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
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
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.

- Nurse Staffing Plan - emailed to nursestaffing@doh.wa.gov

- 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.
- Nurse Staffing Plan - emailed to nursestaffing@doh.wa.gov
- 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 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.
- Nurse Staffing Plan - emailed to nursestaffing@doh.wa.gov
- 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 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.
- Nurse Staffing Plan - emailed to nursestaffing@doh.wa.gov
- 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.
Application Instructions Checklist

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.

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.
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

<table>
<thead>
<tr>
<th>UBI #</th>
<th>Federal Tax ID (FEIN) #</th>
</tr>
</thead>
</table>

Legal Owner/Operator Name

Mailing Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

Facility Phone (enter 10 digit #)  Fax (enter 10 digit #)

Mailing Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>
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 □ Laboratory □ Outpatient
   _____ # of beds

□ Anesthesia and Recovery □ Medical Unit(s) □ Pediatrics

□ Cardiac Care □ Neonatal—Level 2 □ Pharmaceutical
   _____ # of bassinets

□ Cardiac Care Open heart - adult □ Neonatal—Level 3 _____ # of PPS exempt beds

□ Cardiac Care Open heart - pediatric □ Neonatal—Level 4 _____ # of beds
   _____ # of bassinets

□ Cardiac Care Elective PCI - adult □ Obstetrics _____ # of PPS exempt beds

□ Cardiac Care Elective PCI - pediatric □ Oncology □ Respiratory Care
   _____ # of bassinets

□ Diagnostic Services □ Organ Transplant - Adult □ Social Services

□ Dialysis □ Organ Transplant - Peds □ Surgical

□ Emergency □ Infant Care / Nursery Type_________________

□ Food and Nutrition Type_________________

□ Imaging/Radiology □ Intensive/Critical Care

□ Infant Care / Nursery

□ Intensive/Critical Care

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 __________________________
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

□ 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 □ Neonatal—Level 3 □ # of beds

□ Cardiac Care Elective PCI - adult □ Neonatal—Level 4 □ Rehabilitation

□ Cardiac Care Elective PCI - pediatric □ # of bassinets □ # of PPS exempt beds

□ Diagnostic Services □ # of bassinets □ Respiratory Care

□ Dialysis □ Obstetrics □ Social Services

□ Emergency □ Oncology □ Surgical

□ Food and Nutrition □ Organ Transplant - Adult □ Organ Transplant - Peds

□ Imaging/Radiology □ Type ____________________________ □ Type ____________________________
3. **Key Individuals** (fill in as applicable)

<table>
<thead>
<tr>
<th>Administrator Name</th>
<th>Email Address</th>
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<tbody>
<tr>
<td>Phone (enter 10 digit #)</td>
<td>Fax (enter 10 digit #)</td>
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**Chief Nursing Services**

<table>
<thead>
<tr>
<th>Phone (enter 10 digit #)</th>
<th>Fax (enter 10 digit #)</th>
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**Director of Plant Services**

<table>
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<tr>
<th>Phone (enter 10 digit #)</th>
<th>Fax (enter 10 digit #)</th>
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**Preferred Contact**

<table>
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<tr>
<th>Phone (enter 10 digit #)</th>
<th>Fax (enter 10 digit #)</th>
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4. **Additional Information**

**Change of Ownership Information**

<table>
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<tr>
<th>Previous Name of Legal Owner</th>
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<table>
<thead>
<tr>
<th>Previous Name</th>
<th>Previous Hospital License #</th>
<th>Effective Date of Ownership Change</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Initials of Legal Representative</th>
<th>Date</th>
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</thead>
</table>

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)

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Print Title</th>
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RCW/WAC and Online Web Site Links

RCW/WAC Links
Hospital Laws, RCW 70.41
Hospital Rules, WAC 246-320

On-Line
Program, Web Page