TEXAS Health and Human Services

How to Become a Licensed General or Special Hospital

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for a 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.texas.gov/facilities.

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

Initial Application

- A hospital license application form 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. 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 Health and Human Services Commission, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or http://www.dshs.texas.gov/facilities/architectural-review.aspx).
- The hospital CEO or Administrator shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated Zone Office to schedule attendance (http://www.dshs.texas.gov/facilities/compliance-zones.aspx). ***(Note: It is required that an individual listed on the license application attend the conference).***

Relocation Application

- A hospital license application form 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 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. 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 Health and Human Services Commission, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or http://www.dshs.texas.gov/facilities/architectural-review.aspx).

Change of Ownership (CHOW) Application

- A hospital license application form 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. 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 hospital CEO or Administrator shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated Zone Office to schedule attendance or to request a waiver (http://www.dshs.texas.gov/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 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:

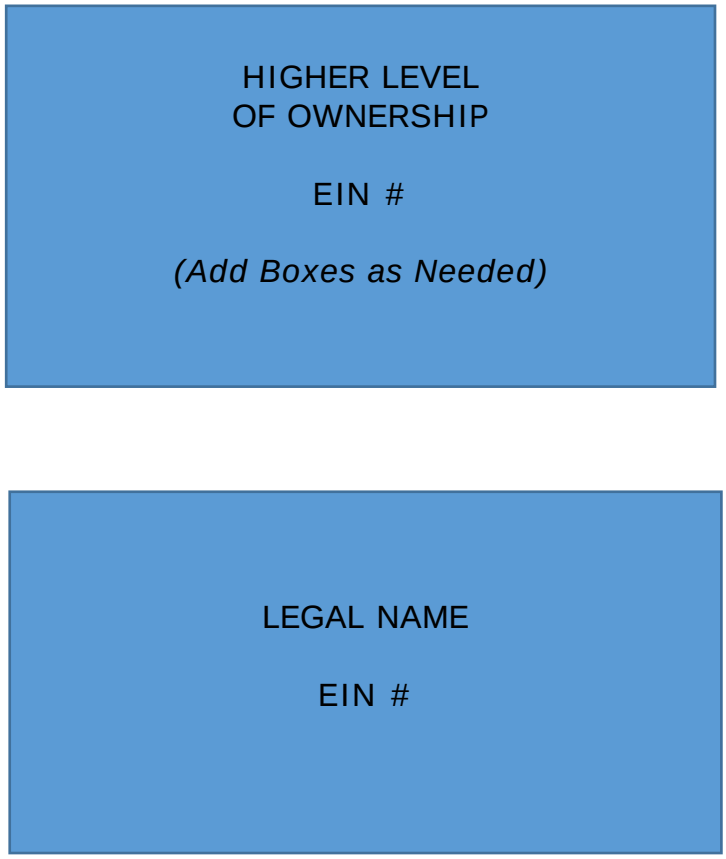
Medicare certification information may be obtained from the zone office for your location (http://www.dshs.texas.gov/facilities/compliance-zones.aspx). The Social Security Act directs the Secretary of the Department of Health and Human Services to use the help of State health agencies or other appropriate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

CLIA information is located on the department's website at http://www.dshs.texas.gov/facilities. For more information, contact the Zone Office for your location http://www.dshs.texas.gov/facilities/compliance-zones.aspx.

The Facility Licensing Group is dedicated to assist you through this process and is available to answer your questions. If you have any questions, contact the Hospital Licensing Section: 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: 529201039
DEPT ID: ZZ101 FUND: 152

TEXAS Health and Human Services

APPLICATION FOR A LICENSE TO OPERATE A GENERAL OR SPECIAL HOSPITAL

☐ 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 #: _____

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1. HOSPITAL INFORMATION:

a. Hospital within a hospital: ☐ Yes ☐ No

b. Name the hospital 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 hospital.

c. Street Address:

_____
Street

_____
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 numbers are unknown at this time.

Name of Hospital: _____ SERVICE CODE: 529201039
DEPT. ID ZZ101/FUND 152

2. OWNERSHIP INFORMATION:

_____

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 City/State/Zip

_____ _____ _____

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

f. Status: ☐ Profit ☐ Non-Profit

g. 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

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

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

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

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3. PHYSICIAN OWNERSHIP:

Does this hospital have physician owners? ☐ Yes ☐ No

If yes was marked, also complete the attached Physician Ownership Addendum.

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4. HOSPITAL SERVICES: *(Select either General or Special)*

☐ **GENERAL** - The term "general hospital" means any establishment offering services, facilities, and beds for use for more than twenty-four (24) hours for two (2) or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy, and regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

Name of Hospital: _____ SERVICE CODE: 529201039
DEPT. ID ZZ101/FUND 152

Services: *(Check all services offered)*

- ☐ Surgery
- ☐ Obstetrical Care
- ☐ Clinical Laboratory Services (*required contracted or onsite*)
- ☐ Diagnostic X-ray Services *(required)*
- ☐ Emergency Department *(required)*
- ☐ Pediatric *(if 15 or more beds)*
- ☐ Comprehensive Medical Rehabilitation
- ☐ ESRD – Acute Services* *(in an identifiable part of the hospital)*
- ☐ Mental Health Services *(in an identifiable part of the hospital)*
- ☐ Chemical Dependency *(in an identifiable part of the hospital)*
  - ☐ Inpatient ☐ Outpatient
- ☐ Other Definitive Medical or Surgical Treatment: _____

☐ **SPECIAL -** The term "special hospital" means any establishment offering services, facilities, and beds for use for more than twenty-four (24) hours for two (2) or more unrelated individuals who are regularly admitted, treated, and discharged and who require services more intensive than room, board, personal services, and general nursing care, and has clinical laboratory facilities, diagnostic X-ray facilities, treatment facilities, or other definitive medical treatment, has a medical staff in regular attendance, and maintains records of the clinical work performed for each patient.

Services: *(Check all services offered):*

- ☐ Medical
- ☐ Emergency Department
- ☐ Emergency Treatment Room *(required if no Emergency Department)*
- ☐ Clinical Laboratory Services *(required contracted or onsite)*
- ☐ Diagnostic X-ray Services *(minimum portable X-ray required)*
- ☐ Pediatric *(if 15 or more beds)*
- ☐ Comprehensive Medical Rehabilitation
- ☐ ESRD – Acute Services* *(in an identifiable part of the hospital)*
- ☐ Mental Health Services *(in an identifiable part of the hospital)*
- ☐ Chemical Dependency *(in an identifiable part of the hospital)*
  - ☐ Inpatient ☐ Outpatient
- ☐ Other Definitive Medical 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

Does the hospital provide peritoneal dialysis? ☐ Yes ☐ No

How many stations does the hospital have? _____ *(not included in bed count)*

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

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

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6. LICENSED BEDS:

a. 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 approval and possible fees.

b. 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.

c. 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)

_____ ICU/CCU	_____ Postpartum
_____ Intermediate Care	_____ Adolescent
_____ Universal Care	_____ Pediatric *(if 15 or more beds)*
_____ Neonatal ICU	_____ Skilled Nursing
_____ Continuing Care Nursery	_____ Comprehensive Medical Rehabilitation
_____ Antepartum	_____ Mental Health

_____ Labor/Delivery/Recovery/Postpartum
_____ Chemical Dependency

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7. FEES: *Fees paid to the department are not refundable – Make checks payable to Health and Human Services Commission.*

Total number of licensed beds: _____ *(Include all licensed beds at all locations under a common license)*

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

8. MEDICARE CERTIFICATION (CHOWS and RELOCATIONS ONLY)

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

If YES, provide the hospital's CCN Number: _____

9. SAFE-READY FACILITY

Is your facility a SAFE-ready facility? ☐ Yes ☐ No

"SAFE-ready facility" means a health care facility designated as a Sexual Assault Forensic Exam-ready facility under TX Health and Safety Code Section 323.0015. A SAFE-ready facility employs or contracts with a sexual assault forensic examiner or uses a telemedicine system of sexual assault forensic examiners to provide consultation to a licensed nurse or physician when conducting a sexual assault forensic medical examination.

10. ACCREDITATION (CHOWS and RELOCATIONS ONLY)

(Check the appropriate category)
Attach a copy of the most recent hospital letter or certificate of accreditation.

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

11. FIRE SAFETY SURVEY:

A completed Fire Safety Survey Report shall be submitted. Annual fire safety inspections are required for continued licensure status. 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.

12. 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 HHSC). If you have a written waiver, 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.

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13. 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 Medical Board 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

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14. HOSPITAL ADMINISTRATOR (onsite administrator in charge of day-to-day operations at the hospital):

_____ _____
Administrator Title

_____ _____
Telephone Number Email Address

Name of Hospital: _____ SERVICE CODE: 529201039
DEPT. ID ZZ101/FUND 152

OWNERSHIP ADDENDUM

Complete if the owner is a Partnership or a Corporation. Attach additional pages if necessary.

The owner is a: **N/A** ☐

☐ **Partnership - List each general partner who is an individual.**

Print Name: _____
Social Security Number: _____/_____/_____

Print Name: _____
Social Security Number: _____/_____/_____

Print Name: _____
Social Security Number: _____/_____/_____

Print Name: _____
Social Security Number: _____/_____/_____

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: _____/_____/_____

Name of Hospital: _____ SERVICE CODE: 529201039
DEPT. ID ZZ101/FUND 152

PHYSICIAN OWNERSHIP ADDENDUM **N/A** ☐

Complete if the hospital has physician owners. Attach additional pages if necessary.

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)

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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:_____ Time:_____

10. Type of vehicle and company used:
    _____
    Equipment needed: _____
    Personnel needed: _____

11. Facility transported to: _____
    City: _____

12. Diagnosis: _____
    _____

13. Attachments:
    X-rays _____ MD Progress Notes _____
    Lab Reports _____ Nurses Progress Notes _____
    H&P _____ Medication Record _____
    Other _____

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

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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.