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| **Section 1: Licensing Action (Must Be Completed)** | |
| **Initial Hospital Licensure** |  |

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| **Section 2: Type of Hospital (Must Be Completed)** | | | | | | | | |
| **Acute Care Hospital** | **Long Term Acute Care Hospital** | | | | | | **Critical Access Hospital** | |
| **Psychiatric Hospital** | **Rehabilitation Hospital** | | | | | | **Children’s Hospital** | |
| **Section 3: Hospital Information (Must Be Completed)** | | | | | | | | |
| **DBA Name:** | | | | | | | | |
| **Geographical Address:**  **City/State/Zip:** | | | | | | | | |
| **Phone:** | | | | | **Fax:** | | | |
| **Does the hospital have a different Mailing Address?  No  Yes** | | **If yes, please provide the Mailing Address:**  **Mailing Address City/State/Zip:** | | | | | | |
| **Parish of Hospital:** | | **Fiscal Year End:** | | | | **Fiscal Intermediary:** | | |
| **Seeking Accreditation after licensure:  No  Yes** | | | | | | **Accrediting Body:** | | |
|  | | | | | | | | |
| **Section 4: Total Beds/Rooms for Hospital (Must Be Completed)** | | | | | | | | |
| Number of Licensed Beds Campus: | | | Number of Licensed Rooms Campus: | | | | | |
| **Section 5: Administration (Must Be Completed)** | | | | | | | | |
| **Administrator** | | | | **Designated Contact Person for Licensing** | | | | |
| **Name:** | | | | **Name:** | | | | |
| **Phone:** | | | | **Phone:** | | | | |
| **Email:** | | | | **Email:** | | | | |
| **Director of Nursing** | | | | **Medical Director** | | | | |
| **Name:** | | | | **Name:** | | | | |
| **Phone:** | | | | **Phone:** | | | | |
| **Email:** | | | | **Email:** | | | | |
| **Section 6: Legal Entity/Corporation (Must Be Completed)** | | | | | | | | |
| **Legal Entity Name:** | | | | | | | | |
| **Legal Entity Mailing Address:**  **Legal Entity City/State/Zip:** | | | | | | | | |
| **Legal Entity Phone:** | | **Legal Entity Fax:** | | | | | | **Legal Entity EIN:** |

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| **Section 7: Type of Ownership (Must Be Completed)** | | | | |
| **Non-Profit**  **(Must submit evidence of Non-profit status)** | | **For Profit** | | **Government**  **(Must submit evidence of Governmental status)** |
| **Individual/Sole Proprietor** | | **Individual/Sole Proprietor** | | **Federal Facility** |
| **Corporation** | | **Corporation** | | **Hospital Service District** |
| **Limited Liability Corporation** | | **Limited Liability Company** | | **State Facility** |
| **Partnership** | | **Partnership** | | **Combination Gov-N-Profit** |
| **Religious Affiliation** | | **Group Practice** | | **Parish (specify)** |
| **Unincorporated Association** | | **Other:** | | **Other:** |
| **Section 8: Corporation Ownership ( Not applicable)** | | | | |
| If the disclosing entity is a corporation, list name, address, phone number, and email of the President | | | | |
| **President’s Name** | **President’s Address** | | **President’s Telephone #** | |
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| **Section 9: Ownership (Must Be Completed)** | |
| List name, address, phone number, and email for persons or groups of persons, and employer identification number (EIN) for organizations, having direct or indirect ownership or a controlling interest (5% or more) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity. (Attach additional sheets if additional space is needed). | |
| **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** | **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** |
|  |  |
| **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** | **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** |
|  |  |
| **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** | **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** |
|  |  |
| **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** | **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** |
|  |  |
| **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** | **Owner Name:**  **Owner Address:**  **Owner City/State/Zip:**  **Owner Email:**  **Owner Phone:**  **Owner EIN:**  **Percent of Ownership:** |

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| **Section 10: Co-Location Status (Must Be Completed)** |
| **Is the hospital co-located on a campus or in a building of another hospital, or licensed health provider?  No  Yes**  **If yes, list the dba name(s), address(es), CCN(s), and provider type(s):** |
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| **Section 11: Payment Information (Must Be Completed)** | |
| Check or Money Order Number: Check Amount: | |
| Mail Payment & Payment Transmittal Form To | Email License Application To |
| LDH Licensing Fee  PO Box 734350  Dallas, TX 75373-4350 | [HSS-Hospitals@la.gov](mailto:HSS-Hospitals@la.gov) |

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| **Section 12: Attestation & Signature (Must Be Completed)** | |
| I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership or change in geographical address. It is my responsibility to notify the Louisiana Department of Health, Health Standards Section, in writing of any changes in the information provided in this application in a separate packet. I attest that the Hospital currently complies with the requirements of the Office of State Fire Marshal, Office of Public Health and building codes. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Louisiana Department of Health. | |
| **Authorized Representative’s Printed Name & Title:** | |
| **Authorized Representative’s Signature:** | **Date:** |

**Required Licensing Information Checklist available on next page.**

**NOTE: This checklist is provided for guidance. Additional information may be required upon review.**

**Required Licensing Information Checklist**

**NOTE: This checklist is provided for guidance. Additional information may be required upon review.**

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| **Items Needed:** | **Submitted:** | **N/A** |
| 1. **Letter of Intent (LOI):**   **includes dba name, legal name, location, co-location status, services, inpatient beds, anticipated opening, etc.** |  |  |
| 1. **Application for Initial Hospital Licensure (Form HSS-HO-57)** |  |  |
| 1. **Secretary of State, Articles of Organization showing the legal entity name.** |  |  |
| 1. **IRS Documentation showing the legal entity name and Tax ID number.** |  |  |
| 1. **Ownership Structure Diagram showing all persons/entities with a 5% or greater direct or indirect ownership/control/interest/membership in any of the entities in the hospital’s ownership structure.** |  |  |
| 1. **Floor Plans (all areas/rooms labeled)** |  |  |
| 1. **Site Map (all buildings and areas labeled)** |  |  |
| 1. **Bedroom Worksheet**   **(Form HSS-HO-016a for beds/rooms included in bed capacity)** |  |  |
| 1. **Bedroom Worksheet**   **(Form HSS-HO-016b for beds/rooms not included in bed capacity: NICU, Nursery, ED, Observation, PACU)** |  |  |
| 1. **AR Plan Review**   **(Released for HSS viewing on the OSFM website. User name and password will be HSSHospitals.)** |  |  |
| 1. **DH Plan Review**   **(Released for HSS viewing on the OSFM website. User name and password will be HSSHospitals.)** |  |  |
| 1. **DH Plan Review Attestation (Form HSS-PR-02)** |  |  |
| 1. **OSFM Inspection showing the dba name of the hospital and SPECIFIC geographical address.** |  |  |
| 1. **OPH Inspection showing the dba name of the hospital and SPECIFIC geographical address (2 page report)** |  |  |
| 1. **OPH Retail Food Permit showing the dba name of the hospital and SPECIFIC geographical address, if applicable.** |  |  |
| 1. **CLIA Certificate** |  |  |
| 1. **Key Personnel Qualifications/CVs/Resumes/Licenses: Administrator, Director of Nursing, and Medical Director.**   **NOTE: Licensed Clinical Social Worker information is required for Psychiatric Hospitals.** |  |  |
| 1. **For Rehabilitation Hospitals: Form CMS-437B (Rehabilitation Hospital Criteria Worksheet)** |  |  |
| 1. **855A approval letter** |  |  |
| 1. **Health Insurance Agreement (Form CMS-1561)** |  |  |
| 1. **Office of Civil Rights Form** |  |  |
| 1. **Copy of payment and payment transmittal form** |  |  |