



# TEXAS DEPARTMENT OF STATE HEALTH SERVICES

## How to Become a Licensed Psychiatric Hospital

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for a Psychiatric Hospital. 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 <http://www.dshs.state.tx.us/facilities/>.

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

### Initial Application

- A psychiatric hospital license application form submitted approximately 90 calendar days prior to the projected opening date of the hospital.
- A license fee of \$200.00 per bed shall be submitted. *License fees are not refundable.*
- Patient Transfer Documents:
  - A copy of the hospital'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 hospital's Memorandum of Transfer form that is in accordance with §134.43(d)(10)(B) shall be submitted.
  - Patient transfer agreements for Private Psychiatric Hospitals 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 <http://www.dshs.state.tx.us/facilities/architectural-review.aspx>).
- The applicant shall attend a presurvey conference at the zone office designated by the department. Please contact the designated zone office to schedule the presurvey conference (<http://www.dshs.state.tx.us/facilities/compliance-zones.aspx>). (*Note: It is required that the CEO or Administrator listed on the license application attend the conference.*)

### Relocation Application

- A psychiatric hospital license application form submitted approximately 90 calendar days prior to the projected opening date of the hospital.
- A license fee of \$200.00 per bed shall be submitted. *License fees are not refundable.*
- Patient Transfer Documents:
  - A copy of the hospital'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 hospital's Memorandum of Transfer form that is in accordance with §134.43(d)(10)(B) shall be submitted.

### **Relocation Application Continued:**

- Patient transfer agreements for Private Psychiatric Hospitals are not required to be submitted to the department for approval.
- A copy of the letter or certificate of accreditation from an authorized accrediting agency which includes effective dates 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 <http://www.dshs.state.tx.us/facilities/architectural-review.aspx>).

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

- A psychiatric hospital license 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 hospital'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 hospital's Memorandum of Transfer form that is in accordance with §134.43(d)(10)(B) shall be submitted.
  - Patient transfer agreements for Private Psychiatric Hospitals are not required to be submitted to the department for approval.
- A copy of the letter or certificate of accreditation from an authorized accrediting agency which includes effective dates 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 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. (<http://www.dshs.state.tx.us/facilities/compliance-zones.aspx>). (*Note: It is required that the CEO or Administrator listed on the license application attend the conference.*)
- A Bill of Sale or other legal document shall be submitted. The document shall include the effective date of the change of ownership and both parties signed agreement to the transaction.

### **Important Items to Note:**

- The D/B/A or Assumed Name listed on the application must match the D/B/A or Assumed Name listed on applications filed with the Texas State Board of Pharmacy, Texas Department of Public Safety – Controlled Substances Registration, and the Drug Enforcement Agency.
- The D/B/A or Assumed name of the facility is the name that will appear on the license certificate and should match advertisements and signage of the facility.
- The Legal Name is the name of the direct owner legally responsible for the day to day operation of the facility, whether by lease or ownership. The Legal Name and EIN on the application should be an exact match with the IRS letter.
- The organizational chart showing ownership structure should reflect all levels of ownership and include EIN numbers. The chart should start with the D/B/A or Assumed Name, continue with the Legal Name (direct owner), and end with any additional ownership levels. An example has been attached for your reference.

**Additional Information:**

Medicare certification information may be obtained from the zone office for your location (<http://www.dshs.state.tx.us/facilities/compliance-zones.aspx>). 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 obtaining provider certification, please contact zone office staff.

CLIA information is located on the department's website at <http://www.dshs.state.tx.us/facilities/>. For more information, please contact the Zone Office for your location <http://www.dshs.state.tx.us/facilities/compliance-zones.aspx>.

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.

**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**

**EXAMPLE**  
**OWNERSHIP STRUCTURE**

HIGHER LEVEL  
OF OWNERSHIP

EIN #

*(Add Boxes as Needed)*

LEGAL NAME

EIN #

DOING BUSINESS AS (D/B/A)  
or ASSUMED NAME



# Application for a License to Operate a Psychiatric Hospital

Initial  
Projected date facility will open: \_\_\_\_\_ Architectural Project #: \_\_\_\_\_

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

Relocation  
Projected Date Facility Will Open: \_\_\_\_\_ Current License #: \_\_\_\_\_  
Architectural Project #: \_\_\_\_\_

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## 1. HOSPITAL INFORMATION:

a. Hospital within a hospital:  Yes  No

b. Name the hospital will be doing business as (d/b/a):

\_\_\_\_\_  
*This is the name that will appear on the license and should match advertisements and signage of the hospital.*

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

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

e. Telephone Number \_\_\_\_\_ f. Fax Number \_\_\_\_\_  
\_\_\_\_\_  
*Leave blank if number is unknown at this time.* *Leave blank if number is unknown at this time.*

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## 2. OWNERSHIP INFORMATION:

a. Legal Name (*Name of direct owner legally responsible for the day to day operation of the hospital, whether by lease or ownership*)

b. Mailing Address \_\_\_\_\_ c. City/State/Zip \_\_\_\_\_

d. EIN Number \_\_\_\_\_ e. Telephone Number \_\_\_\_\_ f. Email Address \_\_\_\_\_

g. Status:  Profit  Non-Profit

**2. OWNERSHIP INFORMATION CONTINUED:**

- h. 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: _____ |  |  |

i. Provide a copy of the IRS letter assigning the federal employer identification number (EIN).

j. Provide a copy of the Certificate of Filing from the Office of the Secretary of State.

k. Attach an organizational chart showing the ownership structure. *See Example.*

**3. HOSPITAL SERVICES:**

**PRIVATE PSYCHIATRIC** - The term "private psychiatric" means an establishment offering inpatient services, including treatment facilities, and beds for use beyond 24 hours, for the primary purpose of providing psychiatric assessment and diagnostic services and psychiatric inpatient care and treatment for mental illness. Such services must be more intensive than room, board, personal services, and general medical and nursing care. Although substance abuse services may be offered, a majority of beds must be dedicated to the treatment of mental illness in adults and/or children. Services other than those of an inpatient nature are not licensed or regulated by the department and are considered only to the extent that they affect the stated resources for the inpatient components.

Services: (Please check all services offered)

- Psychiatric
- Chemical Dependency
- Laboratory Services (*Onsite or Contracted*)
- Emergency Treatment Room (*Required*)

**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 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.*

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

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

Is the hospital 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 - 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)
- 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

\_\_\_\_\_  
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 hospital.
- 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:**

(The fire safety survey form is available on our website at <http://www.dshs.state.tx.us/facilities/hospitals/forms.aspx#general-special>)

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 fire inspection report conducted within the last 12 months & a second report conducted within the last 13 to 24 months shall be submitted.

**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

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

**13. 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

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

## MEMORANDUM OF TRANSFER (sample)

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**SECTION A (To Be Filled Out At Transferring Hospital)**  
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|   |   |
|---|---|
| <p>1. Name of Transferring Hospital: _____<br/>                 Address: _____<br/>                 Phone Number: (____) _____</p> <p>2. Patient Information (If Known)<br/>                 Patient's full name: _____<br/>                 Address: _____<br/>                 Phone Number: (____) _____<br/>                 Sex: ____M ____F Age: _____<br/>                 National origin: _____ Race: _____<br/>                 Religion: _____ Physical Handicap: _____</p> <p>3. Next of Kin:(If Known) _____<br/>                 Address: _____<br/>                 Phone Number: (____) _____<br/>                 Next of Kin notified? (____) Yes (____) No</p> <p>4. Date of Arrival: __/__/__ Time: _____</p> <p>5. Initial contact with receiving hospital administration:<br/>                 Date: __/__/____ Time: _____<br/>                 Name of contact person at receiving hospital: _____</p> <p>6. Receiving physician secured by transferring physician:<br/>                 Date: __/__/____ Time: _____<br/>                 Name of receiving physician: _____</p> | <p>7. Transferring physician's signature or signature of hospital staff acting under physician's orders: _____<br/>                 Name of transferring physician: _____<br/>                 Phone Number: (____) _____<br/>                 Address: _____</p> <p>8. <b>Accepting hospital secured by transferring hospital:</b><br/>                 Date: __/__/____ Time: _____<br/>                 Name of receiving hospital administration person: _____</p> <p>9. <b>Transferring hospital administration who contacted the receiving hospital:</b><br/>                 Signature: _____<br/>                 Title: _____ Time: _____</p> <p>10. <b>Type of vehicle and company used:</b><br/>                 Equipment needed: _____<br/>                 Personnel needed: _____</p> <p>11. <b>Facility transported to:</b> _____<br/>                 City: _____</p> <p>12. <b>Diagnosis:</b> _____</p> <p>13. <b>Attachments:</b><br/>                 X-Rays _____ MD Progress Notes _____<br/>                 Lab Reports _____ Nurses Progress Notes _____<br/>                 H &amp; P _____ Medication Record _____<br/>                 Other _____</p> |
|---|---|

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)**  
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|   |   |
|---|---|
| <p>1. Name of Receiving Hospital: _____<br/>                 _____<br/>                 Address: _____<br/>                 _____<br/>                 Phone Number: (____) _____</p> <p>2. Date of Arrival: __/__/__ Time: _____</p> <p>3. Receiving Hospital Administration Signature:<br/>                 _____<br/>                 _____<br/>                 Title: _____ Date: __/__/____</p> | <p>4. <b>Receiving physician assumed responsibility for the patient:</b><br/>                 Date: __/__/____ Time: _____<br/>                 Receiving Physician's signature: _____<br/>                 Name: _____<br/>                 Address: _____<br/>                 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.<br/>                 _____<br/>                 _____<br/>                 _____<br/>                 _____</p> |
|---|---|

DISTRIBUTION: Original to accompany patient to receiving hospital. Copy to be retained at transferring hospital.