TEXAS Health and Human Services

How to Become a Licensed Ambulatory Surgical Center

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for an Ambulatory Surgical Center. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 135, Ambulatory Surgical Center Licensing Rules, §135.20 Initial Application and Issuance of License. Information regarding licensure for health care facilities, including contact information for the Health Facility Compliance Zone Office for your location is located on the department's website at 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 facility.
- A license fee of $5,200.00 shall be submitted. ***License fees are not refundable.***
- Approval for occupancy shall be obtained from the Architectural Review Group: (512) 834-6649 or http://www.dshs.texas.gov/facilities/architectural-review.aspx).
- The Administrator, Medical Chief of Staff, and/or Director of Nurses listed on the application shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated office to schedule the presurvey conference (http://www.dshs.texas.gov/facilities/compliance-zones.aspx).

Change of Ownership (CHOW) Application

- A license application form to be submitted at least 30 calendar days before the date of the change of ownership.
- A license fee of $5,200.00 shall be submitted. ***License fees are not refundable.***
- If applicable, submit a letter or certificate of accreditation from an accrediting organization which includes dates of accreditation.
- The Administrator, Medical Chief of Staff, and/or Director of Nurses listed on the application shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated office to schedule the presurvey conference (http://www.dshs.texas.gov/facilities/compliance-zones.aspx).

- Submit a Bill of Sale or other legal document which shows both parties agreement to the sale.

Relocation Application

- A license application form submitted approximately 90 calendar days prior to the projected opening date of the facility.
- A license fee of $5,200.00 shall be submitted. ***License fees are not refundable.***
- If applicable, submit a letter or certificate of accreditation from an accrediting organization which includes dates of accreditation.
- Approval for occupancy shall be obtained from the Architectural Review Group: (512) 834-6649 or http://www.dshs.texas.gov/facilities/architectural-review.aspx).

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 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 legal entity directly responsible for the day to day operation of the facility. The Legal Name and EIN on the application should be an exact match with the IRS letter, Secretary of State documentation, and ownership structure.
- The 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, and end with any additional ownership levels. An example has been attached for your reference.

Additional Information:

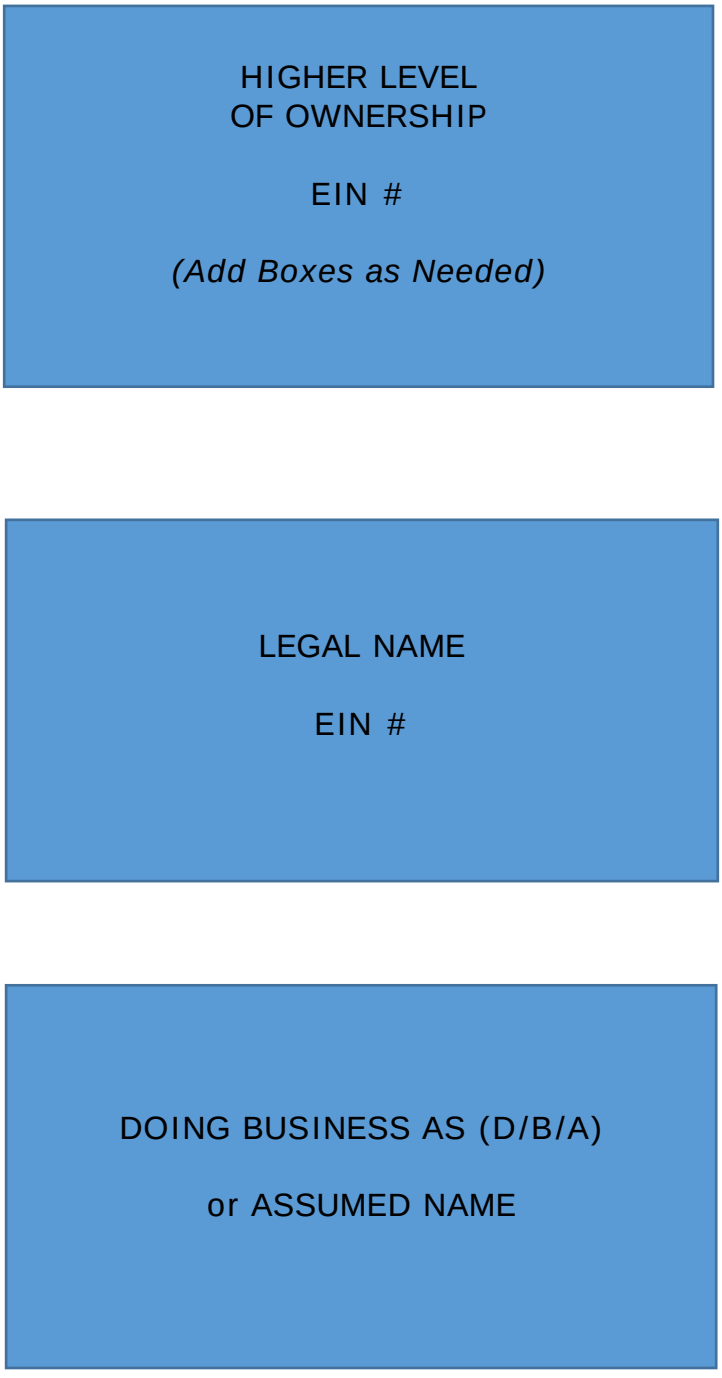
Medicare certification information may be obtained from the Health Facility Compliance Zone Office for your location (http://www.dshs.texas.gov/facilities/compliance-zones.aspx). The Social Security Act directs the Secretary of the Department of Health and Human Services to use the help of State health agencies or other appropriate agencies to determine if health care entities meet Federal standards. This task is one of the Texas Health and Human Services Commission's responsibilities. For information on gaining provider certification, contact Zone Office staff.

CLIA information is located on the department's website at http://www.dshs.texas.gov/facilities/clia.aspx. For more information, contact the Health Facility Compliance 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 Facility Licensing Group: phone (512) 834-6648, fax (512) 834-4514.

MAILING ADDRESS:
HHSC AR
P.O. BOX 149055
Austin, Texas 78714-9055

EXAMPLE
OWNERSHIP STRUCTURE



SERVICE CODE: 529201046

TEXAS Health and Human Services

AMBULATORY SURGICAL CENTER LICENSE APPLICATION

☐ Initial
Projected date facility will open: _____ Architectural Project #:_____

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

☐ Relocation
Projected Date Facility Will Open: _____
Current License #: _____ Architectural Project #: _____

1. Facility Information:

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

_____

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

b. Street Address:

_____
Address

_____
City/State/Zip County

c. Mailing Address:

_____
Street Address or P.O. Box Number

_____
City/State/Zip

d. Telephone Number **e.** Fax Number

_____ _____

Leave blank if numbers are unknown at this time.

Name of Facility: _____ SERVICE CODE: 529201046

2. Ownership Information:

_____

a. Legal Name

_____

b. Mailing Address City/State/Zip

_____ _____ _____

c. EIN Number **d.** Telephone Number **e.** Email Address

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

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

h. Attach an ownership structure. *See Example.*

i. Status: ☐ Profit ☐ Non-Profit

j. Type of Ownership:

☐ City
☐ Corporation
☐ County
☐ Hospital
☐ LTD
☐ Sole Owner/Proprietorship
☐ State
☐ Other: _____
☐ Hospital District/Authority
☐ Limited Liability Company (LLC)
☐ Limited Liability Partnership (LLP)
☐ Limited Partnership (LP)
☐ Partnership

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3. Ownership and Control Interest Disclosure:

a. The owner/legal entity 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** ☐ **No** ☐
2. Federal or state (any state) tax liens? **Yes** ☐ **No** ☐
3. Unsatisfied final judgments? **Yes** ☐ **No** ☐
4. Federal or state (any state) criminal misdemeanor arrests or convictions? **Yes** ☐ **No** ☐
5. Injunctive orders from any court? **Yes** ☐ **No** ☐
6. Unresolved final state or federal Medicare or Medicaid audit exceptions? **Yes** ☐ **No** ☐

b. The owner/legal entity 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 ASC license or any health agency in any state or any other enforcement action? **Yes** ☐ **No** ☐
2. Denial, suspension, revocation, or other enforcement action against a health care facility licensed in any state, which is or was proposed by the licensing agency and the status of the proposal? **Yes** ☐ **No** ☐
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** ☐ **No** ☐
4. Federal or state (any state) criminal felony arrests or convictions? **Yes** ☐ **No** ☐
5. Federal or state Medicaid or Medicare sanctions or penalties relating to the operation of a health care facility? **Yes** ☐ **No** ☐
6. Operating a health care facility that has been decertified with Medicare or Medicaid? **Yes** ☐ **No** ☐
7. Debarment, exclusion, or contract cancellation from Medicare or Medicaid in any state? **Yes** ☐ **No** ☐

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4. License Fee:

☐ Initial	$5,200.00
☐ Relocation	$5,200.00
☐ Change of Ownership	$5,200.00

Make checks payable to the Texas Health and Human Services Commission.
Fees paid to the Commission are not refundable.

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5. Services:

Mark all surgical specialties that are offered at this facility:

☐ Abortion	☐ Gastroenterology	☐ Ophthalmology	☐ Pain Management
☐ Cardiovascular	☐ General	☐ Oral	☐ Plastic
☐ Chiropractic	☐ Neurological	☐ Orthopedic	☐ Thoracic
☐ Endoscopy	☐ OB/GYN	☐ Otolaryngology	☐ Urology
☐ Foot	☐ Other: _____		

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6. Medicare Certification (CHOWS and Relocations ONLY):

Is the facility certified to participate in the Medicare Program? ☐ Yes ☐ No
If YES, provide the facility's CCN Number: _____

7. Accreditation (CHOWS and Relocations ONLY):
(Check the appropriate category)
Attach a copy of the most recent letter or certificate of accreditation.

- ☐ Accreditation Association for Ambulatory Healthcare (AAAHC)
- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ Healthcare Facilities Accreditation Program (HFAP)
- ☐ Institute for Medical Quality (IMQ)
- ☐ The Joint Commission
- ☐ Other Accreditation Agency: _____
- ☐ Pending Accreditation: _____
- ☐ Not accredited

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8. Treatment & Procedure Rooms:

a. Total Number of Operating Rooms: _____

b. Total Number of Treatment/Procedure Rooms: _____

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9. Medical Staff:

a. Provide the total number of physicians, dentists, podiatrists, and/or advanced practice registered nurses providing services at the facility:

Physicians _____ Dentists _____Podiatrists _____ APRNs _____

b. Medical Chief of Staff:

_____	_____	_____
Name **(PRINT)**	License #	Expiration Date

c. Director of Nurses:

_____	_____	_____
Name **(PRINT)**	License #	Expiration Date

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10. Additional Required Documents:

- ☐ Bill of Sale *(CHOW application only; can be submitted separately from application)*

11. Administrator's Signature & Attestation:

The administrator attests that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 135, Ambulatory Surgical Centers. 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 **(PRINT)** Title
Person responsible for day-to-day operations at the facility

_____ _____
Administrator's Signature Date Signed

_____ _____
Administrator's Email Address Administrator's Telephone Number

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12. Contact Person:

_____ _____
Name of the person completing this application Title

_____ _____
Telephone Number Email Address