Hospital License Application

1. Type of Action		
New Hospital License? ◯	License Change? See Section 3 ◯	

2. Demographic Information		
Hospital Legal Name:		
Hospital DBA Name (if applicable):		
Hospital Physical Address, City, State & ZIP:		
Hospital Mailing Address (if different from above):		
Phone:	Fax:	County:
Existing Hospital License #:		
Accredited? ◯ Y ◯ N	If yes, what Accrediting Agency?	
Hospital E-Mail:	Fiscal Year Ending Date (MM/DD):	
Ownership Category (If non-profit, partnership, corporation, or LLC, list each person having five percent of more interest on a separate page.)		
☐ Church	☐ State	☐ Health District	☐ Partnership
☐ City	☐ County	☐ Individual	☐ Corporation or LLC
Name of Owner(s):		Tax ID #:	
Address, City, State, and Zip Code of Owner(s):			
Phone:	Fax:	County:	

3. License Change	
☐ Inpatient bed count increase to beds.	☐ Inpatient bed count decrease to beds.
☐ Name Change	☐ Services to be Added:
☐ Address Change	☐ Services to be Removed:
☐ Change of Administrator	☐ Add or Change On-Campus Building
☐ Change of Ownership	☐ Other – Please Specify:
Effective Date(s) of Requested Change(s):	

4. Key Contact Information			
	Name	Email	Phone
Hospital Administrator			
Emergency Contact			
Chief Nursing Officer/Nurse Executive			
Person who filled out this application			

5. Hospital Nurse Staffing Committee			
Nurse Manager Co-Chair	Name:	Title:	Email:
Direct Care Co-Chair	Name:	Title:	Email:

6. Hospital Classification (choose one)
◯ General Hospital – see OAR 333-500-0032(2)(a)
◯ Psychiatric Hospital – see OAR 333-500-0032(2)(c)
◯ Low Occupancy Acute Care Hospital (25 beds or less) – see OAR 333-500-0032(2)(b)

7. Licensed Bed Capacity	
Total on-campus inpatient beds:	
Total on-campus inpatient psychiatric beds:	
Total satellite inpatient psychiatric beds:	
Swing Beds?	◯ Y ◯ N

7. **Services** (check all that apply) (All services are required for General Hospitals)	☐ Maternity	☐ Surgical	☐ Emergency

8. Hospital operates off-campus satellite location(s)	Y ◯	N ◯	Total # operated:

Complete a "Satellite Information Form" for each satellite operated by the hospital (see page 3 of this application). A "satellite location" is any location that is geographically separate from the main hospital building and is more than 250 yards from any exterior wall of the hospital's main building as measured by radial distance ("as a crow flies").

9. Hospital operates on-campus buildings	Y ◯	N ◯	Total # operated:

Complete the "on-campus" building information for below each on-campus provider-based service. An on-campus building is any building that is within 250 yards of any exterior wall of the hospital's main building.

10. On-Campus Building Information (attach extra pages as needed)			
Name of the building	Address (including suite number)	Description of services provided	Days and hours of operation

I declare, under penalty of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct, and complete. I will notify the Health Care Regulation and Quality Improvement Section, in writing, of any changes in this information within 30 days of any such change. Oregon Administrative Rules Chapter 333, Divisions 500-535 requires that all accredited hospitals provide the Health Care Regulation and Quality Improvement Section all accrediting survey and inspection reports, and written evidence of all corrective actions and progress reports related to accrediting surveys.

Administrator's Signature Print Name

Print Title Date (mm/dd/year)

11. Fee Schedule Note: The fees listed below are for new and renewed licenses. There is no fee required for bed decreases and name or address changes. Changes of ownership (CHOW) requires a new license and payment of the full license fee.

$1,250.00	01 – 25 Beds	$6,525.00	100 – 199 Beds	$750.00 Per Satellite Location
$1,850.00	26 – 49 Beds	$8,500.00	200 – 499 Beds	
$3,800.00	50 – 99 Beds	$12,070.00	500 or more Beds	

Application Checklist	
Is your application complete?	
☐	**Payment calculated correctly.**
☐	**All applicable sections of the Hospital Licensed Application completed correctly.**
☐	**Satellite Information Form(s) attached, as applicable.**
☐	**On-campus building list completed, as applicable.**
☐	**Payment made payable to Oregon Health Authority**
☐	**Payment enclosed.**

Make check payable to: **Oregon Health Authority**
Mail payment to: **Health Care Regulation and Quality Improvement**
800 NE Oregon St., Suite 465
Portland, OR 97232

Questions?
Email: mailbox.hclc@odhsoha.oregon.gov
Phone: 971-673-0540

HCRQI Office Use Only						
Approved/Denied by:					Entered by:	
☐ Initial Licensure	☐ Approved	☐ Denied	Initials:	Date:	Initials:	Date:
☐ License Renewal	☐ Approved	☐ Denied	Initials:	Date:	Initials:	Date:
☐ Change	☐ Approved	☐ Denied	Initials:	Date:	Initials:	Date:

12. Satellite Information Form

Satellite Name:	
Satellite Street Address:	
Phone:	Hours of Operation:

Type

- ☐ Outpatient Satellite
- ☐ Psychiatric Satellite
- ☐ Emergency Medical Services Satellite (also known as “Off-campus Emergency Departments”)

Describe type and scope of the services provided. If multiple suites at this location are not separately licensed, list suite number and services provided in each suite.

13. Type of Action

New Satellite?	Y◯	N◯	☐ Include a map depicting the location for all new satellite locations.
Existing Satellite?	Y◯	N◯	License #:

14. Satellite Change: What type of satellite change is requested?

☐ Satellite Closure	☐ Addition of Services to Satellite
☐ Satellite Relocation	☐ Removal of Services to Satellite
☐ Other. Please Specify:	
Effective Date of Requested Change:	

I declare, under penalty of perjury, that I have examined this satellite information form and that to the best of my knowledge and belief, this building has a radial distance of more than 250 yards from any exterior wall of the main hospital building. I will notify the Health Care Regulation and Quality Improvement Section, in writing, of any changes in this information within 30 days of any such change. Oregon Administrative Rule Chapter 333, Divisions 500-535 requires that all accredited hospitals provide the Health Care Regulation and Quality Improvement Section all accrediting survey and inspection reports, and written evidence of all corrective action and progress reports related to accrediting surveys.

Administrator Signature | Print Name

Print Title | Date (mm/dd/year)