



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

How to Become a Licensed End Stage Renal Disease Facility

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for an End Stage Renal Disease Facility. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 117, End Stage Renal Disease Facility Licensing Rules, §117.12 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.texas.gov/facilities/default.aspx>.

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 ranging from \$3,500.00 - \$6,700.00 based on total number of stations shall be submitted. Please refer to the license application to determine required fee. ***License fees are not refundable.***
- 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.
- 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.texas.gov/facilities/architectural-review.aspx>).
- 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>).
- The facility shall submit a complete chemical analysis of the product water, and reports to verify that bacteriological and endotoxin levels of product water and dialysate are in compliance with §117.32 (relating to Water Treatment, Dialysate Concentrates, and Reuse). Reports shall be submitted to the designated zone office for approval. Please contact the designated zone office with any questions.
- Medicare certified facilities shall complete the Life Safety Code Attestation available on our website at <http://www.dshs.texas.gov/facilities/esrd/forms.aspx>.

Relocation Application

- A license application form submitted approximately 90 calendar days prior to the projected opening date of the facility.
- A license fee ranging from \$3,500.00 - \$6,700.00 based on total number of stations shall be submitted. Please refer to the license application to determine required fee. *License fees are not refundable.*
- 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.
- 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.texas.gov/facilities/architectural-review.aspx>).
- The facility shall submit a complete chemical analysis of the product water, and reports to verify that bacteriological and endotoxin levels of product water and dialysate are in compliance with §117.32 (relating to Water Treatment, Dialysate Concentrates, and Reuse). Reports shall be submitted to the designated zone office for approval. Please contact the designated zone office with any questions.
- Medicare certified facilities shall complete the Life Safety Code Attestation available on our website at <http://www.dshs.texas.gov/facilities/esrd/forms.aspx>.

Change of Ownership (CHOW) Application

- A license application form to be submitted at least 60 calendar days before the date of the change of ownership.
- A license fee ranging from \$3,500.00 - \$6,700.00 based on total number of stations shall be submitted. Please refer to the license application to determine required fee. *License fees are not refundable.*
- 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.
- 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 and a second report conducted within the last 13 to 24 months indicating approval by the local fire authority.
- 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>).
- Medicare certified facilities shall complete the Life Safety Code Attestation available on our website at <http://www.dshs.texas.gov/facilities/esrd/forms.aspx> or agree to have a Life Safety Code survey at a later date.
- 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.

Additional Information:

Medicare certification information may be obtained from the 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 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.texas.gov/facilities/cliia.aspx>. 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 Facility Licensing Group: phone (512) 834-6646, 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



Application for a License to Operate an End Stage Renal Disease Facility

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: _____
Street Address

City/State/Zip County

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

City/State/Zip

d. Telephone Number (include area code)

e. 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:

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

2. Ownership Information Continued:

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.*

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 end stage renal disease license or any health agency in any state or any other enforcement action? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 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 <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. Dialysis Technicians *(please check appropriate box):*

- Each dialysis technician on staff in the facility has completed the training and competency evaluation programs described in 25 TAC §117.62 and 117.63.
- This facility does not use dialysis technicians.

5. Dialysis Services:

Please Note: A station is defined as--An area in the facility in which a patient receives in-center dialysis treatment, or dialysis instruction, (i.e., home hemodialysis training, or peritoneal dialysis training). **A change to any stations or services requires prior DSHS approval.**

- a. Number of hemodialysis stations: _____
 Number of hemodialysis training stations: _____
 Number of peritoneal training stations: _____
 Number of isolation stations: _____
Total number of stations: _____

- b. Isolation room or CMS Waiver for the Isolation Room
For a change of ownership application only, please choose one of the above or one of the following: Separate Isolation Area
 Transfer Agreement

- c. Services: Adult Only
 Pediatric Only
 Pediatric and Adult

 In-center Hemodialysis
 Home Hemodialysis
 Home Peritoneal

6. Personnel:

Provide names, license numbers and expiration dates for each of the following individuals:

- a. **Board Certified** Medical Director:

Name	License #	Expiration Date
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- b. Supervising Nurse:

Name	License #	Expiration Date
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- c. Social Worker:

Name	License #	Expiration Date
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- d. Dietitian:

Name	License #	Expiration Date
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7. Licensing Fee: (License fee not required if this facility is owned/operated by the State of Texas)

Initial/Relocation/Change of Ownership:	1-10 stations	=	\$3,500.00
	11-20 stations	=	\$4,300.00
	21-30 stations	=	\$5,100.00
	31-40 stations	=	\$5,900.00
	41 or more stations	=	\$6,700.00

Make checks payable to the Department of State Health Services. **Fees paid to the Department are not refundable.**

8. Additional Required Documents:

- Fire Safety Survey - 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 copy of two completed Fire Safety Survey Report forms shall be submitted; one report dated within the last 12 months and a second report dated within the last 13 to 24 months.
- 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.
- (Bill of Sale) *(Shall be submitted with change of ownership applications only; can be submitted separately from the license application).*
- Life Safety Code Attestation

9. Administrator's Signature:

The administrator attests that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 117, End Stage Renal Disease Facilities. 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. The administrator attests that if a change of ownership has occurred, the new owner shall be responsible for previous regulatory violations and shall ensure compliance with all rules and regulations.

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

 Title

 Administrator's Signature

 Date Signed

 Administrator's Email Address

 Administrator's Telephone Number

10. 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