



Revenue Section  
P.O. Box 1099  
Olympia, WA 98507-1099  
206.418.5600

<http://www.doh.wa.gov/hsqa/fsl/HHHACS>

## Child Birth Center License Application Packet

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### Important Information:

In order to process your request:

Return completed application and the following information:

- **Disclosure Statement** – Attach a copy of the Disclosure Statement for the on-site Administrator/ Director and owner dated within 3 months of the initial application date. Agencies must keep current copies of the disclosure statement on file as stated in [WAC 246-329-075](#).
- **Criminal History Background Check (CBC)** – Attach a copy of the current CBC for the on-site Administrator/Director and owner dated within 3 months of the initial application date. Agencies must keep current copies of the disclosure statement on file as stated in [WAC 246-329-075](#).

Mail this information to:

Department of Health  
Revenue Section  
PO Box 1099  
Olympia, WA 98504-1099





Revenue Section

P.O. Box 1099

Olympia, WA 98507-1099

360.236.2917

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## Child Birth Center Application Checklist and Instructions

Indicate type of application – new, change of ownership, amended or renewal

### **New – Submit the following:**

- Application and 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 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.
- Approval from the state fire marshal.
- Proof that a certificate of occupancy by the local building official has been approved and issued.

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

- Full name, address, and phone number of the current and new owner.
- Name address and phone number of the currently licensed childbirth center.
- Name under which the agency will operate.
- Date of the proposed change of ownership.
- Any changes in office location.

The prospective owner must submit

- 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 all office locations.
- Copy of current business license

**Amended** – To request the addition of a Service Category; add or eliminate Service(s), change Accreditation information, add or eliminate a Service Area(s), change Administrator, Clinical Director or Direct Supervisor information, add Other Office Locations.

**Renewal – submit the following:**

- Application and fee.
- Disclosure statements and background checks on the administrator, owner, and director of services when they are new to the birth center since initial license or last renewal.

Check One:

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

Section #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 and Fax Numbers:** Enter the owner's phone and fax number.

**Email and Web Address:** Enter the owner's email and agency 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 and county.

**Phone and Fax Numbers:** Enter the agency's phone and fax number.

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

**Section #2: Facility Specific Information:**

**A. In-patient beds:**

Indicate total of licensed birthing rooms and average daily patient census.

**B. Services Provided**

Check all that apply.

**C. Accreditation Information**

List name of accreditation agency, last accreditation survey date and expiration date.

**D. Transfer Agreement:**

List name of hospital with a signed transfer agreement to admit birth center patients.

Section #3: Key Individuals:

**Administrator:** Enter the administrators name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

**Director of Services:** Enter the directors name, phone number, fax number, email address, and hire date.

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

Section #4: Additional Information:

**Legal Owner Information:**

List the names, titles, addresses, and phone numbers of the corporate officers, LLC members, partners, individuals owning 10% or more of the agency. Attach additional sheet, if necessary.

**Change of Ownership Information:**

List the previous legal owner name, previous name of facility/agency, previous IHS license #, effective date of ownership change and physical address.

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

Revenue Section

PO Box 1099

Olympia, WA 98507-1099

360.236.2917

<http://www.doh.wa.gov/hsqa/fsl>

Date Stamp Here

Revenue: 0520632340

# Child Birth Center License Application

**This is for:**  New  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

<b>UBI #</b>	<b>Federal Tax ID (FEIN) #</b>
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Legal Owner/Operator Name

Mailing Address

City	State	Zip	County
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Phone# (    )	Fax# (    )
---------------	-------------

Email Address	Web Address:
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Facility/Agency Name (Business name as advertised on signs or Web site)

Physical Address

City	State	Zip	County
------	-------	-----	--------

Facility Phone# (    )	Fax# (    )
------------------------	-------------

Mailing Address (If different than physical address)

City	State	Zip	County
------	-------	-----	--------

### For Office Use Only

Credential # \_\_\_\_\_

## 2. Facility Information

### A. In-patient Beds

Total Licensed Birthing Rooms \_\_\_\_\_ Average Daily Patient Census \_\_\_\_\_

### B. Check all services provided:

ARNP Midwife       Medical Physician       Midwife       Naturopathic Physician

### C. Accreditation:

Name of Accreditation Agency \_\_\_\_\_

Last Accreditation Survey Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

### D. Transfer Agreement

Name of hospital with a signed transfer agreement to admit birth center patients  
\_\_\_\_\_

## 3. Key Individuals

### Administrator Name

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email Address \_\_\_\_\_

### Director of Services

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email Address \_\_\_\_\_

### Preferred Contact

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email Address \_\_\_\_\_

## 4. Additional Information

### Legal Owner Information—attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

Name	Address	Phone #	Title

### Change of Ownership Information

Previous Name of Legal Owner \_\_\_\_\_

Previous Name of Facility \_\_\_\_\_ Previous License # \_\_\_\_\_ Effective Date of Ownership Change \_\_\_\_\_

Physical Address \_\_\_\_\_

## 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

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

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