How to Become a Licensed Ambulatory Surgical Center

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for an Ambulatory Surgical Center. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 135, Ambulatory Surgical Center Licensing Rules, §135.20 Initial Application and Issuance of License. Information regarding licensure for health care facilities, including contact information for the Health Facility Compliance Zone Office for your location is located on the department’s website at www.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 $5,200.00 shall be submitted. **License fees are not refundable.**
- Approval for occupancy shall be obtained from the Architectural Review Group: (512) 834-6649 or http://www.dshs.texas.gov/facilities/architectural-review.aspx).
- The Administrator, Medical Chief of Staff, and/or Director of Nurses listed on the application shall attend a pre-survey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated office to schedule the pre-survey conference (http://www.dshs.texas.gov/facilities/compliance-zones.aspx).

**Change of Ownership (CHOW) Application**

- A license application form to be submitted at least 30 calendar days before the date of the change of ownership. A license fee of $5,200.00 shall be submitted. **License fees are not refundable.**
- If applicable, submit a letter or certificate of accreditation from an accrediting organization which includes dates of accreditation.
• The Administrator, Medical Chief of Staff, and/or Director of Nurses listed on the application shall attend a pre-survey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated office to schedule the pre-survey conference (http://www.dshs.texas.gov/facilities/compliance-zones.aspx).

• Submit a Bill of Sale or other legal document which shows both parties agreement to the sale.

Relocation Application

• A license application form submitted approximately 90 calendar days prior to the projected opening date of the facility. A license fee of $5,200.00 shall be submitted. License fees are not refundable.

• If applicable, submit a letter or certificate of accreditation from an accrediting organization which includes dates of accreditation.

• Approval for occupancy shall be obtained from the Architectural Review Group: (512) 834-6649 or http://www.dshs.texas.gov/facilities/architectural-review.aspx).

Important Items to Note:

• The D/B/A or Assumed Name listed on the application must match the D/B/A or Assumed Name listed on applications filed with the Texas State Board of Pharmacy and the Drug Enforcement Agency.

• 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, Secretary of State documentation, and ownership structure.

• The 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, and end with any additional ownership levels. An example has been attached for your reference.

Additional Information:

Medicare certification information may be obtained from the Health Facility Compliance Zone Office for your location (http://www.dshs.texas.gov/facilities/compliance-zones.aspx). The Social Security Act directs the Secretary of the Department of Health and Human Services to use the help of State health agencies or other appropriate agencies to determine if health care entities meet Federal standards. This task is one of the Texas Health and Human Services Commission’s responsibilities. For information on gaining provider certification, contact Zone Office staff.
CLIA information is located on the department’s website at http://www.dshs.texas.gov/facilities/clia.aspx. For more information, contact the Health Facility Compliance Zone Office for your location. 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) 8344514.

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

EXAMPLE
OWNERSHIP STRUCTURE

HIGHER LEVEL
OF OWNERSHIP
EIN #

(Add Boxes as Needed)
AMBULATORY SURGICAL CENTER LICENSE APPLICATION

☐ Initial
   Projected date facility will open: _________ Architectural Project #: ____________

☐ Change of Ownership
   Effective Date: ________________ Current License #: ________________

☐ Relocation
   Projected Date Facility Will Open: ________________
   Current License #: ________________ Architectural Project #: ____________

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.

   Name of Facility: ____________________                      SERVICE CODE: 529201046

2. Ownership Information:
a. Legal Name

_______________________________

_______________________________

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 Ownership:

City Hospital District/Authority Corporation

Limited Liability Company (LLC) County
Limited Liability Partnership (LLP) Hospital
Limited Partnership (LP) LTD
Partnership Sole Owner/Proprietorship State Other:

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