



# TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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COMMISSIONER

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## How to Become a Licensed Crisis Stabilization Unit (CSU)

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for a Crisis Stabilization Unit. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 134, Private Psychiatric Hospitals and Crisis Stabilization Units Licensing Rules, §134.22 Application and Issuance of Initial License. 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 CSU application form submitted no earlier than 90 calendar days prior to the projected opening date of the CSU.
- A license fee of \$200.00 per bed shall be submitted. *License fees are not refundable.*
- Patient Transfer Documents:
  - A copy of the CSU's Patient Transfer Policy that is in accordance with §134.43 Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
  - A copy of the CSU's Memorandum of Transfer form that is in accordance with §134.43(d)(10)(B) shall be submitted.
  - Patient transfer agreements for CSUs are not required to be submitted to the department for approval.
- A completed Fire Safety Survey Report form shall be submitted. 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 indicating approval by the local fire authority.
- Approval for occupancy shall be obtained from the Department of State Health Services, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or [www.dshs.state.tx.us/hfp/arch\\_review.shtm](http://www.dshs.state.tx.us/hfp/arch_review.shtm)).
- 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)).

## **Relocation Application**

- A CSU application form submitted no earlier than 90 calendar days prior to the projected opening date of the CSU.
- A license fee of \$200.00 per bed shall be submitted. *License fees are not refundable.*
- Patient Transfer Documents:
  - A copy of the CSU's Patient Transfer Policy that is in accordance with §134.43 Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
  - A copy of the CSU's Memorandum of Transfer form that is in accordance with §134.43(d)(10)(B) shall be submitted.
  - Patient transfer agreements for CSUs are not required to be submitted to the department for approval.
- A copy of the letter of accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or Det Norske Veritas (DNV) verifying accreditation and the effective date of accreditation.
- A completed Fire Safety Survey Report form shall be submitted. 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 indicating approval by the local fire authority.
- Approval for occupancy shall be obtained from the Department of State Health Services, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or [www.dshs.state.tx.us/hfp/arch\\_review.shtm](http://www.dshs.state.tx.us/hfp/arch_review.shtm)).

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

- A CSU application form submitted prior to the date of the change of ownership or not later than 10 calendar days following the date of the change of ownership.
- A license fee of \$200.00 per bed shall be submitted. *License fees are not refundable.*
- Patient Transfer Documents:
  - A copy of the CSU's Patient Transfer Policy that is in accordance with §134.43 Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
  - A copy of the CSU's Memorandum of Transfer form that is in accordance with §134.43(d)(10)(B) shall be submitted.
  - Patient transfer agreements for CSUs are not required to be submitted to the department for approval.
- A copy of the letter of accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or Det Norske Veritas (DNV) verifying accreditation and the effective date of accreditation.
- A copy of two completed Fire Safety Survey Report forms shall be submitted. 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 and a second report conducted within the last 13 to 24 months indicating approval by the local fire authority.
- 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 waiver. ([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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**Additional Information:**

Medicare certification information may be obtained from the zone office for your location ([www.dshs.state.tx.us/hfp/contact.shtm](http://www.dshs.state.tx.us/hfp/contact.shtm)). The Social Security Act directs the Secretary of the Department of Health and Human Services to use the help of State health agencies or other appropriate agencies to determine if health care entities meet Federal standards. This task is one of the Department of State Health Services' responsibilities. For information on gaining provider certification, please contact zone office staff.

CLIA information is located on the department's website at [www.dshs.state.tx.us/hfp](http://www.dshs.state.tx.us/hfp). For more information, please contact the zone office for your location.

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 Hospital Licensing Section: phone (512) 834-6648, fax (512) 834-4514, email [angela.arthur@dshs.state.tx.us](mailto:angela.arthur@dshs.state.tx.us) or [pamela.adams@dshs.state.tx.us](mailto:pamela.adams@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**

Revised 11/19/13



# Application for a License to Operate a Crisis Stabilization Unit (CSU)

Initial  
 Projected date CSU will open: \_\_\_\_\_ Architectural Project or Application #: \_\_\_\_\_

Change of Ownership  
 Effective Date: \_\_\_\_\_ (*Signed Bill of Sale is required*)  
 Current License #: \_\_\_\_\_

Relocation  
 Projected date CSU will open: \_\_\_\_\_ Architectural Project or Application #: \_\_\_\_\_  
 Current License #: \_\_\_\_\_

**1. CSU INFORMATION:**

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

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

c. Mailing Address: \_\_\_\_\_  
 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 hospital, whether by lease or ownership*)

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

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

Status:  Profit  Non-Profit

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

**3. 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)

**4. 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.*

**5. FEES: (Fees paid to the department are not refundable)**

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

Total fee due is \$200.00 per bed with a minimum total due of \$6,000.00. Amount paid: \$\_\_\_\_\_

**6. MEDICARE CERTIFICATION (CHOWS and RELOCATIONS ONLY)**

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: \_\_\_\_\_

**7. ACCREDITATION (CHOWS and RELOCATIONS ONLY)**

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.

**8. MEDICAL AND PROFESSIONAL STAFF:**

Provide the name of the physician in charge of the care and treatment of the patients.

\_\_\_\_\_  
Name of Physician (*please print*)

\_\_\_\_\_  
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 Counselors

\_\_\_\_\_ MDs

\_\_\_\_\_ Registered Nurses

\_\_\_\_\_ Recreational Therapists

\_\_\_\_\_ Master Social Workers

\_\_\_\_\_ Occupational Therapists

\_\_\_\_\_ Licensed Vocational Nurses

\_\_\_\_\_ Activity Therapists

\_\_\_\_\_ PhDs

\_\_\_\_\_ Psychiatric Technicians

\_\_\_\_\_ Other: \_\_\_\_\_

**9. 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.

**10. FIRE SAFETY SURVEY:**

A completed Fire Safety Survey Report form shall be submitted. 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 indicating approval by the local fire authority. For change of ownership applications, a copy of two completed Fire Safety Survey Report forms shall be submitted; one report dated within the last 12 months and a second report dated within the last 13 to 24 months.

**11. PATIENT TRANSFER POLICY and MEMORANDUM OF TRANSFER:**

- Submit a copy of the hospital's Memorandum of Transfer form and the Patient Transfer Policy developed in accordance with the rules governing patient transfer policies which is signed by both the chairman and secretary of the hospital's governing body attesting to the date of adoption of the policy and the policy's effective date.

**12. 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
**13. 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, 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

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

## MEMORANDUM OF TRANSFER (sample)

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SECTION A (To Be Filled Out At Transferring Hospital)

<p>1. Name of Transferring Hospital: _____                  Address: _____                  Phone Number: (____) _____</p> <p>2. Patient Information (If Known)                  Patient's full name: _____                  Address: _____                  Phone Number: (____) _____                  Sex: ____M ____F Age: _____                  National origin: _____ Race: _____                  Religion: _____ Physical Handicap: _____</p> <p>3. Next of Kin:(If Known) _____                  Address: _____                  Phone Number: (____) _____                  Next of Kin notified? (____) Yes (____) No</p> <p>4. Date of Arrival: __/__/__ Time: _____</p> <p>5. Initial contact with receiving hospital administration:                  Date: __/__/__ Time: _____                  Name of contact person at receiving hospital: _____</p> <p>6. Receiving physician secured by transferring physician:                  Date: __/__/__ Time: _____                  Name of receiving physician: _____</p>	<p>7. Transferring physician's signature or signature of hospital staff acting under physician's orders: _____                  Name of transferring physician: _____                  Phone Number: (____) _____                  Address: _____</p> <p>8. Accepting hospital secured by transferring hospital:                  Date: __/__/__ Time: _____                  Name of receiving hospital administration person: _____</p> <p>9. Transferring hospital administration who contacted the receiving hospital:                  Signature: _____                  Title: _____ Time: _____</p> <p>10. Type of vehicle and company used:                  Equipment needed: _____                  Personnel needed: _____</p> <p>11. Facility transported to: _____                  City: _____</p> <p>12. Diagnosis: _____</p> <p>13. Attachments:                  X-rays _____ MD Progress Notes _____                  Lab Reports _____ Nurses Progress Notes _____                  History _____ Medication Record _____                  Other _____</p>
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PHYSICIAN CERTIFICATION: based upon the information available at the time of the transfer the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks of the transfer to the patient and, in the case of labor, the unborn child.

Summary of Risks and Benefits \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_

\*\*\*\*\*  
SECTION B (To Be Filled Out At Receiving Hospital)

<p>1. Name of Receiving Hospital: _____                  Address: _____                  Phone Number: (____) _____</p> <p>2. Date of Arrival: __/__/__ Time: _____</p> <p>3. Receiving Hospital Administration Signature:                  _____                  Title: _____ Date: __/__/__</p>	<p>4. Receiving physician assumed responsibility for the patient:                  Date: __/__/__ Time: _____                  Receiving Physician's signature: _____                  Name: _____                  Address: _____                  Phone Number: (____) _____</p> <p>5. If response to the transfer request was delayed beyond thirty (30) minutes, document the reason(s) for the delay, including any agreed time extensions. Use additional sheet, if necessary.                  _____                  _____                  _____</p>
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DISTRIBUTION: Original to accompany patient to receiving hospital. Copy to be retained at transferring hospital.