How to Become a Licensed Abortion Facility

Attached is an application packet for an Initial or Change of Ownership (CHOW) License for an Abortion Facility. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 139, Abortion Facility Reporting and Licensing Rules, §139.13 Application Procedures and Issuance of Licenses. Information regarding licensure for health care facilities, including contact information for the zone office for your location is located on the department's website at http://dshs.texas.gov/facilities/.

The following documents, fees, and actions shall be completed and approved before a license will be issued:

Initial Application

- A license application form submitted approximately 90 calendar days prior to the projected opening date of the facility.
- A license fee of $5,000.00 shall be submitted. ***License fees are not refundable.***
- The Administrator listed on the application shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated office to schedule the presurvey conference (http://www.dshs.texas.gov/facilities/compliance-zones.aspx).

Change of Ownership (CHOW) Application

- A license application form to be submitted at least 60 calendar days before the date of the change of ownership.
- A license fee of $5,000.00 shall be submitted. ***License fees are not refundable.***
- The Administrator listed on the application shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated office to schedule the presurvey conference (http://www.dshs.texas.gov/facilities/compliance-zones.aspx).
- The applicant shall include evidence (Bill of Sale, lease agreement, or legal court document) of the Change of Ownership. This document can be submitted separately from the license application.

Important Items to Note:

- The D/B/A or Assumed name of the facility is the name that will appear on the license certificate and should match advertisements and signage of the facility.
- The Legal Name is the name of the legal entity directly responsible for the day to day operation of the facility. The Legal Name and EIN on the application should be an exact match with the IRS letter.
- The organizational chart showing ownership structure should reflect all levels of ownership and include EIN numbers. The chart should start with the D/B/A or Assumed Name, continue with the Legal Name (direct owner), and end with any additional ownership levels. An example has been attached for your reference.

The Facility Licensing Group is dedicated to assist you through this process and is available to answer your questions. If you have any questions, please contact the Facility Licensing Group: phone (512) 834-6648, fax (512) 834-4514.

MAILING ADDRESS:
HHSC AR
P.O. BOX 149055
Austin, Texas 78714-9055

EXAMPLE
OWNERSHIP STRUCTURE

HIGHER LEVEL
OF OWNERSHIP

EIN #

(Add Boxes as Needed)

LEGAL NAME

EIN #

DOING BUSINESS AS (D/B/A)

or ASSUMED NAME

SERVICE CODE: 529201048

ABORTION FACILITY LICENSE APPLICATION

☐ Initial
Projected Date Facility Will Open: ______________________

☐ Change of Ownership
Effective Date: ________________________
Current License #: _____________________

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1. Facility Information:

a. Name the facility will be Doing Business As (D/B/A) or Assumed Name:

____

This is the name that will appear on the license and should match advertisements and signage of the facility.

b. Street Address:

____
Address

____
City/State/Zip County

c. Mailing Address:

____
Street Address or P.O. Box Number

____
City/State/Zip

d. Telephone Number: **e.** Fax Number:

______________________________________ ______________________________________

Leave blank if numbers are unknown at this time.

2. Ownership Information:

____

a. Legal Name
Name of legal entity directly responsible for day to day operation of the facility.

______________________________ ______________________________
b. Mailing Address City/State/Zip

__________________ __________________ __________________
c. EIN Number **d.** Telephone Number **e.** Email Address

f. Provide a copy of the IRS letter assigning the employer identification number (EIN).

g. Provide a copy of the Certificate of Filing from the Office of the Secretary of State.

h. Attach an ownership structure. *See Example.*

i. Status: ☐ Profit ☐ Non-Profit

j. Type of Legal Entity:

- ☐ City
- ☐ Corporation
- ☐ County
- ☐ Hospital
- ☐ LTD
- ☐ Hospital District/Authority
- ☐ Limited Liability Company (LLC)
- ☐ Limited Liability Partnership (LLP)
- ☐ Limited Partnership (LP)
- ☐ Partnership
- ☐ Sole Owner/Proprietorship
- ☐ State
- ☐ Other: ______________________________

3. Ownership and Control Interest Disclosure:

a. The owner/legal entity must disclose the following data for the two-year period preceding the application date. Check yes or no to the following questions. If yes is checked, you must provide details, including ownership and facility information, circumstances, dates and final action, on a separate sheet with this application.

1. Eviction involving any property used as a health care facility in any state? **Yes** ☐ **No** ☐
2. Federal or state (any state) tax liens? **Yes** ☐ **No** ☐
3. Unsatisfied final judgments? **Yes** ☐ **No** ☐
4. Federal or state (any state) criminal misdemeanor arrests or convictions? **Yes** ☐ **No** ☐
5. Injunctive orders from any court? **Yes** ☐ **No** ☐
6. Unresolved final state or federal Medicare or Medicaid audit exceptions? **Yes** ☐ **No** ☐

b. The owner/legal entity must disclose the following data. Check yes or no to each question. If yes is checked, provide details on a separate sheet, including all ownership and facility information, circumstances, dates and final action.

1. Denial, suspension, or revocation of an abortion facility license or any health agency in any state or any other enforcement action? **Yes** ☐ **No** ☐
2. Denial, suspension, revocation, or other enforcement action against a health care facility licensed in any state, which is or was proposed by the licensing agency and the status of the proposal? **Yes** ☐ **No** ☐
3. Surrendered a license before expiration of the license or allowing a license to expire in lieu of the department proceeding with enforcement action? **Yes** ☐ **No** ☐
4. Federal or state (any state) criminal felony arrests or convictions? **Yes** ☐ **No** ☐
5. Federal or state Medicaid or Medicare sanctions or penalties relating to the operation of a health care facility? **Yes** ☐ **No** ☐
6. Operating a health care facility that has been decertified with Medicare or Medicaid? **Yes** ☐ **No** ☐
7. Debarment, exclusion, or contract cancellation from Medicare or Medicaid in any state? **Yes** ☐ **No** ☐

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4. Licensing Fee:

☐	Initial	$5,000.00
☐	Change of Ownership	$5,000.00

Make checks payable to the Texas Health and Human Services Commission.
Fees paid to the Department are not refundable.

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5. Personnel:

Submit names, Texas Provider Identification numbers if Medicaid-enrolled, National Provider Identification numbers, and license numbers and expiration dates of **all licensed professionals** who provide services at the abortion facility. *(Use attached page if necessary.)*

Name: ____
Texas Provider Id #: ________________________________
National Provider ID #: _____________________________
License #: ____
Expiration Date: ____________________________________

Name: ____
Texas Provider Id #: ________________________________
National Provider ID #: _____________________________
License #: ____
Expiration Date: ____________________________________

6. Other – The following documents are required and must be attached in order to complete the application:

☐ Organizational structure of the staffing for the facility.

☐ Agreement to sale. *(Change of Ownership Only.)*

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7. Administrator's Signature:

The administrator attests that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 139, Abortion Facility Reporting and Licensing Rules. The administrator attests that all information contained in this application is true and correct. The administrator attests that all copies submitted with the application are original copies or copies of the original documents.

______________________________	______________________________
Administrator's Name **(Print)** *Person responsible for day-to-day operations at the facility*	Title
______________________________	______________________________
Administrator's Signature	Date Signed
______________________________	______________________________
Administrator's Email Address	Administrator's Telephone Number

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8. Contact Person:

______________________________	______________________________
Name of the person completing this application	Title
______________________________	______________________________
Telephone Number	Email Address

Name of Facility: ______________________________ SERVICE CODE: 529201048

PERSONNEL CONTINUED…

Provide names, Texas Provider Identification numbers if Medicaid-enrolled, National Provider Identification numbers, and license numbers and expiration dates of <u>**all licensed professionals**</u> who provide services at the abortion facility. *(Do not include names of individuals already included on page 2.)*

Name: ____
Texas Provider Id #: ____
National Provider ID #: ____
License #: ____
Expiration Date: ____

Name: ____
Texas Provider Id #: ____
National Provider ID #: ____
License #: ____
Expiration Date: ____

Name: ____
Texas Provider Id #: ____
National Provider ID #: ____
License #: ____
Expiration Date: ____

Name: ____
Texas Provider Id #: ____
National Provider ID #: ____
License #: ____
Expiration Date: ____

Name: ____
Texas Provider Id #: ____
National Provider ID #: ____
License #: ____
Expiration Date: ____