## Special Inpatient Care Facility License Application Form

### Type of Action

<table>
<thead>
<tr>
<th>Action</th>
<th>Accredited?</th>
<th>Accrediting Agency?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ New Facility</td>
<td>☐ Y ☐ N</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>☐ License Renewal (Due 12/1)</td>
<td>☐ Add/Remove Services</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>License #:</td>
<td>☐ Bed Increase/Decrease</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>☐ Name/Address Change</td>
<td>☐ Other. Please Specify:</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>☐ Ownership Change</td>
<td>☐ ☐ ☐</td>
<td></td>
</tr>
</tbody>
</table>

### Effective Date of Change:

### Facility Category (Choose One)

- Drug/Alcohol Treatment Center ☐
- Rehabilitation Center ☐
- College Infirmary ☐
- Infirmary for the Homeless ☐
- Christian Science Sanatorium ☐
- Inpatient 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:
- Name of Administrator & Phone:
- Administrator Email:
- Emergency Contact Person & Phone:
- Emergency Contact Email:
- Chief Nursing Officer/Director of Nursing Services:
- Chief Nursing Officer/Director of Nursing Services Email:

### Nurse Staffing Committee

<table>
<thead>
<tr>
<th>Nurse Staffing Committee</th>
<th>Direct Care Co-Chair</th>
<th>Nurse Manager Co-Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>Title:</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td></td>
</tr>
</tbody>
</table>
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

Ownership Type: For Profit □ Non-Profit □ Tax ID#:

Name of Owner(s):

Address, City, State & ZIP of Owner(s):

Phone: Fax: County:

Licensed Bed Capacity: Is this a new bed capacity: □ Yes □ No

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,250.00</td>
<td>01 – 25 Beds</td>
</tr>
<tr>
<td>$1,850.00</td>
<td>26 – 49 Beds</td>
</tr>
<tr>
<td>$3,800.00</td>
<td>50 – 99 Beds</td>
</tr>
<tr>
<td>$6,525.00</td>
<td>100 – 199 Beds</td>
</tr>
<tr>
<td>$8,500.00</td>
<td>200 – 499 Beds</td>
</tr>
<tr>
<td>$12,070.00</td>
<td>500 or more Beds</td>
</tr>
</tbody>
</table>

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

Questions about this application?
Phone: 971-673-0540
Email: mailbox.hclc@state.or.us

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