



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

How to Become a Licensed Multiple Location General or Special Hospital

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for a Multiple Location General or Special Hospital. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 133, Hospital Licensing Rules, §133.22 Application and Issuance of Initial License. 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.state.tx.us/facilities/>.

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

Initial Application

- A multiple location hospital license application form for multiple hospitals to be licensed under a single license number shall be submitted approximately 90 calendar days prior to the projected opening date of the hospital.
- A license fee of \$39.00 per bed shall be submitted. *License fees are not refundable.*
- Patient Transfer Documents:
 - A copy of the hospital's Patient Transfer Policy that is in accordance with §133.44 Hospital Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
 - A copy of the hospital's Memorandum of Transfer form that is in accordance with §133.44(c)(10)(B) shall be submitted.
 - Patient Transfer Agreements between General Hospitals are voluntary. If the application is for a Special hospital, a copy of a written agreement the Special Hospital has entered into with a General Hospital, which provides for the prompt transfer to and the admission of any patient when special services are needed but are unavailable at the Special Hospital, shall be submitted. This agreement is required and is separate from any voluntary patient transfer agreements the hospital may enter into in accordance with §133.61 (relating to Hospital Patient Transfer Agreements).
- A completed Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority.
- Approval for occupancy shall be obtained from the Department of State Health Services, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or <http://www.dshs.state.tx.us/facilities/architectural-review.aspx>).
- The applicant 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.state.tx.us/facilities/compliance-zones.aspx>). (*Note: It is required that an individual listed on the license application attend the conference.*)

Relocation Application

- A multiple location hospital license application form for multiple hospitals to be licensed under a single license number shall be submitted if applicable, no earlier than 90 calendar days prior to the projected opening date of the hospital.
- A license fee of \$39.00 per bed shall be submitted. *License fees are not refundable.*

Relocation Application Continued:

- Patient Transfer Documents:
 - A copy of the hospital's Patient Transfer Policy that is in accordance with §133.44 Hospital Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
 - A copy of the hospital's Memorandum of Transfer form that is in accordance with §133.44(c)(10)(B) shall be submitted.
 - Patient Transfer Agreements between General Hospitals are voluntary. If the application is for a Special hospital, a copy of a written agreement the Special Hospital has entered into with a General Hospital, which provides for the prompt transfer to and the admission of any patient when special services are needed but are unavailable at the Special Hospital, shall be submitted. This agreement is required and is separate from any voluntary patient transfer agreements the hospital may enter into in accordance with §133.61 (relating to Hospital Patient Transfer Agreements).
- A copy of the letter or certificate of accreditation from an authorized accrediting agency which includes effective dates of accreditation.
- A completed Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority.
- Approval for occupancy shall be obtained from the Department of State Health Services, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or <http://www.dshs.state.tx.us/facilities/architectural-review.aspx>).

Change of Ownership (CHOW) Application

- A multiple location hospital license application form for multiple hospitals to be licensed under a single license number shall be submitted prior to the date of the change of ownership or not later than 10 calendar days following the date of the change of ownership.
- A license fee of \$39.00 per bed shall be submitted. *License fees are not refundable.*
- Patient Transfer Documents:
 - A copy of the hospital's Patient Transfer Policy that is in accordance with §133.44 Hospital Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
 - A copy of the hospital's Memorandum of Transfer form that is in accordance with §133.44(c)(10)(B) shall be submitted.
 - Patient Transfer Agreements between General Hospitals are voluntary. If the application is for a Special hospital, a copy of a written agreement the Special Hospital has entered into with a General Hospital, which provides for the prompt transfer to and the admission of any patient when special services are needed but are unavailable at the Special Hospital, shall be submitted. This agreement is required and is separate from any voluntary patient transfer agreements the hospital may enter into in accordance with §133.61 (relating to Hospital Patient Transfer Agreements).
- A copy of the letter or certificate of accreditation from an authorized accrediting agency which includes effective dates of accreditation.
- A copy of two completed Fire Safety Survey Report forms shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months & a second report conducted within the last 13 to 24 months indicating approval by the local fire authority.
- The applicant 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.state.tx.us/facilities/compliance-zones.aspx>). *(Note: It is required that an individual listed on the license application attend the conference).*
- A Bill of Sale or other legal document shall be submitted. The document shall include the effective date of the change of ownership and both parties signed agreement to the transaction.

Important Items to Note:

- The D/B/A or Assumed Name listed on the application must match the D/B/A or Assumed Name listed on applications filed with the Texas State Board of Pharmacy, Texas Department of Public Safety – Controlled Substances Registration, and the Drug Enforcement Agency.
- 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.

Additional Information:

Medicare certification information may be obtained from the zone office for your location (<http://www.dshs.state.tx.us/facilities/compliance-zones.aspx>). The Social Security Act directs the Secretary of the Department of Health and Human Services to use the help of State health agencies or other appropriate agencies to determine if health care entities meet Federal standards. This task is one of the Department of State Health Services' responsibilities. For information on gaining provider certification, please contact zone office staff.

CLIA information is located on the department's website at <http://www.dshs.state.tx.us/facilities/>. For more information, please contact the zone office for your location.

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 Hospital Licensing Section: phone (512) 834-6648, fax (512) 834-4514.

Mailing address for applications with fees:

**DEPARTMENT OF STATE HEALTH SERVICES
REGULATORY LICENSING UNIT - FACILITY LICENSING GROUP
MAIL CODE 2003
P.O. 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**

EXAMPLE
OWNERSHIP STRUCTURE

HIGHER LEVEL
OF OWNERSHIP

EIN #

(Add Boxes as Needed)

LEGAL NAME

EIN #

DOING BUSINESS AS (D/B/A)

or ASSUMED NAME



Multiple Location Hospital Application (for Hospitals Licensed Under A Single License Number)

Name of Main Hospital: _____

Main Hospital License Number: _____ Multi Hospital Designation: General Special

Multi Application Type: Initial Change of Ownership Relocation

Projected Opening Date or Projected CHOW Effective Date: _____

1. HOSPITAL INFORMATION:

a. Hospital within a hospital: Yes No

b. Name the multiple location hospital will be doing business as (d/b/a):

This is the name that will appear on the license and should match advertisements and signage of the hospital.

c. Street Address: _____
Street Number

City/State/Zip

County

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

City/State/Zip

e. Telephone Number (include area code)

f. Fax Number (include area code)

Leave blank if number is unknown at this time.

Leave blank if number is unknown at this time.

2. OWNERSHIP INFORMATION: *Ownership information must exactly match ownership for parent hospital.*

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

b. Mailing Address

c. City/State/Zip

d. EIN Number

e. Telephone Number

f. Email Address

g. Status: Profit Non-Profit

Name of Main Hospital: _____

BUDGET: ZZ101

Name of Multiple Location Hospital: _____

FUND: 152

License Number: _____

2. OWNERSHIP INFORMATION CONTINUED:

- h. 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: _____ | | |

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

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

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

3. NICHE: Is this hospital a Niche hospital? Yes No

The term "Niche hospital" means that, (A) two-thirds of the hospital's Medicare patients or all patients are classified in no more than two major diagnosis related groups (DRG) or surgical diagnosis-related groups; or (B) specializes in one or more of the following areas: cardiac, orthopedics, surgery, or women's health and is not a public hospital, is not a hospital for which the majority of inpatients claims are for major DRG relating to rehabilitation, psychiatry, alcohol and drug treatment, or children or newborns, or is not a hospital with fewer than ten (10) claims per bed per year.

4. HOSPITAL SERVICES:

Services: (Please check all services offered)

- Medical (*Special hospitals only*)
- Surgery (*General hospitals only*)
- Obstetrical Care (*General hospitals only*)
- Clinical Laboratory Services (*contracted or onsite*)
- Diagnostic X-ray Services (*i.e. MRI, ultrasound, portable x-ray*)
- Emergency Department
- Emergency Treatment Room** (*required if no Emergency Department*)
- Pediatric (*if 15 or more pediatric beds*)
- Comprehensive Medical Rehabilitation
- ESRD – Acute Services*
- Mental Health Services (*in an identifiable part of the hospital*)
- Chemical Dependency Services (*in an identifiable part of the hospital*) Inpatient Outpatient
- Other Definitive Medical or Surgical Treatment: _____

***Answer the questions below if ESRD Stations are provided for treatment within a designated area of the hospital:**

- What patient populations are being served? pediatric adult
 Do you provide peritoneal dialysis? Yes No
 How many stations do you have? _____ (*not included in bed count*)

****Does this location currently have a waiver for the Emergency Department?** Yes No

5. OTHER SERVICES: (*Please select any of the following if applicable*)

- Long Term Acute Care Hospital Critical Access Hospital Skilled Nursing Unit None

Name of Main Hospital: _____
Name of Multiple Location Hospital: _____
License Number: _____

BUDGET: ZZ101
FUND: 152

6. LICENSED BEDS AND FEES:

How many total licensed beds are at this hospital location? _____ (total bed design capacity of this hospital only)
* A change in the bed design capacity requires prior Department approval and possible fees.

Total fee due is \$39.00 per bed. Amount paid: \$ _____

How many emergency treatment room beds and/or emergency department beds are at this hospital location? _____
* This count is not included in the licensed bed count above and will not affect fees. A minimum of one bed is required.

Please provide the total number of licensed beds in each unit or area of service at this hospital location:

_____ Medical/Surgical (may include pediatric beds if pediatric bed count is less than 15 beds)	_____ Postpartum
_____ ICU/CCU	_____ Adolescent
_____ Intermediate Care	_____ Pediatric (if 15 or more beds)
_____ Universal Care	_____ Skilled Nursing
_____ Neonatal ICU	_____ Comprehensive Medical Rehabilitation
_____ Continuing Care Nursery	_____ Mental Health
_____ Antepartum	_____ Chemical Dependency
_____ Labor/Delivery/Recovery/Post Partum	

7. ACCREDITATION

(Please check the category(ies) that apply – attach a copy of the most recent accreditation letter or certificate)

- Joint Commission (JC)
- American Osteopathic Association (AOA)
- DNV GL
- Center for Improvement in Healthcare Quality (CIHQ)
- Not accredited

8. MEDICARE CERTIFICATION

Is the hospital certified to participate in the Title XVIII Medicare Program? Yes No

If YES, please provide the hospital's Medicare Provider Number: _____

9. COMMUNITY WIDE DESIGNATED HOSPITALS FOR SEXUAL ASSAULT SURVIVORS:

Is the hospital designated as providing treatment for survivors of sexual assault? Yes No

10. FIRE SAFETY SURVEY: (The fire safety survey form is available on our website at

(The fire safety survey form is available on our website at <http://www.dshs.state.tx.us/facilities/hospitals/forms.aspx#general-special>)

A completed Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority. For change of ownership applications, a fire inspection report conducted within the last 12 months & a second report conducted within the last 13 to 24 months shall be submitted.

Name of Main Hospital: _____
Name of Multiple Location Hospital: _____
License Number: _____

BUDGET: ZZ101
FUND: 152

11. PATIENT TRANSFER POLICY/MEMORANDUM OF TRANSFER/PATIENT TRANSFER AGREEMENT:

- Submit a copy of the hospital's Memorandum of Transfer form and the Patient Transfer Policy developed in accordance with the rules governing patient transfer policies and agreements which is signed by both the chairman and secretary of the hospital's governing body attesting to the date of adoption of the policy and the policy's effective date.

- Submit copies of all Patient Transfer Agreements between the hospital and another hospital licensed under Health and Safety Code (HSC), Chapter 241, developed in accordance with the rules governing hospital patient transfer policies and agreements (unless you have a written waiver granted by DSHS). If you have a written waiver, please attach a list of hospitals that your hospital has agreements with and include the effective dates of the agreements. Only submit agreements between hospitals that are licensed under HSC Chapter 241.

12. SIGNATURE AND ATTESTATION:

I attest that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 133, Hospital Licensing Rules. I attest that all information contained in this application is true and correct. I attest that all copies submitted with the application are original copies or copies of the original documents. In compliance with Health and Safety Code §241.022(c)(1) and the Hospital Licensing Rules, this is to attest that the physicians on the medical staff of this hospital are currently licensed by the Texas State Board of Medical Examiners and are qualified legally, professionally and ethically for the positions to which they are appointed.

Chief Executive Officer Signature

Date Signed

Printed Name of CEO

Title

Telephone Number

Email Address

13. HOSPITAL ADMINISTRATOR:

Onsite Administrator in charge of day-to-day operations

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, TX 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, TX 78756

Name of Main Hospital: _____

BUDGET: ZZ101

Name of Multiple Location Hospital: _____

FUND: 152

License Number: _____

OWNERSHIP ADDENDUM

Please complete if the owner is a Partnership or a Corporation. Attach additional pages if necessary. (Social security numbers will be kept confidential under Government Code Section 552.147).

The owner is a:

N/A

Partnership - List each general partner who is an individual.

Print Name: _____

Social Security Number: _____/_____/_____

Corporation - List any individual who has an ownership interest of 25% or more in the corporation.

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Name of Main Hospital: _____

BUDGET: ZZ101

Name of Multiple Location Hospital: _____

FUND: 152

License Number: _____

OWNERSHIP ADDENDUM (cont.)

N/A

Please complete if the hospital is a Niche Hospital. Attach additional pages if necessary. (Social security numbers will be kept confidential under Government Code Section 552.147).

Niche Hospital - the name, social security number, address and license number of any physician licensed by the Texas Medical Board who has a financial interest in the ownership of the hospital.

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____ Social Security Number: _____

Address: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____ Social Security Number: _____

Address: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____ Social Security Number: _____

Address: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____ Social Security Number: _____

Address: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____ Social Security Number: _____

Address: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____ Social Security Number: _____

Address: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____ Social Security Number: _____

Address: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____ Social Security Number: _____

Address: _____

MEMORANDUM OF TRANSFER (sample)

SECTION A (To Be Filled Out At Transferring Hospital)

1. Name of Transferring Hospital:
Address:
Phone Number:
2. Patient Information (If Known)
Patient's full name:
Address:
Phone Number:
Sex: M F Age:
National origin: Race:
Religion: Physical Handicap:
3. Next of Kin:(If Known)
Address:
Phone Number:
Next of Kin notified? () Yes () No
4. Date of Arrival: / / Time:
5. Initial contact with receiving hospital administration:
Date: / / Time:
Name of contact person at receiving hospital:
6. Receiving physician secured by transferring physician:
Date: / / Time:
Name of receiving physician:
7. Transferring physician's signature or signature of hospital staff acting under physician's orders:
Name of transferring physician:
Phone Number: ()
Address:
8. Accepting hospital secured by transferring hospital:
Date: / / Time:
Name of receiving hospital administration person:
9. Transferring hospital administration who contacted the receiving hospital:
Signature:
Title:
10. Type of vehicle and company used:
Equipment needed:
Personnel needed:
11. Facility transported to:
12. Diagnosis:
13. Attachments:
X-rays MD Progress Notes
Lab Reports Nurses Progress Notes
History Medication Record

PHYSICIAN CERTIFICATION: based upon the information available at the time of the transfer the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks of the transfer to the patient and, in the case of labor, the unborn child.

Summary of Risks and Benefits

PHYSICIAN'S SIGNATURE

SECTION B (To Be Filled Out At Receiving Hospital)

1. Name of Receiving Hospital:
Address:
Phone Number:
2. Date of Arrival: / / Time:
3. Receiving Hospital Administration Signature:
Title: Date: / /
4. Receiving physician assumed responsibility for the patient:
Date: / / Time:
Receiving Physician's signature:
Name:
Address:
Phone Number: ()
5. If response to the transfer request was delayed beyond thirty (30) minutes, document the reason(s) for the delay, including any agreed time extensions. Use additional sheet, if necessary.

DISTRIBUTION: Original to accompany patient to receiving hospital. Copy to be retained at transferring hospital.