



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

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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.
- 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](#).
- 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 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.
- 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 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.
- 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

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.

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Application Instructions Checklist

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.



Fees
Acute Care Hospital..... Fee
All application fees are nonrefundable.

Date Stamp Here

Revenue 0597632300

Hospital License Application

This is for: Initial 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) #	
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 _____

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.

- | | | |
|---|---|---|
| <input type="checkbox"/> Alcohol and Chemical Dependency
_____ # of beds | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> Anesthesia and Recovery | <input type="checkbox"/> Medical Unit(s) | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Cardiac Care | <input type="checkbox"/> Neonatal—Level 2
_____ # of bassinets | <input type="checkbox"/> Pharmaceutical |
| <input type="checkbox"/> Cardiac Care Open heart - adult | <input type="checkbox"/> Neonatal—Level 3
_____ # of bassinets | <input type="checkbox"/> Psychiatric
_____ # of PPS exempt beds |
| <input type="checkbox"/> Cardiac Care Open heart - pediatric | <input type="checkbox"/> Neonatal—Level 4
_____ # of bassinets | <input type="checkbox"/> SNF/Long Term Care
_____ # of beds |
| <input type="checkbox"/> Cardiac Care Elective PCI - adult | <input type="checkbox"/> Neonatal—Level 4
_____ # of bassinets | <input type="checkbox"/> Rehabilitation
_____ # of PPS exempt beds |
| <input type="checkbox"/> Cardiac Care Elective PCI - pediatric | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Diagnostic Services | <input type="checkbox"/> Oncology | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Organ Transplant - Adult
Type _____ | <input type="checkbox"/> Surgical |
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Organ Transplant - Peds
Type _____ | |
| <input type="checkbox"/> Food and Nutrition | | |
| <input type="checkbox"/> Imaging/Radiology | | |
| <input type="checkbox"/> Infant Care / Nursery | | |
| <input type="checkbox"/> 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 _____

D. Certification:

Medicaid Certified? Yes No Provider # _____ Effective Date _____

Medicare Certified? Yes No Provider # _____ Effective Date _____

Medicare Dialysis? Yes No Provider # _____ Effective Date _____

Medicare Psychiatric? Yes No Provider # _____ Effective Date _____

Medicare Hospice? Yes No Provider # _____ Effective Date _____

Medicare Rehabilitation? Yes No Provider # _____ Effective Date _____

Medicare SNF/Long Term Care? Yes No Provider # _____ Effective 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.

<input type="checkbox"/> Alcohol and Chemical Dependency _____ # of beds	<input type="checkbox"/> Infant Care / Nursery	<input type="checkbox"/> Outpatient
<input type="checkbox"/> Anesthesia and Recovery	<input type="checkbox"/> Intensive/Critical Care	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Cardiac Care	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Pharmaceutical
<input type="checkbox"/> Cardiac Care Open heart - adult	<input type="checkbox"/> Medical Unit(s)	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Cardiac Care Open heart - pediatric	<input type="checkbox"/> Neonatal—Level 2 _____ # of bassinets	_____ # of PPS exempt beds
<input type="checkbox"/> Cardiac Care Elective PCI - adult	<input type="checkbox"/> Neonatal—Level 3 _____ # of bassinets	<input type="checkbox"/> SNF/Long Term Care
<input type="checkbox"/> Cardiac Care Elective PCI - pediatric	<input type="checkbox"/> Neonatal—Level 4 _____ # of bassinets	_____ # of PPS exempt beds
<input type="checkbox"/> Diagnostic Services	<input type="checkbox"/> Obstetrics	<input type="checkbox"/> Respiratory Care
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Oncology	<input type="checkbox"/> Social Services
<input type="checkbox"/> Emergency	<input type="checkbox"/> Organ Transplant - Adult	<input type="checkbox"/> Surgical
<input type="checkbox"/> Food and Nutrition	<input type="checkbox"/> Organ Transplant - Peds	
<input type="checkbox"/> Imaging/Radiology	Type _____	Type _____

This page may be duplicated.

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

[Hospital Laws, RCW 70.41](#)

[Hospital Rules, WAC 246-320](#)

Online

[Program, Web Page](#)