OREGON HEALTH AUTHORITY

SPECIAL INPATIENT CARE FACILITY APPLICATION

License Application Form
Health Care Regulation and Quality Improvement

Phone: 971-673-0540 Fax: 971-673-0556

Type of Action

New Facility ☐ License Renewal ☐ License # _____ Name/Address Change ☐ Ownership Change ☐ Effective Date of Change: _____	Provider # (if applicable) _____ Accredited? ☐Y / ☐N Accrediting Agency? _____ Deemed? ☐Y / ☐N Add/Remove Services ☐ Bed Increase/Decrease* ☐ Other ☐ (Specify) _____
* Fee Payment Required (See back of this form for amount). There is no fee required for bed decreases, name or address changes.	

Facility Category (Choose One)

Alcohol Treatment Center ☐	Rehabilitation Center ☐	College Infirmaries ☐
Infirmary for the Homeless ☐	Christian Science Sanatorium ☐	Freestanding Hospice ☐

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:		
Fiscal Year Ending Date (MM/DD) :		
Name of Administrator & Phone:		
Administrator Email:		
Emergency Contact Person & Phone:		

Owner Information

(If partnership or corporation, list each person having 5% or more interest on an additional page)

Ownership Category (Non-Profit, Proprietary or Government):			
Church ☐	State ☐	Health District ☐	Partnership ☐
City ☐	County ☐	Individual ☐	Corporation ☐
Licensed Bed Capacity:	**Is this a new bed capacity**: ☐ Yes ☐ No		
Is the building owned by licensee? ☐Yes ☐No			
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 of any changes in this information within 30 days of any such change.

Administrator's Signature	***Print Name***
Print Title	***Date (mm/dd/year)***

Fee Schedule*

*** Yearly Renewal Due By December 1st**

$1,250.00	**01 – 25 Beds**
$1,850.00	**26 – 49 Beds**
$3,800.00	**50 – 99 Beds**
$6,525.00	**100 – 199 Beds**
$8,500.00	**200 - 499 Beds**
$12,070.00	**500 or more Beds**

Make check payable to Oregon Health Authority and mail to:
Health Care Regulation and Quality Improvement
P.O. Box 14260
Portland, OR 97260

HCRQI Office Use Only

Effective date of initial licensure: _____ Initials: _____ Date: _____

Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____

Initials: _____ Date: _____

CASH OFFICE: QC **441** initial/QC **444** renewal **50202 51035**