



# General and Special Hospital License Renewal Application

Name of Hospital: \_\_\_\_\_

Hospital License Number: \_\_\_\_\_ Status:  Profit  Non-Profit Hospital within a hospital:  Yes  No

Type of Ownership:

<input type="checkbox"/> City	<input type="checkbox"/> Hospital District/Authority	<input type="checkbox"/> LTD
<input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company (LLC)	<input type="checkbox"/> Partnership
<input type="checkbox"/> County	<input type="checkbox"/> Limited Liability Partnership (LLP)	<input type="checkbox"/> Sole Owner/Proprietorship
<input type="checkbox"/> Hospital	<input type="checkbox"/> Limited Partnership (LP)	<input type="checkbox"/> State
<input type="checkbox"/> Other:		

## 1. HOSPITAL SERVICES: *(Please 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:** *(Please check all services offered)*

- Surgery
- Obstetrical Care
- Clinical Laboratory Services *(required)*
- 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\*
- 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:** *(Please 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 *(includes MRI, ultrasound, portable x-ray)*
- Comprehensive Medical Rehabilitation
- Pediatric *(if 15 or more pediatric beds)*
- ESRD – Acute Services\*
- 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)*

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

**5. 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: \$ \_\_\_\_\_

(The fee should include a 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.)

**6. FIRE SAFETY SURVEY:**

The fire safety survey form is available on our website at <http://www.dshs.texas.gov/facilities/hospitals/forms.aspx#general-special>.

Two completed Fire Safety Survey Report forms must be submitted for all hospital 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.

**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>.

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**8. MEDICARE CERTIFICATION:**

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

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**9. ACCREDITATION:**

Please check the category that applies. Attach a copy of the most recent accreditation letter or certificate.

- Joint Commission (JC)
- American Osteopathic Association (AOA)
- DNV GL
- Center for Improvement in Healthcare Quality (CIHQ)
- Other: \_\_\_\_\_
- Not accredited

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

Yes  No

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**11. 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 Signature

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

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

\_\_\_\_\_  
Title

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

\_\_\_\_\_  
Email Address

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**12. 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 49<sup>th</sup> Street, Austin, Texas 78756

Name of Hospital: \_\_\_\_\_  
License Number: \_\_\_\_\_

BUDGET: ZZ101  
FUND: 152

### OWNERSHIP ADDENDUM

Please complete if the owner is a Partnership or a Corporation. Attach additional pages if necessary. (Social security numbers will be kept confidential under Government Code Section 552.147.)

**The owner is a:**

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

Name of Hospital: \_\_\_\_\_  
License Number: \_\_\_\_\_

BUDGET: ZZ101  
FUND: 152

**OWNERSHIP ADDENDUM (cont.)**

Please complete if the hospital is a Niche Hospital. Attach additional pages if necessary. (Social security numbers will be kept confidential under Government Code Section 552.147.)

**Niche Hospital - the name, social security number, address and license number of any physician licensed by the Texas Medical Board who has a financial interest in the ownership of the hospital.**

N/A

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 \_\_\_\_\_%

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