESRD 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 ☐Administrator ☐Ownership ☐Station increase/decrease ☐Add/remove services ☐Other (specify)	Effective date(s) of change(s): Additional information about the requested changes (please attach additional pages as needed):

*Fee payment required (see page 2 for details). There is no fee required for station decreases, name, or address changes.

Facility Information – For change-only applications, complete the Facility Name and any changes selected above		
Facility Legal Name:		
Facility Doing Business As 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:		
Emergency contact name:	Emergency contact phone:	
Emergency contact email:		
Name of Accrediting Organization (if applicable):		
Number of Stations:	Number of Training Rooms:	

800 NE Oregon Street, Suite 465, Portland, OR, 97232

Voice: (971) 673-0540 | Fax: (971) 673-0556 | All relay calls accepted

http://www.healthoregon.org/hflc | mailbox.hclc@odhsoha.oregon.gov

Days and Hours of Operation**	Mon	Tue	Wed	Thu	Fri	Sat	Sun
First shift starts:							
Last shift ends:							

**Please notify Health Care Regulation and Quality Improvement in writing before changing days of operations.

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 (If non-profit, list all board members on a separate page)			
Tax ID#:			
Name of Owner(s):			
Address, City, State & ZIP of Owner(s):			

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 Long-Term Care (LTC), please attach a list of locations where this occurs	☐ Home PD Training and Support	☐ PD in LTC	☐ Dialyzer Reuse
☐ Other (please 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.

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

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

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

Fee Schedule	
$2,000.00	New license
$2,000.00	License renewal
$2,000.00	Change of Ownership

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.hclc@odhsoha.oregon.gov

HCRQI Office Use Only
Renewal Licensure/change: Approved:_____ Denied:_____ Withdrawn:_____ Initials:_____ Date:_____
CASH OFFICE: QC 619 initial / QC 620 renewal