SERVICE CODE: 529201039
DEPT ID: ZZ101 FUND: 152

TEXAS Health and Human Services

General and Special Hospital License Renewal Application

Name of Hospital: _____

Hospital License Number: _____ **Status:** ☐ Profit ☐ Non-Profit

Renewal Fee Submitted ☐ By Mail ☐ Online *(See Renewal Notice for Fee Amount)*

Hospital within a hospital: ☐ Yes ☐ No

Type of Ownership:

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

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1. 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.

Services: *(Check all services offered)*

☐ Surgery
☐ Obstetrical Care
☐ Clinical Laboratory Services (*required contracted or onsite*)
☐ Diagnostic X-ray Services *(required)*
☐ Emergency Department *(required)*
☐ Emergency Treatment Room *(with approved ED waiver)*
☐ Pediatric *(if 15 or more pediatric 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 *(contracted or onsite)*
☐ Diagnostic X-ray Services *(required)*
☐ Comprehensive Medical Rehabilitation
☐ Pediatric *(if 15 or more pediatric beds)*
☐ 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)*

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2. Does this location currently have a STATE waiver of any hospital regulations?
☐ Yes ☐ No
If yes was marked, provide a copy of the waiver.

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3. OTHER SERVICES: *(Select one of the following)*

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

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4. Does this hospital have physician owners? ☐ Yes ☐ No
If yes was marked, also complete the attached Physician Ownership Addendum.

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5. 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
_____ Intermediate Care
_____ Universal Care
_____ Neonatal ICU
_____ Continuing Care Nursery
_____ Antepartum
_____ Labor/Delivery/Recovery/Postpartum
_____ Chemical Dependency
_____ Postpartum
_____ Adolescent
_____ Pediatric *(if 15 or more beds)*
_____ Skilled Nursing
_____ Comprehensive Medical Rehabilitation
_____ Mental Health

6. FEES: *(Fees paid to the department are not refundable)*

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

Total fee due is $39.00 per bed + $20.00 (Texas Online Subscription Fee).
Amount paid: $_____

7. HOSPITAL DATABASE WORKSHEET:
Complete the Hospital Database Worksheet for all hospital locations. The worksheet is available on our website at:
http://www.dshs.texas.gov/facilities/hospitals/forms.aspx#general-special.

8. MEDICARE CERTIFICATION:
Is the hospital certified to participate in the 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:

(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:

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 fire inspector must be certified by the Texas Commission of Fire Protection in order to conduct the inspection.**

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 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

13. HOSPITAL ADMINISTRATOR:

_____ _____
Onsite Administrator in charge of day-to-day operations Title

_____ _____
Telephone Number Email Address

LICENSE NUMBER: _____ SERVICE CODE: 529201039

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: _____/_____/_____

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: _____