



Revenue Section
P.O. Box 1099
Olympia, WA 98507-1099
206.418.5600
<http://www.doh.wa.gov/hsqa/fsl/HHHACS>

Acute Care Hospital 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

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Revenue Section
P.O. Box 1099
Olympia, WA 98507-1099
360.236.2917

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

Acute Care Hospital Application Checklist and Instructions

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

New – Submit the following:

- Application
- 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.

Annual Update – submit the following:

- Application and fee.

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 bed capacity and average daily patient census.

B. Services Provided

Check all that apply.

C. Certification – Accreditation

Check yes or no if you are Joint Commission accredited or list other accreditation agency, and last accreditation date. Check yes or no if you are medicare certified and list provider #.

D. Multiple Buildings

Only fill this area out if you have multiple buildings to be licensed that are not located on the main facility campus. Make as many copies of this page as needed.

Section #3: Key Individuals:

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

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

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

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

Section #4: Additional Information:

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.

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Revenue Section
 PO Box 1099
 Olympia, WA 98507-1099
 360.236.2917
<http://www.doh.wa.gov/hsqa/fsl>

Date
Stamp
Here

Revenue: 0597632300

Acute Care Hospital License Application

This is for: New Change of Ownership Amended Renewal Annual Update

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) #
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Legal Owner/Operator Name

Mailing Address

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

Phone# ()	Fax# ()
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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# ()
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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 Bed Capacity _____

Average Daily Patient Census _____

Beds	Total		Yes	No	# Beds
Level 2 Bassinet	_____	Medicare PPS Psychiatric Exempt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Level 3 Bassinet	_____	Medicare PPS Rehabilitation Exempt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Long-Term Care/SNF Bed	_____	Medicare Central Access Hospital	<input type="checkbox"/>	<input type="checkbox"/>	_____
		Medicare Distinct Part SNF	<input type="checkbox"/>	<input type="checkbox"/>	_____

B. Check all services provided:

- | | | |
|--|---|--|
| <input type="checkbox"/> Cardiac Care | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Medical | <input type="checkbox"/> Pediatric |
| <input type="checkbox"/> Diagnostic Services | <input type="checkbox"/> Neonatal–Level 2 | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Neonatal–Level 3 | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Nursery | <input type="checkbox"/> Recovery (anesthesia) |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Imaging/Radiology | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Infant Care | <input type="checkbox"/> Oncology | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Intensive/Critical Care | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Surgery Services |

C. Certification – Accreditation:

Joint Commission Accredited? Yes No American Osteopathic Association Accredited? Yes No

Last Accreditation Survey Date _____ Last Accreditation Survey Date _____

Medicare Certified? Yes No Provider # _____

Other Accreditation _____ Last Accreditation Survey _____

2. Facility Information (continued)

D. Multiple Buildings

Only to be completed if the hospital has multiple buildings to be licensed that are not located on the main facility campus. Make as many copies of this page as needed.

DOH construction review approved? Yes No CRS approval # _____

Facility/Building Name: _____

Site Address _____

Services Provided (check all services provided at this site).

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cardiac Care | <input type="checkbox"/> Infant Care | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Intensive/Critical Care | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Recovery (anesthesia) |
| <input type="checkbox"/> Diagnostic Services | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Oncology | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Medical | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Neonatal–Level 2 | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Neonatal–Level 3 | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Surgery Services |
| <input type="checkbox"/> Imaging/Radiology | <input type="checkbox"/> Nursery | <input type="checkbox"/> Pharmacy | |

DOH construction review approved? Yes No CRS approval # _____

Facility/Building Name: _____

Site Address _____

Services Provided (check all services provided at this site).

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cardiac Care | <input type="checkbox"/> Infant Care | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Intensive/Critical Care | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Recovery (anesthesia) |
| <input type="checkbox"/> Diagnostic Services | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Oncology | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Medical | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Neonatal–Level 2 | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Neonatal–Level 3 | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Surgery Services |
| <input type="checkbox"/> Imaging/Radiology | <input type="checkbox"/> Nursery | <input type="checkbox"/> Pharmacy | |

DOH construction review approved? Yes No CRS approval # _____

Facility/Building Name: _____

Site Address _____

Services Provided (check all services provided at this site).

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cardiac Care | <input type="checkbox"/> Infant Care | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Intensive/Critical Care | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Recovery (anesthesia) |
| <input type="checkbox"/> Diagnostic Services | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Oncology | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Medical | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Neonatal–Level 2 | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Neonatal–Level 3 | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Surgery Services |
| <input type="checkbox"/> Imaging/Radiology | <input type="checkbox"/> Nursery | <input type="checkbox"/> Pharmacy | |

2. Facility Information (continued)

D. Multiple Buildings (continued)

DOH construction review approved? Yes No CRS approval # _____

Facility/Building Name: _____

Site Address _____

Services Provided (check all services provided at this site).

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cardiac Care | <input type="checkbox"/> Infant Care | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Intensive/Critical Care | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Recovery (anesthesia) |
| <input type="checkbox"/> Diagnostic Services | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Oncology | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Medical | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Neonatal–Level 2 | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Neonatal–Level 3 | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Surgery Services |
| <input type="checkbox"/> Imaging/Radiology | <input type="checkbox"/> Nursery | <input type="checkbox"/> Pharmacy | |

DOH construction review approved? Yes No CRS approval # _____

Facility/Building Name: _____

Site Address _____

Services Provided (check all services provided at this site).

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cardiac Care | <input type="checkbox"/> Infant Care | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Intensive/Critical Care | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Recovery (anesthesia) |
| <input type="checkbox"/> Diagnostic Services | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Oncology | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Medical | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Neonatal–Level 2 | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Neonatal–Level 3 | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Surgery Services |
| <input type="checkbox"/> Imaging/Radiology | <input type="checkbox"/> Nursery | <input type="checkbox"/> Pharmacy | |

DOH construction review approved? Yes No CRS approval # _____

Facility/Building Name: _____

Site Address _____

Services Provided (check all services provided at this site).

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cardiac Care | <input type="checkbox"/> Infant Care | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Intensive/Critical Care | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Recovery (anesthesia) |
| <input type="checkbox"/> Diagnostic Services | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Oncology | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Medical | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Neonatal–Level 2 | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Neonatal–Level 3 | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Surgery Services |
| <input type="checkbox"/> Imaging/Radiology | <input type="checkbox"/> Nursery | <input type="checkbox"/> Pharmacy | |

3. Key Individuals

Administrator Name

Phone #	Fax #	Email Address
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Chief Nursing Executive

Phone #	Fax #	Email Address
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Director of Plant Services

Phone #	Fax #	Email Address
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Preferred Contact

Phone #	Fax #	Email Address
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4. Additional Information

Change of Ownership Information

Previous Name of Legal Owner

Previous Name	Previous Hospital License #	Effective Date of Ownership Change
---------------	-----------------------------	------------------------------------

Physical Address

Complies with certificate of need requirements, RCW 70.38? Yes No N/A

Complies with non-profit hospital commission requirements? Yes No N/A

Complies with anti-trust immunity? Yes No N/A

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