Hospital License Application Packet

Contents:

In order to process your request:

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

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Hospital Credentialing
P.O. 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.

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License Requirements

Thank you for your interest in obtaining an acute care hospital license.

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

- Initial
- Change of Ownership
- Amended
- Renewal
- Annual update

Initial—Submit the following:

- Application and **fee** for each bed space within the authorized bed capacity and meets the following:
  - Include all bed spaces in rooms complying with physical plant and movable equipment requirements of **WAC 246-320-199** for 24-hour assigned patient care.
  - Include level 2, 3, and 4 bassinet spaces.
  - Include bed spaces assigned for less than 24-hour patient use as part of the licensed bed capacity when:
    - Physical plant requirements of this chapter are met without movable equipment and;
    - The hospital currently possesses the required movable equipment and certifies this fact to the department.
  - Exclude all normal infant bassinets.
- Disclosure statements and criminal history background checks for the administrator, owner, and director of services.
- Name of managing personnel, officers, administrator, director of clinical services, or supervisor of clinical services.
- Description of the organizational structure.
- Name, address, and phone numbers of all office locations.
- Copy of current business license.
- Proof of completion of the department's construction review process.
- Proof of compliance with local codes and ordinances.
- Policies related to access to care:
  - Admission;
  - Nondiscrimination;
  - End of life care;
  - Reproductive health care.

The policies received will be posted on the Department of Health website, any changes or additions to any of these policies must be submitted within 30 days. See **WAC 246-320-141(5)**

Note: **Certificate of Need** or **Construction Review** approval may be necessary when submitting an application.

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.
- Name of managing personnel, officers, administrator, director of clinical services or supervisor of clinical services.
- Description of the organizational structure.
- Name, address, and phone numbers of each location.
- Copy of current business license.
- Policies related to access to care:
  - Admission;
  - Nondiscrimination;
  - End of life care;
  - Reproductive health care.

  The policies received will be posted on the Department of Health website, any changes or additions to any of these policies must be submitted within 30 days. See **WAC 246-320-141(5)**

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**.

Renewals—Submit the following:

- Completed application and **fee** for each bed space within the licensed bed capacity and meets the following:
  - Include all bed spaces in rooms complying with physical plant and movable equipment requirements of **WAC 246-320-199** for 24-hour assigned patient care.
  - Include level 2, 3, and 4 bassinet spaces..
  - Include bed spaces assigned for less than 24-hour patient use as part of the licensed bed capacity when:
    - Physical plant requirements of this chapter are met without movable equipment and;
    - The hospital currently possesses the required movable equipment and certifies this fact to the department.
  - Exclude all normal infant bassinets.
- Disclosure statements and background checks on the administrator, owner, and director of services when they are new to the hospital since initial license or last renewal.

Annual Update—Submit the following:

- Completed application and **fee** for each bed space within the licensed bed capacity and meets the following:
  - Include all bed spaces in rooms complying with physical plant and movable equipment requirements of **WAC 246-320-199** for 24-hour assigned patient care.
  - Include level 2, 3, and 4 bassinet spaces.
  - Include bed spaces assigned for less than 24-hour patient use as part of the licensed bed capacity when:
    - Physical plant requirements of this chapter are met without movable equipment and;
    - The hospital currently possesses the required movable equipment and certifies this fact to the department.
  - Exclude all normal infant bassinets.
- Disclosure statements and background checks on the administrator, owner, and director of services when they are new to the hospital since initial license or last renewal

Important Information: When your application for a 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 typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

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Application Instructions Checklist

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

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

C. **Accreditation:**
Check yes or no if you are Joint Commission accredited, American Osteopathic Association (AOA) accredited, Det Norske Veritas (DNV), or Center for Improvement in Healthcare Quality (CIHQ) accredited and the last accreditation date.

D. **Certification:**

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

E. Additional sites, including provider-based status locations:
Complete only if the hospital has additional building sites that are not located on the main facility campus. Sites may include provider based clinics. 42 CFR 413.65, requires that provider based clinics will be operated under the hospital license unless the state requires additional licensing. Washington State does not require a separate license for provider based clinics therefore they should be listed under the hospital license.

☐ **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.

Washington State Department of HEALTH

Fees
Acute Care Hospital..... Fee
All application fees are nonrefundable.

Date Stamp Here

Revenue 0597632300

Hospital License Application

This is for: ☐ Initial ☐ Change of Ownership
☐ Amended ☐ Renewal ☐ Annual Update

Check One

☐ Association ☐ Limited Partnership ☐ Public Hospital District
☐ Corporation ☐ Municipality (City) ☐ Sole Proprietor
☐ Federal Government Agency ☐ Municipality (County) ☐ State Government Agency
☐ Limited Liability Company ☐ Non-Profit Corporation ☐ Tribal Government Agency
☐ Limited Liability Partnership ☐ Partnership ☐ 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 _____

Critical Access Beds? ☐ Yes ☐ No If yes, # of critical access beds _____

Swing Beds? See **CFR.42.482.66**
☐ Yes ☐ No If yes, # of swing beds _____

B. Main site:

Facility/Building Name _____

Site Address _____

DOH Construction Review (CRS) approved? ☐ Yes ☐ No CRS approval # _____

Check all services and indicate number of beds or stations for each service provided for the address above.

- ☐ Alcohol and Chemical Dependency
  - ____ # of beds
- ☐ Anesthesia and Recovery
- ☐ Cardiac Care
- ☐ Cardiac Care Open heart - adult
- ☐ Cardiac Care Open heart - pediatric
- ☐ Cardiac Care Elective PCI - adult
- ☐ Cardiac Care Elective PCI - pediatric
- ☐ Diagnostic Services
- ☐ Dialysis
- ☐ Emergency
- ☐ Food and Nutrition
- ☐ Imaging/Radiology
- ☐ Infant Care / Nursery
- ☐ Intensive/Critical Care
- ☐ Laboratory
- ☐ Medical Unit(s)
- ☐ Neonatal—Level 2
  - ____ # of bassinets
- ☐ Neonatal—Level 3
  - ____ # of bassinets
- ☐ Neonatal—Level 4
  - ____ # of bassinets
- ☐ Obstetrics
- ☐ Oncology
- ☐ Organ Transplant - Adult
  - Type_____
- ☐ Organ Transplant - Peds
  - Type_____
- ☐ Outpatient
- ☐ Pediatrics
- ☐ Pharmaceutical
- ☐ Psychiatric
  - ____ # of PPS exempt beds
- ☐ SNF/Long Term Care
  - ____ # of beds
- ☐ Rehabilitation
  - ____ # of PPS exempt beds
- ☐ Respiratory Care
- ☐ Social Services
- ☐ Surgical

C. Accreditation:

Choose One:

Joint Commission Accredited? ☐ Yes ☐ No

American Osteopathic Association Accredited? ☐ Yes ☐ No

Det Norske Veritas (DNV) Accredited? ☐ Yes ☐ No

Center for Improvement in Healthcare Quality (CIHQ) Accredited? ☐ Yes ☐ No

Last Accreditation Survey Date _____

D. Certification:

Medicaid Certified? ☐ Yes ☐ No Provider # _____ Effective Date _____

Medicare Certified? ☐ Yes ☐ No Provider # _____ Effective Date _____

Medicare Dialysis? ☐ Yes ☐ No Provider # _____ Effective Date _____

Medicare Psychiatric? ☐ Yes ☐ No Provider # _____ Effective Date _____

Medicare Hospice? ☐ Yes ☐ No Provider # _____ Effective Date _____

Medicare Rehabilitation? ☐ Yes ☐ No Provider # _____ Effective Date _____

Medicare SNF/Long Term Care? ☐ Yes ☐ No Provider # _____ Effective Date _____

E. Additional sites, including provider-based status locations:

Complete only if the hospital has additional building sites that are not located on the main facility campus. Sites may include provider based clinics.
42 CFR 413.65, requires that provider based clinics will be operated under the hospital license unless the state requires additional licensing. Washington State does not require a separate license for provider based clinics therefore they should be listed under the hospital license.

Facility/Building Name _____

Site Address _____

DOH Construction Review (CRS) approved? ☐ Yes ☐ No CRS approval # _____

Is this a free standing emergency department? ☐ Yes ☐ No

Is this an Urgent Care Facility? ☐ Yes ☐ No

Check all services and indicate number of beds or Stations for each service provided for the address above.

☐ Alcohol and Chemical Dependency	☐ Infant Care / Nursery	☐ Outpatient
____ # of beds	☐ Intensive/Critical Care	☐ Pediatrics
☐ Anesthesia and Recovery	☐ Laboratory	☐ Pharmaceutical
☐ Cardiac Care	☐ Medical Unit(s)	☐ Psychiatric
☐ Cardiac Care Open heart - adult	☐ Neonatal—Level 2	____ # of PPS exempt beds
☐ Cardiac Care Open heart - pediatric	____ # of bassinets	☐ SNF/Long Term Care
☐ Cardiac Care Elective PCI - adult	☐ Neonatal—Level 3	____ # of beds
☐ Cardiac Care Elective PCI - pediatric	____ # of bassinets	☐ Rehabilitation
☐ Diagnostic Services	☐ Neonatal—Level 4	____ # of PPS exempt beds
☐ Dialysis	____ # of bassinets	☐ Respiratory Care
☐ Emergency	☐ Obstetrics	☐ Social Services
☐ Food and Nutrition	☐ Oncology	☐ Surgical
☐ Imaging/Radiology	☐ Organ Transplant - Adult	☐ Organ Transplant - Peds
	Type_____	Type_____

This page may be duplicated.

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

Hospital Laws, RCW 70.41

Hospital Rules, WAC 246-320

Online

Program, Web Page