



## TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.  
COMMISSIONER

P.O. Box 149347  
Austin, Texas 78714-9347  
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TTY: 1-800-735-2989  
[www.dshs.state.tx.us](http://www.dshs.state.tx.us)

### How to Become a Licensed Abortion Facility

Attached is an application packet for an Initial or Change of Ownership (CHOW) License for an Abortion Facility. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 139, Abortion Facility Reporting and Licensing Rules, §139.13 Application Procedures and Issuance of Licenses. 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 [www.dshs.state.tx.us/hfp](http://www.dshs.state.tx.us/hfp).

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

#### **Initial Application**

- A license application form submitted no earlier than 90 calendar days prior to the projected opening date of the facility.
- A license fee of \$5,000.00 shall be submitted. *License fees are not refundable.*
- The applicant or the applicant's representative shall attend a presurvey conference at the zone office designated by the department. Please contact the designated zone office to schedule the presurvey conference ([www.dshs.state.tx.us/hfp/contact.shtm](http://www.dshs.state.tx.us/hfp/contact.shtm)).

#### **Change of Ownership (CHOW) Application**

- A license application form to be submitted at least 60 calendar days before the date of the change of ownership.
- A license fee of \$5,000.00 shall be submitted. *License fees are not refundable.*
- The applicant or the applicant's representative shall attend a presurvey conference at the zone office designated by the department. The designated zone office may waive the presurvey conference requirement for a Change of Ownership. Please contact the designated zone office to schedule the presurvey conference or to request a wavier ([www.dshs.state.tx.us/hfp/contact.shtm](http://www.dshs.state.tx.us/hfp/contact.shtm)).
- The applicant shall include evidence (Bill of Sale, lease agreement, or legal court document) of the Change of Ownership. This document can be submitted separately from the license application.

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The Facility Licensing Group is dedicated to assist you through this process and is available to answer your questions. If you have any questions, please contact the Facility Licensing Group: phone (512) 834-6646, fax (512) 834-4514, email [gina.smith@dshs.state.tx.us](mailto:gina.smith@dshs.state.tx.us) or [melanie.moore@dshs.state.tx.us](mailto:melanie.moore@dshs.state.tx.us).

**Mailing address for applications with fees:**

**DEPARTMENT OF STATE HEALTH SERVICES  
REGULATORY LICENSING UNIT - FACILITY LICENSING GROUP  
MAIL CODE 2003  
P.O. 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 49<sup>TH</sup> STREET  
AUSTIN, TEXAS 78756**



# Application for a License to Operate an Abortion Facility

Initial  
Projected Date Facility Will Open: \_\_\_\_\_

Change of Ownership  
Effective Date: \_\_\_\_\_ Current License #: \_\_\_\_\_

## 1. Facility Information:

a. Name the facility will be doing business as (d/b/a):  
\_\_\_\_\_

b. Street Address: \_\_\_\_\_  
Street Number  
\_\_\_\_\_  
City/State/Zip County

c. Mailing Address: \_\_\_\_\_  
(If different) Street or P.O. Box Number  
\_\_\_\_\_  
City/State/Zip

d. Telephone Number (include area code) Fax Number (include area code)  
( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
*Leave blank if number is unknown at this time.* *Leave blank if number is unknown at this time.*

## 2. Ownership Information:

\_\_\_\_\_  
Name of Owner (*entity legally responsible for the operation of the facility, whether by lease or ownership*)

\_\_\_\_\_  
Mailing Address City/State/Zip

\_\_\_\_\_  
Tax ID Number or SS# Telephone Number E-Mail Address

Status:  Profit  Non-Profit

Type of Ownership:  Sole Proprietor  County  Limited Liability Company  LTD  
 Corporation  City  Limited Liability Partnership  LP  
 Partnership  City-County  Hospital District/Authority  Other: \_\_\_\_\_

**3. Ownership and Control Interest Disclosure:**

a. The owner must disclose the following data for the two-year period preceding the application date. Check yes or no to the following questions. If yes is checked, you must provide details, including ownership and facility information, circumstances, dates and final action, on a separate sheet with this application.

- 1. Eviction involving any property used as a health care facility in any state? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 2. Federal or state (any state) tax liens? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 3. Unsatisfied final judgments? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 4. Federal or state (any state) criminal misdemeanor arrests or convictions? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 5. Injunctive orders from any court? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 6. Unresolved final state or federal Medicare or Medicaid audit exceptions? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

b. The owner must disclose the following data. Check yes or no to each question. If yes is checked, provide details on a separate sheet, including all ownership and facility information, circumstances, dates and final action.

- 1. Denial, suspension, or revocation of abortion facility license or any health agency in any state or any other enforcement action? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 2. Denial, suspension or revocation or other enforcement action against a health care facility license in any state, which is or was proposed by the licensing agency and the status of the proposal? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 3. Surrendered a license before expiration of the license or allowing a license to expire in lieu of the department proceeding with enforcement action? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 4. Federal or state (any state) criminal felony arrests or convictions? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 5. Federal or state Medicaid or Medicare sanctions or penalties relating to the operation of a health care facility? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 6. Operating a health care facility that has been decertified with Medicare or Medicaid? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- 7. Debarment, exclusion, or contract cancellation from Medicare or Medicaid in any state? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

- 4. Licensing Fee:**     Initial                      \$5,000.00  
                                Change of Ownership    \$5,000.00

*Fees paid to the Department are not refundable. Application will not be processed without the appropriate fee.*

**5. Personnel:**

Submit names, Texas Provider Identification numbers if Medicaid-enrolled, National Provider Identification numbers, and license numbers and expiration dates of all licensed professionals who provide services at the abortion facility. (Use attached page if necessary.)

Name: \_\_\_\_\_  
 Texas Provider Id #: \_\_\_\_\_  
 National Provider ID #: \_\_\_\_\_  
 License #: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Texas Provider Id #: \_\_\_\_\_  
 National Provider ID #: \_\_\_\_\_  
 License #: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_

**6. Other – The following documents are required and must be attached in order to complete the application:**

- Organizational structure of the staffing for the facility.
- Agreement to sale. (*Change of Ownership Only.*)

**7. Administrator’s Signature:**

The administrator attests that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 139, Abortion Facility Reporting and Licensing Rules. The administrator attests that all information contained in this application is true and correct. The administrator attests that all copies submitted with the application are original copies or copies of the original documents.

\_\_\_\_\_  
Administrator’s Name (***Please Print***)  
*Person responsible for day-to-day operations at the facility*

\_\_\_\_\_  
Title

\_\_\_\_\_  
Administrator’s Signature

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

\_\_\_\_\_  
Administrator’s Email Address

\_\_\_\_\_  
Administrator’s Telephone Number

**8. Contact Person:**

\_\_\_\_\_  
Name of the person completing this application

\_\_\_\_\_  
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, TX 78714-9347

**Overnight mailing address for applications with fees:** Department of State Health Services, Facility Licensing Group, Mail Code 2003, 1100 West 49<sup>th</sup> Street, Austin, TX 78756

Name of Facility: \_\_\_\_\_

DEPT. ID ZZ101/FUND 170

**PERSONNEL CONTINUED...**

Provide names, Texas Provider Identification numbers if Medicaid-enrolled, National Provider Identification numbers, and license numbers and expiration dates of all licensed professionals who provide services at the abortion facility. *(Do not include names of individuals already included on page 2.)*

Name: \_\_\_\_\_  
Texas Provider Id #: \_\_\_\_\_  
National Provider ID #: \_\_\_\_\_  
License #: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Texas Provider Id #: \_\_\_\_\_  
National Provider ID #: \_\_\_\_\_  
License #: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Texas Provider Id #: \_\_\_\_\_  
National Provider ID #: \_\_\_\_\_  
License #: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Texas Provider Id #: \_\_\_\_\_  
National Provider ID #: \_\_\_\_\_  
License #: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Texas Provider Id #: \_\_\_\_\_  
National Provider ID #: \_\_\_\_\_  
License #: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Texas Provider Id #: \_\_\_\_\_  
National Provider ID #: \_\_\_\_\_  
License #: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_