Special Inpatient Care Facility License Application Form

Type of Action		
☐ New Facility	Accredited? Y ☐ N ☐	Accrediting Agency?
☐ License Renewal **(Due 12/1)**	☐ Add/Remove Services	
License #:	☐ Bed Increase/Decrease	
☐ Name/Address Change	☐ Other. Please Specify:	
☐ Ownership Change		
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:		

		Direct Care Co-Chair	Nurse Manager Co-Chair
Nurse Staffing Committee	Name:		
	Title:		
	Email:		
	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 ◯
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	
$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**
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