
4. 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>)

Two completed Fire Safety Survey Report forms must 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.

5. 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: _____

6. ACCREDITATION:

(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
-

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

8. 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.

Name of Hospital: _____
License Number: _____

DEPT. ID ZZ101/FUND 150

9. HOSPITAL DATABASE WORKSHEET:

Complete the Hospital Database Worksheet for all hospital locations. You can access the worksheet at the following address:
<http://www.dshs.state.tx.us/facilities/hospitals/forms.aspx>

10. 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

Date Signed

Printed Name of CEO

Title

Telephone Number

Email Address

11. 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, TX 78714-9347

Overnight mailing address for applications with fees: Department of State Health Services, Facility Licensing Group, Mail Code 2003, 1100 West 49th 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:

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: _____/_____/_____