Private Alcohol and Chemical Dependency 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
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Alcohol and Chemical Dependency
Hospital Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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License Requirements

Thank you for your interest in obtaining a private alcohol and chemical dependency 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.
- Nurse Staffing Plan - Emailed to **nursestaffing@doh.wa.gov**
- 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.

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.
- 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.

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**

Application Instructions Checklist

Important Information: When your application for an alcohol and chemical dependency 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 bed space 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.

Washington State Department of HEALTH

Fees
Alcohol and Chemical Dependency Hospital ..... Fee **All application fees are nonrefundable.**

Date Stamp Here

Revenue 0597632301

Private Alcohol and Chemical Dependency Hospital License Application

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

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 _____

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 Alcohol and Chemical Dependency Hospital Rules, WAC 246-324

Online

Hospital Program Web Page