Application for License to Operate a Hospital

OIG 003 – January 2017 Edition

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

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

II. IDENTIFICATION

License Number _____
(Do not fill in License Number if this is an application for provisional 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 (Select one in each column.)

State: ○
County: ○
City: ○
Private: ○

Profit: ○
Nonprofit: ○

Individual: ○
Partnership: ○
Corporation: ○

IV. OWNERSHIP Name and address of direct owner

_____

_____

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

- The of name, mailing address, email address and phone number 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.

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**

TYPE BEDS	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
☐ Critical Access	_____	_____
☐ Psychiatric	_____	_____
☐ Rehabilitation	_____	_____

☐ **General Hospital**

TYPE BEDS	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
☐ Acute	_____	_____
☐ Chemical Dependency	_____	_____
☐ Psychiatric	_____	_____
☐ Rehabilitation	_____	_____
☐ Other: _____	_____	_____

☐ **Psychiatric Hospital**

TYPE BEDS	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
☐ Chemical Dependency	_____	_____
☐ Psychiatric	_____	_____

☐ **Rehabilitation Hospital**

TYPE BEDS	NUMBER OF BEDS CURRENTLY LICENSED	NUMBER OF BEDS REQUESTED
☐ 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 as a condition precedent to provisional licensure, this facility shall be in compliance with all state and federal statutes and administrative regulations applicable to the license requested.

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

For Office Use Only: Check # _____ Amount _____