Special Inpatient Care Facility (SICF) License Application

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

Facility Category (choose one)		
☐Drug/Alcohol Treatment Center	☐Rehabilitation Hospital	☐Inpatient Hospice
☐Religious Institution		

Facility Information – For change-only applications, complete the Facility Name and any changes selected above		
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 email:		
Administrator name:	Administrator phone:	
Administrator email:		
Name of facility manager:		

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

Emergency contact name:	Emergency contact phone:
Emergency contact email:	
Chief Nursing Officer/Director of Nursing Services:	
Chief Nursing Officer/Director of Nursing Services email:	
Name of Accrediting Organization (if applicable):	
Total number of licensed beds:	Adding licensed beds? Yes ☐ No ☐

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

Professional/Technical Staffing Committee		
	Professional/Technical Manager Co-Chair	Professional/Technical Staff Co-Chair
Name:		
Title:		
Email:		
Phone:		

Service Staffing Committee		
	Service Staff Manager Co-Chair	Service Staff Co-Chair
Name:		
Title:		
Email:		
Phone:		

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 of LLC ☐
Ownership Type: For-Profit ☐	Non-Profit ☐	Tax ID#:	
Name of Owner(s)/Non-Profit Entity:			

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, 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)** _____

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

Fee Schedule	
$5,000.00	01 – 25 Beds
$7,400.00	26 – 49 Beds
$13,800.00	50 – 99 Beds
$26,100.00	100 – 199 Beds
$34,000.00	200 – 499 Beds
$48,280.00	500 or more Beds

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 441 initial / QC 444 renewal