



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

How to Become a Licensed Birthing Center

Attached is an application packet for an Initial or Change of Ownership (CHOW) License for a Birthing Center. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 137, Birthing Centers Licensing Rules, §137.11 Application Procedures and Issuance of Licenses. Information regarding licensure for health care facilities, including contact information for the zone office for your location is located on the department's website at <http://www.dshs.texas.gov/facilities>.

The following documents, fees, and actions shall be completed and approved before a license will be issued:

Initial Application

- A license application form submitted approximately 90 calendar days prior to the projected opening date of the center.
- A license fee of \$2,000.00. ***License fees are not refundable.***
- The administrator or a licensed professional who is listed on the license application shall attend a presurvey conference at the zone office designated by the department. Please contact the designated zone office to schedule the presurvey conference (<http://www.dshs.texas.gov/facilities/compliance-zones.aspx>).

Change of Ownership (CHOW) Application

- A license application form submitted at least 60 calendar days before the date of the change of ownership.
- A license fee of \$2,000.00. ***License fees are not refundable.***
- The administrator or a licensed professional who is listed on the license application shall attend a presurvey conference at the zone office designated by the department. The designated zone office may waive the presurvey conference requirement for a Change of Ownership. Please contact the designated zone office to schedule the presurvey conference or to request a waiver (<http://www.dshs.texas.gov/facilities/compliance-zones.aspx>).
- The applicant shall include evidence (Bill of Sale, Lease Agreement, or legal court document) of the Change of Ownership. This document can be submitted separately from the license application.

Important Items to Note:

- The D/B/A or Assumed name of the facility is the name that will appear on the license certificate and should match advertisements and signage of the facility.
- The Legal Name is the name of the direct owner legally responsible for the day to day operation of the facility, whether by lease or ownership. The Legal Name and EIN on the application should be an exact match with the IRS letter.
- The organizational chart showing ownership structure should reflect all levels of ownership and include EIN numbers. The chart should start with the D/B/A or Assumed Name, continue with the Legal Name (direct owner), and end with any additional ownership levels. An example has been attached for your reference.

The Facility Licensing Group is dedicated to assist you through this process and is available to answer your questions. If you have any questions, please contact the Facility Licensing Group: phone (512) 834-6646, fax (512) 834-4514.

Mailing address:

Department of State Health Services
Regulatory Licensing Unit
Facility Licensing Group
Mail Code 2003
PO Box 149347
Austin, Texas 78714-9347

Overnight mailing address:

Department of State Health Services
Regulatory Licensing Unit
Facility Licensing Group
Mail Code 2003
1100 West 49th Street
Austin, Texas 78714-9347

EXAMPLE
OWNERSHIP STRUCTURE

HIGHER LEVEL
OF OWNERSHIP

EIN #

(Add Boxes as Needed)

LEGAL NAME

EIN #

DOING BUSINESS AS (D/B/A)

or ASSUMED NAME



Application for a License to Operate a Birthing Center

Initial
Projected Date Facility Will Open: _____

Change of Ownership
Effective Date: _____ Current License #: _____

1. Facility Information:

a. Name the facility will be Doing Business As (D/B/A) or Assumed Name:

b. Street Address: _____
Street Number

_____ City/State/Zip County

c. Mailing Address: _____
(If different) Street or P.O. Box Number

_____ City/State/Zip

d. Telephone Number: _____

e. Fax Number: _____

Leave blank if number is unknown at this time.

Leave blank if number is unknown at this time.

2. Ownership Information:

a. Legal Name (*Name of direct owner legally responsible for the day to day operation of the facility, whether by lease or ownership*)

b. Mailing Address _____

c. City/State/Zip _____

d. EIN Number _____

e. Telephone Number _____

f. Email Address _____

g. Provide a copy of the IRS letter assigning the federal employer identification number (EIN).

h. Provide a copy of the Certificate of Filing from the Office of the Secretary of State.

i. Attach an organizational chart showing the ownership structure. *See Example.*

2. Ownership Information Continued:

j. Status: Profit Non-Profit

k. Type of Ownership:

<input type="checkbox"/> City	<input type="checkbox"/> Hospital District/Authority	<input type="checkbox"/> LTD
<input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company (LLC)	<input type="checkbox"/> Partnership
<input type="checkbox"/> County	<input type="checkbox"/> Limited Liability Partnership (LLP)	<input type="checkbox"/> Sole Owner/Proprietorship
<input type="checkbox"/> Hospital	<input type="checkbox"/> Limited Partnership (LP)	<input type="checkbox"/> State
<input type="checkbox"/> Other: _____		

3. Ownership and Control Interest Disclosure:

a. The owner must disclose the following data for the two-year period preceding the application date. Check yes or no to the following questions. If yes is checked, you must provide details, including ownership and facility information, circumstances, dates and final action, on a separate sheet with this application.

- | | |
|---|--|
| 1. Eviction involving any property used as a health care facility in any state? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Federal or state (any state) tax liens? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Unsatisfied final judgments? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Federal or state (any state) criminal misdemeanor arrests or convictions? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Injunctive orders from any court? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Unresolved final state or federal Medicare or Medicaid audit exceptions? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

b. The owner must disclose the following data. Check yes or no to each question. If yes is checked, provide details on a separate sheet, including all ownership and facility information, circumstances, dates and final action.

- | | |
|---|--|
| 1. Denial, suspension, or revocation of birthing center license or any health agency in any state or any other enforcement action? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Denial, suspension or revocation or other enforcement action against a health care facility license in any state, which is or was proposed by the licensing agency and the status of the proposal? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Surrendered a license before expiration of the license or allowing a license to expire in lieu of the department proceeding with enforcement action? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Federal or state (any state) criminal felony arrests or convictions? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Federal or state Medicaid or Medicare sanctions or penalties relating to the operation of a health care facility? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Operating a health care facility that has been decertified with Medicare or Medicaid? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. Debarment, exclusion, or contract cancellation from Medicare or Medicaid in any state? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

4. **Licensing Fee:** Initial \$2,000.00
 Change of Ownership \$2,000.00

Fees paid to the Department are not refundable. The application will not be processed without the appropriate fee.

5. Personnel:

Provide names, license numbers and expiration dates of personnel who provide services at the birthing center.
(Use attached page if necessary.)

Physician

Name	License #	Expiration Date
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Certified Nurse-Midwife

Name	License #	Expiration Date
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Licensed Midwife

Name	License #	Expiration Date
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6. Other – The following documents are required and must be attached in order to complete the application:

- A written plan for the orderly transfer of care of patients and clinical records in the event the facility is unable to maintain services under the license.
- Organizational structure of the staffing for the facility.
- Agreement to sale. *(Change of Ownership Only.)*

7. Administrator's Signature:

The administrator attests that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 137, Birthing Centers Licensing Rules. The administrator attests that all information contained in this application is true and correct. The administrator attests that all copies submitted with the application are original copies or copies of the original documents.

Administrator's Name (***Please Print***)
Person responsible for day-to-day operations at the center

Title

Administrator's Signature

Date Signed

Administrator's Email Address

Administrator's Telephone Number

Name of Facility: _____

DEPT. ID ZZ101/FUND 169

8. Contact Person:

Name of the person completing this application

Title

Telephone Number

Email Address

Mailing address for applications with fees:

Department of State Health Services
Facility Licensing Group
Mail Code 2003
PO Box 149347
Austin, Texas 78714-9347

Overnight mailing address for applications with fees:

Department of State Health Services
Facility Licensing Group
Mail Code 2003
1100 West 49th Street
Austin, Texas 78756

PERSONNEL CONTINUED...

Provide names, license numbers and expiration dates of personnel who provide services at the birthing center.
(Do not include names of individuals already included on page 2.)

Physicians:

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date

Certified Nurse-Midwives:

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date

Licensed Midwives:

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date

_____	_____	_____
Name	License #	Expiration Date