CABINET FOR HEALTH AND FAMILY SERVICES
Office of the Inspector General

OIG-20:490, December 2022

Application for Licensure to Operate a Rural Emergency Hospital (REH)

- If you have questions regarding this application, please call (502) 564–7963.
- Please answer all questions completely and accurately. Supporting documentation must be attached. An incomplete or illegible application will be returned without being processed.
- A non-refundable fee in the amount of $1,000 for initial licensure or annual renewal must accompany this application. Approval will not be issued without receipt of this fee.
- All renewal applications shall be filed sixty (60) days prior to the expiration date of the current license.
- Please return the application, required documents, and the non-refundable licensure fee payable to the Kentucky State Treasurer to:

Cabinet for Health and Family Services
Office of Inspector General
Division of Health Care
275 E. Main St., 5 E-A
Frankfort, KY 40621

A. Type of Application

☐ Initial Licensure
☐ Annual Renewal of Licensure
☐ Change of Name
☐ Change of Location
☐ Change of Ownership

B. Identification

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

2. Name of Facility _____

3. Physical Location of Facility _____
(Street) (City)

_____
(County) (State) (Zip Code)

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

_____
(County) (State) (Zip Code)

5. Telephone Number _____ Email Address _____
(Primary contact for correspondence)

6. Administrator Name _____

7. Date Facility Began Operating at Current Address _____

8. Date Facility Began Operating under Current Owner _____

C. Control (Select one in each column.)

☐ State	☐ Profit	☐ Individual
☐ County	☐ Nonprofit	☐ Partnership
☐ City		☐ Corporation
☐ Private		

D. Ownership

List the name and address of the direct owner.

_____

_____

E. Supporting Documentation

Please provide the following as attachments to this application:

- The name, mailing address, email address, and phone number of each person or legal entity having an 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.
- Documentation of certification from the Centers for Medicare and Medicaid Services designating the facility as an REH.
- **For initial licensure, an action plan for initiating REH services, including a detailed transition plan that lists the specific services the facility will retain, modify, add, and discontinue.**
- A description of services the facility intends to provide or currently provides on an outpatient basis.

F. Verification

I understand that I am required to report any change in the information provided within this application that affects my licensure status to the Office of Inspector General and complete a new application at that time. I agree that this facility and all aspects of its operation shall allow state agency 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 shall result in the denial or revocation of licensure.

_____ _____
Signature of Authorized Representative Title

_____ _____
Name (please print or type) Date