



# Crisis Stabilization Unit License Renewal Application

Name of CSU: \_\_\_\_\_

CSU License Number: \_\_\_\_\_

- Type of Ownership:
- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> County      | <input type="checkbox"/> Limited Liability Company |
| <input type="checkbox"/> Corporation     | <input type="checkbox"/> City        | <input type="checkbox"/> Hospital District         |
| <input type="checkbox"/> Partnership     | <input type="checkbox"/> City-County | <input type="checkbox"/> Hospital Authority        |
| <input type="checkbox"/> LTD             | <input type="checkbox"/> LP          | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Profit          | <input type="checkbox"/> Non-Profit  |  |

## 1. CSU SERVICES:

**CRISIS STABILIZATION UNIT (CSU)** - The term "crisis stabilization unit" means a mental health facility operated by a community center or other entity designated by the Texas Department of Mental Health and Mental Retardation in accordance with Texas Health and Safety Code, §534.054, that provides treatment to individuals who are the subject of a protective custody order issued in accordance with Texas Health and Safety Code, §574.022.

Services: (Please check all services offered)

- Psychiatric
- Chemical Dependency
- Emergency Treatment Room (Required)

## 2. LICENSED BEDS:

How many total licensed beds are at this location? \_\_\_\_\_

*\* A change in the bed design capacity requires prior Department approval and possible fees.*

How many emergency treatment room beds are at this location? \_\_\_\_\_

*\* This count is not included in the licensed bed count above and will not affect fees. A minimum of one bed is required.*

## 3. FEES: (Fees paid to the department are not refundable)

Total number of licensed beds: \_\_\_\_\_

Total fee due is \$200.00 per bed + \$20.00 (Texas.gov Subscription Fee) with a minimum total due of \$6,020.00.

Amount paid: \$\_\_\_\_\_

*(The fee should include a Texas.gov subscription fee of \$20 (authorized by Senate Bill 1152, 78<sup>th</sup> Regular Legislative Session 2003) which must be paid whether or not you renew online.*

---

**4. FIRE SAFETY SURVEY:**

Two completed Fire Safety Survey Report forms must be submitted for all locations. 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 & a second report conducted within the last 13 to 24 months indicating approval by the local fire authority. Both surveys are required for continued licensure on renewing facilities.

---

**5. MEDICARE CERTIFICATION**

Is the CSU currently certified to participate in the Title XVIII Medicare Program?  Yes  No  
If YES, please provide the hospital's Medicare Provider Number: \_\_\_\_\_

---

**6. CERTIFICATION/ACCREDITATION:**

Please check the category(ies) that apply. If applicable, attach a copy of the most recent accreditation letter.

- Joint Commission (JC)
- American Osteopathic Association (AOA)
- Det Norske Veritas (DNV)
- Not accredited.

---

**7. MEDICAL AND PROFESSIONAL STAFF:**

Provide the name and address of the physician to be in charge of the facility care and treatment of the patients.

_____ Name of Physician ( <i>please print</i> )	_____ Title
_____ License Number	_____ Expiration Date

Provide the numbers of all professional staff below. On a separate sheet include an explanation of the duties and qualifications of the professional staff.

_____ Licensed Counselor	_____ MD
_____ Registered Nurse	_____ Recreational Therapist
_____ Master Social Worker	_____ Occupational Therapist
_____ Licensed Vocational Nurse	_____ Activity Therapist
_____ PhD	_____ Psychiatric Technicians
_____ Other: _____	

Name of CSU: \_\_\_\_\_  
License Number: \_\_\_\_\_

BUDGET: ZZ101  
FUND: 150

---

**8. EQUIPMENT AND FACILITIES:**

- Attach a description of any major medical equipment and facilities used by the CSU.
- Attach a plan (campus map) of the premises that describes the buildings and grounds and the manner in which the various parts of the premises are intended to be used. The plan should also include the names of the buildings, the licenses held by each building, and the number of beds in each building.

---

**9. SIGNATURE AND ATTESTATION:**

I attest that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 134, Private Psychiatric Hospitals and Crisis Stabilization Units 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.

\_\_\_\_\_  
Chief Executive Officer Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Printed Name of CEO

\_\_\_\_\_  
Title

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
E-mail Address

---

**10. CSU 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  
REGULATORY LICENSING UNIT - FACILITY LICENSING GROUP  
DELIVERY CODE 2835  
P.O. BOX 149347, MC 2003  
AUSTIN, TEXAS 78714-9347**

**Overnight mailing address for applications with fees:**

**FACILITY LICENSING GROUP, MC 2003  
DEPARTMENT OF STATE HEALTH SERVICES  
1100 WEST 49<sup>TH</sup> STREET  
AUSTIN, TEXAS 78756**

Name of CSU: \_\_\_\_\_  
License Number: \_\_\_\_\_

**BUDGET: ZZ101**  
**FUND: 150**

**OWNERSHIP ADDENDUM**

Please complete if the owner is a partnership with individuals as partners, or a corporation in which an individual has an ownership interest of at least 25% of the business entity. Attach additional pages if necessary (*Social security numbers will be kept confidential under Government Code Section 552.147*).

**The owner is a:**

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

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: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Print Name: \_\_\_\_\_ Percent Ownership \_\_\_\_\_%

Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_