

Application for License to Operate a Hospital

OIG 003 – June 2014 Edition

I. TYPE OF APPLICATION (Write or type an X next to all that apply.)

Initial Licensure Change of Name
 Annual Re-licensure Change of Location
 Change in Number/Type of beds Change of Ownership

II. IDENTIFICATION

License Number _____
(Do not fill in License Number if this is an initial application for licensure)

Name of Facility _____

Physical Location of Facility _____
(Street) (City)

(County) (State) (Zip Code)

Mailing Address _____
(If different from above) (Street) (City)

(County) (State) (Zip Code)

Telephone Number _____

Email Address _____
(Primary contact for correspondence)

Administrator Name _____

Date facility began operating at current address _____

Date facility began operating under current owner _____

III. CONTROL (Check one in each column.)

State	<input type="checkbox"/>	Profit	<input type="checkbox"/>	Individual	<input type="checkbox"/>
County	<input type="checkbox"/>	Nonprofit	<input type="checkbox"/>	Partnership	<input type="checkbox"/>
City	<input type="checkbox"/>			Corporation	<input type="checkbox"/>
Private	<input type="checkbox"/>				

For Office Use Only: Check # _____ Amount _____

IV. OWNERSHIP Name and address of direct owner

A. Provide the following supporting documentation as an attachment to this application:

- The name, mailing address, email address and phone number of each person having at least a twenty-five (25) percent ownership interest in the facility;
- If owned by a corporation, the name, mailing address, email address and phone number of each officer or director of the corporation;
- If owned by a partnership, the name, mailing address, email address and phone number of each partner.

V. TYPE OF LICENSE (Please indicate the type of hospital for which you are applying. Please mark an X next to the type of beds, enter the number of beds listed on your current license, and if applicable, number of beds you are requesting.)

Critical Access Hospital

	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
TYPE BEDS		
<input type="checkbox"/> Critical Access	_____	_____
<input type="checkbox"/> Psychiatric	_____	_____
<input type="checkbox"/> Rehabilitation	_____	_____

General Hospital

	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
TYPE BEDS		
<input type="checkbox"/> Acute	_____	_____
<input type="checkbox"/> Chemical Dependency	_____	_____
<input type="checkbox"/> Psychiatric	_____	_____
<input type="checkbox"/> Rehabilitation	_____	_____
<input type="checkbox"/> Other:	_____	_____

Psychiatric Hospital

	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
TYPE BEDS		
<input type="checkbox"/> Chemical Dependency	_____	_____
<input type="checkbox"/> Psychiatric	_____	_____

Rehabilitation Hospital

	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
TYPE BEDS		
<input type="checkbox"/> Rehabilitation	_____	_____

- B. Please provide a list as an attachment to this application of all outpatient services which are licensed as part of the hospital, but located in separate building on the hospital campus or contiguous to the hospital campus. The following information should be provided: location address (include name of building, if applicable), telephone number, and outpatient service(s) provided.
- C. Please provide a list as an attachment to this application of all provider-based entities which share the hospital's Medicare provider number. The following information should be provided: facility name, address, telephone number, administrator, license number and type (if applicable) and outpatient service provided. (Do not include in this list other hospital-based services such as skilled nursing facilities, home health agencies, etc., which are qualified to participate in Medicare but do not share the hospital's Medicare number.)

An incomplete application or failure to submit the applicable licensure fee may result in return of the application to the applicant. A completed application should not be submitted to the Office of Inspector General until the facility is ready for an inspection.

I understand that **any change** in the information provided in within this application affecting the licensure status of this facility or service will be reported to the Office of Inspector General and **a new application** will be completed at that time. I agree that this facility/service and all aspects of its operation shall allow all state agency licensure personnel entrance upon its premises for the purpose of inspection. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application may result in denial or revocation of licensure.

Signature of Authorized Representative

Title

Date

Submit the application, fee and supportive documentation to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621