



## **Private Psychiatric Hospital License Application Packet**

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### **In order to process your request:**

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
PO Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Psychiatric Hospital Credentialing  
PO Box 47877  
Olympia, WA 98504-7877

### **Contact us:**

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [doh.information@doh.wa.gov](mailto:doh.information@doh.wa.gov).

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## License Requirements

Thank you for your interest in obtaining a private psychiatric hospital license.

You will need to submit this application if you are applying for any of the following:

- Initial
- Change of Ownership
- Amended
- Renewal

### **Initial—Submit the following:**

- Application and [fee](#) for each bed space within the authorized bed capacity.
- Disclosure statements and criminal history background checks for the administrator, owner, and director of services.
- Proof of completion of the department's construction review process.
- Proof of completion of the department's certificate of need review process if applicable.
- Proof of compliance with local codes and ordinances according to the state director of fire protection.
- Nurse Staffing Plan - Emailed to [nursestaffing@doh.wa.gov](mailto:nursestaffing@doh.wa.gov)

### **Change of Ownership—must submit in writing:**

The current owner must submit:

- Cover letter indicating changes occurring.
- Full name, address, and phone number of the current and new owner.
- Name, address, and phone number of the currently licensed hospital.
- Name under which the agency will operate.
- Date of the proposed change of ownership.
- Any changes in each location.

The proposed owner must submit:

- Completed application and change of ownership [fee](#).
- Disclosure statements and criminal history background checks for the administrator, owner, and director of services.
- Proof of completion of the department's construction review process.
- Proof of completion of the department's certificate of need review process if applicable.
- Proof of compliance with local codes and ordinances according to the state director of fire protection.

- Nurse Staffing Plan - Emailed to [nursestaffing@doh.wa.gov](mailto:nursestaffing@doh.wa.gov)

**Amended**—you will need to submit this application if any of the following are changing:

- Adding or eliminating services
- Change in accreditation information
- Change in administration
- Change to the building, adding a new or existing building, or remodeling
- Add or change in bed count

**Submit the following:**

- Cover letter indicating changes.
- Completed application and **fee**.

Note: **Certificate of Need** or **Construction Review** approval may be necessary prior to amending a license.

**Renewals—Submit the following:**

- Completed application and **fee** for each bed space within the authorized bed capacity.
- Nurse Staffing Plan - Emailed to [nursestaffing@doh.wa.gov](mailto:nursestaffing@doh.wa.gov)

## Application Instructions Checklist

**Important Information:** When your application for a psychiatric hospital is received by the Department of Health, you will be notified in writing of any outstanding documentation needed to complete the application process.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

**Indicate type of application**—Initial, change of ownership, amended, or renewal.

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

**Application Fee:**  
You can check the [fee page](#) for current fees.

**1. Demographic Information:**  
**Uniform Business Identifier Number (UBI #):** Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

**Federal ID Number (FEIN #):** Enter your Federal ID Number, if the business has been issued one.

**Legal Owner/Operator Name:** Enter the owner's name as it appears on the UBI/ Master Business License.

**Mailing Address:** Enter the owner's complete mailing address.

**Phone, Fax and Cell Numbers:** Enter the owner's phone, cell, and fax numbers.

**Email and Web Address:** Enter the owner's email and facility Web addresses, if applicable.

**Facility/Agency Name:** Enter the agency's name as advertised on signs, brochures, or Web site.

**Physical Address:** Enter the agency's physical street location including city, state, zip code, and county.

**Phone, Fax and Cell Numbers:** Enter the facility's phone, cell, and fax numbers.

**Mailing Address:** Enter the facility's mailing address, if different than the physical address.

**2. Facility Specific Information:**

**A. In-patient beds:**  
Indicate total # of authorized licensed bedspace and average daily patient census.

**B. Facility Site:**  
Complete this section with the information specific to your main facility location.

**C. Accreditation:**  
Check yes or no if you are Joint Commission accredited.

**D. Certification:**

Check yes or no if you are medicare and/or medicaid certified and list provider number for each service provided.

**3. Key Individuals:**

**Administrator:** Enter name, phone number, fax number, and email address.

**Chief Nursing Executive:** Enter name, phone number, fax number, and email address.

**Director of Plant Services:** Enter name, phone number, fax number, and email address.

**Preferred Contact:** Enter name, phone number, fax number, and email address.

**4. Additional Information:**

**Change of Ownership Information:** List the previous legal owner name, previous name of facility, previous license number, effective date of ownership change and physical address, if applicable.

**5. Non-Profit Attestation:**

Complete this section only if you are a non-profit organization. You must sign and date this for us to process the application.

**6. Signature:**

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.



Fees
Psychiatric Hospital ..... <u>Fee</u>
<b>All application fees are nonrefundable.</b>

Date Stamp Here

Revenue 0597632302

## Private Psychiatric Hospital License Application

This is for:     Initial                                       Change of Ownership  
                       Amended                                       Renewal

### Check One

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Association                   | <input type="checkbox"/> Limited Partnership    | <input type="checkbox"/> Public Hospital District |
| <input type="checkbox"/> Corporation                   | <input type="checkbox"/> Municipality (City)    | <input type="checkbox"/> Sole Proprietor          |
| <input type="checkbox"/> Federal Government Agency     | <input type="checkbox"/> Municipality (County)  | <input type="checkbox"/> State Government Agency  |
| <input type="checkbox"/> Limited Liability Company     | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership            | <input type="checkbox"/> Trust                    |

### 1. Demographic Information

UBI #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Name			
Mailing Address			
City	State	Zip Code	County
Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Email address		Web Address	
Facility/Agency Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip Code	County
Facility Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Mailing Address			
City	State	Zip Code	County

## 2. Facility Information

### A. In-patient beds:

Total Authorized Beds for all sites \_\_\_\_\_

Average Daily Patient Census \_\_\_\_\_

### B. Facility site:

Facility/Building Name \_\_\_\_\_

Site Address \_\_\_\_\_

DOH Construction Review (CRS) approved?  Yes  No CRS approval # \_\_\_\_\_

### Check all services that apply:

Alcohol and Chemical Dependency

\_\_\_\_\_ # of beds

Psychiatric

\_\_\_\_\_ # beds

Patient Care

Pharmacy and Medication

Laboratory

Food and Dietary

### C. Accreditation:

#### Choose One:

Joint Commission Accredited?  Yes  No Last Accreditation Survey Date \_\_\_\_\_

Other, please list \_\_\_\_\_

### D. Certification:

Medicaid Certified?  Yes  No Provider # \_\_\_\_\_ Effective Date \_\_\_\_\_

Medicare Certified?  Yes  No Provider # \_\_\_\_\_ Effective Date \_\_\_\_\_

## 3. Key Individuals (fill in as applicable)

**Administrator Name**

Email Address

Phone (enter 10 digit #)

Fax (enter 10 digit #)

**Chief Nursing Services**

Email Address

Phone (enter 10 digit #)

Fax (enter 10 digit #)

**Director of Plant Services**

Email Address

Phone (enter 10 digit #)

Fax (enter 10 digit #)

**Preferred Contact**

Email Address

Phone (enter 10 digit #)

Fax (enter 10 digit #)



#### 4. Additional Information

##### Change of Ownership Information

Previous Name of Legal Owner

Previous Name

Previous Hospital License #

Effective Date of Ownership Change

Physical Address

#### 5. Nonprofit Attestation Complete this section only if you are a non-profit organization.

I attest that the hospital complies with nonprofit hospital community health need assessment and that this information is made available to the public.

Initials of Legal  
Representative

Date

#### 6. Signature

I certify that I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Owner/Authorized Representative

\_\_\_\_\_  
Date (mm/dd/yyyy)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Title

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## **RCW/WAC and Online Web Site Links**

### **RCW/WAC Links**

[Private Establishments, RCW 71.12](#)

[Private Psychiatric Hospital Rules, WAC 246-322](#)

### **Online**

[Hospital Program Web Page](#)