



Multiple Location Hospital License Renewal Application

(for Hospitals Licensed Under A Single License Number)

Name of Main Hospital: _____

Name of Multiple Location Hospital: _____

Hospital License Number: _____

Status: Profit Non-Profit

Multi Hospital Designation: General Special

Hospital within a hospital: Yes No

1. HOSPITAL SERVICES:

Services: (Please check all services offered)

- Medical (*Special hospitals only*)
- Obstetrical Care (*General hospitals only*)
- Surgery (*General hospitals only*)
- Clinical Laboratory Services (*contracted or onsite*)
- Diagnostic X-ray Services (*i.e. MRI, ultrasound, portable x-ray*)
- Emergency Department**
- Emergency Treatment Room (*required if no Emergency Department*)
- Pediatric (*if 15 or more pediatric beds*)
- Comprehensive Medical Rehabilitation
- ESRD – Acute Services*
- Mental Health Services (*in an identifiable part of the hospital*)
- Chemical Dependency Services (*in an identifiable part of the hospital*) Inpatient Outpatient
- Other Definitive Medical or Surgical Treatment: _____

***Answer the below questions 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*)

****Does this location currently have a waiver for the Emergency Department?** Yes No

2. NICHE: Is this hospital a Niche hospital? Yes No

The term “Niche hospital” means that, (A) two-thirds of the hospital’s Medicare patients or all patients are classified in no more than two major diagnosis related groups (DRG) or surgical diagnosis-related groups; or (B) specializes in one or more of the following areas: cardiac, orthopedics, surgery, or women’s health and is not a public hospital, is not a hospital for which the majority of inpatients claims are for major DRG relating to rehabilitation, psychiatry, alcohol and drug treatment, or children or newborns, or is not a hospital with fewer than ten (10) claims per bed per year.

3. OTHER SERVICES: (*Please select any of the following if applicable*)

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

4. ACCREDITATION:

If accredited by The Joint Commission (JC), American Osteopathic Association (AOA), DNV GL, or the Center for Improvement in Healthcare Quality (CIHQ), a letter from the accreditation organization stating that the separate location has been included in the accreditation is required.

Name of Main Hospital: _____

BUDGET: ZZ101

Name of Multiple Location Hospital: _____

FUND: 152

License Number: _____

5. LICENSED BEDS:

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 Department approval and possible fees.

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.

Please 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/Post Partum
- _____ Postpartum
- _____ Adolescent
- _____ Pediatric (if 15 or more beds)
- _____ Skilled Nursing
- _____ Comprehensive Medical Rehabilitation
- _____ Mental Health
- _____ Chemical Dependency

6. IS THE HOSPITAL DESIGNATED AS A COMMUNITY WIDE DESIGNATED HOSPITAL FOR SEXUAL ASSAULT SURVIVORS:

Yes No

7. 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 State Board of Medical Examiners and are qualified legally, professionally and ethically for the positions to which they are appointed.

Chief Executive Officer (This must be the CEO over all the facilities licensed under the main hospital license.)

Date Signed

Printed Name of CEO

Title

Telephone Number

E-mail Address

8. HOSPITAL ADMINISTRATOR:

Onsite Administrator in charge of day-to-day operations

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