Hospital License Application Form

Type of Action	
New Hospital? ◯	
Renewal? ◉	**License Renewal Due 12/1**
Existing Hospital License #	
Accredited? ◉ Y ◯ N	If yes, what Accrediting Agency?

Hospital Information		
Hospital Legal Name:		
Hospital DBA Name (if applicable):		
Hospital Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Hospital Mailing Address (if different from above):		
Hospital E-Mail:	Fiscal Year Ending Date (MM/DD):	
Administrator Name:	Emergency Contact Name:	
Administrator Phone:	Emergency Contact Phone:	
Administrator Email:	Emergency Contact Email:	
Name of Hospital Chief Nursing Officer / Chief Nurse Executive:		
CNO/CNE Email:	CNO/CNE Phone Number:	

		Direct Care Co-Chair	Nurse Manager Co-Chair
Hospital Nurse Staffing Committee	Name:		
	Title:		
	Email:		
	Phone:		

Hospital Classification (choose one)	
◯ General Hospital	◯ Mental or Psychiatric Hospital
◯ Low Occupancy Acute Care Hospital (25 beds or fewer)	

Licensed Bed Capacity
Total on-campus inpatient beds: (does **not** include psychiatric **satellite** inpatient beds)
Total psychiatric satellite inpatient beds:

Services (check all that apply) (All services are required for General Hospitals):	☐ Maternity	☐ Surgical	☐ Emergency

Owner Information			
Ownership: (If non-profit, list all board members on a separate page.)			Tax ID#:
Name of Owner(s):			
Address, City, State & ZIP of Owner(s):			
Phone:	Fax:		County:
Ownership Category (If partnership, corporation, or LLC, list each person having five percent of more interest on a separate page.)			
◯ Church	◯ State	◯ Health District	◯ Partnership
◯ City	◯ County	◯ Individual	◯ Corporation or LLC

Hospital operates off-campus satellite location(s)	◯ **Y** ◯ **N**	**Total # of satellites operated:**
Complete a “Satellite Information” template for <u>each</u> satellite operated by the hospital (see page 4 of this application). A "satellite location" is any location that is geographically separate the main hospital building and is more than 250 yards from any exterior wall of the hospital's main building as measured by radial distance (i.e., “as the crow flies").		
Hospital operates on-campus buildings	◯ **Y** ◯ **N**	**Total # operated:**
Attach a list of all on-campus buildings to this application. For each building, please include the following: service name, address (including suite number) and description of services provided. An on-campus building is any building that is within 250 yards of any exterior wall of the hospital's main building.		

Type of Action	
☐ License Renewal	
☐ **Hospital Change:** *What type of hospital change is requested?*	
☐ Inpatient Bed Count Increase to beds.	☐ Inpatient Bed Count Decrease to beds.
☐ Name Change ☐ Address Change ☐ Change of Administrator	☐ Services to be Added: ☐ Services to be Removed: ☐ Add or Change On-Campus Building
☐ Change of Ownership	
☐ Other. Please Specify:	
Effective Date of Requested Change:	
☐ Satellite change (See page 5)	

Person who filled out this license application	
Name:	Email:
Title:	Phone:

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

I declare, under penalty 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 hospitals provide to the Health Care Regulation and Quality Improvement Section all accrediting survey and inspection reports, and written evidence of all corrective actions and progress reports related to accrediting surveys.

Administrator's Signature

Print Name

Print Title

Date (mm/dd/year)

Fee Schedule				
$1,250.00	01 – 25 Beds	$6,525.00	100 – 199 Beds	$750.00 Per Satellite Location
$1,850.00	26 – 49 Beds	$8,500.00	200 – 499 Beds	
$3,800.00	50 – 99 Beds	$12,070.00	500 or more Beds	

Application Process	
Is your application complete?	
☐	**Payment calculated.**
	Note: There is no fee required for bed decreases, name changes or address changes. Change of ownership requires a new license and payment of the full license fee.
☐	**Satellite Information template attached for <u>each</u> satellite operated by the hospital, if any.**
☐	**List of on-campus buildings attached.**
☐	**Payment enclosed.**

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

HCRQI Office Use Only									
Approved/Denied by:								**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 **442** Initial QC **445** Renewal									

SATELLITE INFORMATION	
Satellite Name:	
Satellite Street Address:	
Phone:	Hours of Operation:

Type:
- ☐ Outpatient Satellite
- ☐ Psychiatric Satellite
- ☐ Emergency Medical Services Satellite (also known as “Off-campus Emergency Departments”)

Describe type and scope of services provided. If multiple suites at this location that are not separately licensed, list suite numbers and services provided in each suite.

Type of Action			
New Satellite?	◯ Y	◯ N	☐ Include a map depicting the location for all new satellite locations.
Existing Satellite?	◯ Y	◯ N	License # _____

Satellite Change: What type of satellite change is requested?	
☐ Satellite Closure	☐ Addition of Services to Satellite
☐ Satellite Relocation	☐ Removal of Services to Satellite
☐ Other. Please Specify: _____	
Effective Date of Requested Change:_____	

I declare, under penalty of perjury, that I have examined this satellite information form and that to the best of my knowledge and belief, this building has a radial distance of more than 250 yards from any exterior wall of the main hospital building. 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 hospitals provide to the Health Care Regulation and Quality Improvement Section all accrediting survey and inspection reports, and written evidence of all corrective actions and progress reports related to accrediting surveys.

_____ _____

Administrator’s Signature *Print Name*

_____ _____

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