How to Become a Licensed
Freestanding Emergency Medical Care Facility

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for a Freestanding Emergency Medical Care Facility. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 131, Freestanding Emergency Medical Care Facilities Licensing Rules, §131.25 Application and Issuance of Initial License. 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://www.dshs.texas.gov/facilities/default.aspx.

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 $14,820.00 shall be submitted. ***License fees are not refundable.***
- Patient Transfer Documents:
  - A copy of the facility's Patient Transfer Policy that is in accordance with §131.66 Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted for approval.
  - A copy of the facility's Memorandum of Transfer form that is in accordance with §131.66(b)(9) shall be submitted for approval.
  - A copy of the facility's Patient Transfer Agreement with a General Hospital that is in accordance with §131.67 Patient Transfer Agreements shall be submitted for approval.
- An approved Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority.
- 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 presurvey conference at the

zone office designated by the department. Please contact the designated zone office to schedule the presurvey conference (http://www.dshs.texas.gov/facilities/compliance-contact.aspx).

Relocation Application

- A license application form submitted approximately 90 calendar days prior to the projected opening date of the facility.
- A license fee of $14,820.00 shall be submitted. ***License fees are not refundable.***
- Patient Transfer Documents:
    - A copy of the facility's Patient Transfer Policy that is in accordance with §131.66 Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted for approval.
    - A copy of the facility's Memorandum of Transfer form that is in accordance with §131.66(b)(9) shall be submitted for approval.
    - A copy of the facility's Patient Transfer Agreement with a General Hospital that is in accordance with §131.67 Patient Transfer Agreements shall be submitted for approval.
- A copy of the letter or certificate of accreditation from an authorized accrediting agency which includes effective dates of accreditation.
- An approved Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority.
- Approval for occupancy shall be obtained from the Architectural Review Group, (512) 834-6649, or http://www.dshs.texas.gov/facilities/architectural-review.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 $14,820.00 shall be submitted. ***License fees are not refundable.***
- Patient Transfer Documents:
    - A copy of the facility's Patient Transfer Policy that is in accordance with §131.66 Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted for approval.
    - A copy of the facility's Memorandum of Transfer form that is in accordance with §131.66(b)(9) shall be submitted for approval.
    - A copy of the facility's Patient Transfer Agreement with a General Hospital that is in accordance with §131.67 Patient Transfer Agreements shall be submitted for approval.
- A copy of the letter or certificate of accreditation from an authorized

accrediting agency which includes effective dates of accreditation.

- A copy of two approved Fire Safety Survey Report forms shall be submitted. Annual fire safety inspections are required for continued licensure status. Include a copy of a fire inspection report dated within the last 12 months & a second report dated within the last 13 to 24 months indicating approval by the local fire authority.
- The Administrator, Medical Chief of Staff, and/or Director of Nurses listed on the application shall attend a presurvey conference at the zone office designated by the department. Please contact the designated zone office to schedule the presurvey conference or to request a wavier (http://www.dshs.state.tx.us/facilities/compliance-zones.aspx).
- A Bill of Sale or other legal document shall be submitted. The document shall include the effective date of the change of ownership and both parties signed agreement to the transaction.

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 direct owner legally responsible for the day to day operation of the facility, whether by lease or ownership. 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. Please contact us at: phone (512) 834-6648, fax (512) 834-4514.

MAILING ADDRESS:

HHSC AR
P.O. BOX 149055
Austin, Texas 78714-90557

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: 529201040

FREESTANDING EMERGENCY MEDICAL CARE FACILITY 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: 529201040

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. DISCLOSURE:

a. Check yes or no to each question. If yes is checked, provide details on a separate sheet of paper including circumstances, dates, and final action. The following information must be disclosed for the two-year period preceding the application date concerning the owner.

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

b. Check yes or no to each question. If yes is checked, provide details on a separate sheet of paper including circumstances, dates, and final action. The following information must be disclosed concerning the owner.

1. Denial, suspension, probation, or revocation of a facility license in any state, a license for any health care facility, or a license for a home and community support services agency in any state; or any enforcement action, such as (but not limited to) court civil or criminal action in any state? **Yes** _______ **No** _______
2. Denial, suspension, probation, or revocation of or other enforcement action against a facility license in any state, a license for a health care facility in any state, or a license for a home and community support services agency in any state which is or was proposed by the licensing agency and the status of the proposal? **Yes** _______ **No** _______
3. Surrendering a license before expiration of the license or allowing a license to expire in lieu of the department's proceeding with enforcement action? **Yes** _______ **No** _______
4. Federal or state (any state) criminal felony arrests or convictions? **Yes** _______ **No** _______
5. Medicaid or Medicare sanctions or penalties relating to the operation of a health care facility or home and community support services agency? **Yes** _______ **No** _______
6. Operation of a health care facility or home and community support services agency that has been decertified or terminated from participation in any state u under Medicare or Medicaid? **Yes** _______ **No** _______
7. Debarment, exclusion, or contract cancellation in any state from Medicare or Medicaid? **Yes** _______ **No**_______

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4. LICENSING FEE:

- ☐ Initial $14,820.00
- ☐ Change of Ownership $14,820.00
- ☐ Relocation $14,820.00

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

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5. ACCREDITATION *(for CHOWs and Relocations Only)*:
Please check the category that applies. Attach a copy of the most recent accreditation letter or certificate.

- ☐ Joint Commission (JC)
- ☐ Other ____
- ☐ Not accredited

6. EMERGENCY TREATMENT STATIONS:

Provide the total number of Emergency Treatment Stations: ____________

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7. MEDICAL STAFF:

a. Medical Chief of Staff:

______________________	____________	____________
Name	License #	Expiration Date

b. Director of Nursing:

______________________	____________	____________
Name	License #	Expiration Date

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8. SAFE-READY FACILITY

Is your facility a SAFE-ready facility? ☐ Yes ☐ No

"SAFE-ready facility" means a health care facility designated as a Sexual Assault Forensic Exam-ready facility under TX Health and Safety Code Section 323.0015. A SAFE-ready facility employs or contracts with a sexual assault forensic examiner or uses a telemedicine system of sexual assault forensic examiners to provide consultation to a licensed nurse or physician when conducting a sexual assault forensic medical examination.

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9. PATIENT TRANSFER POLICY/MEMORANDUM OF TRANSFER/PATIENT TRANSFER AGREEMENT:

☐ Submit a copy of the facility's Memorandum of Transfer form and the Patient Transfer Policy developed in accordance with the rules governing patient transfer policies and agreements which is signed by both the chairman and secretary of the hospital's governing body attesting to the date of adoption of the policy and the policy's effective date.

☐ Submit a copy of a written agreement the facility has with a hospital which provides for the prompt transfer to and the admission by the general hospital of any patient when services are needed but are unavailable or beyond the capabilities of the facility in accordance with §131.67 of this title (relating to Patient Transfer Agreements).

10. FIRE SAFETY SURVEY:

- Initial and Relocation Applications – Include a copy of a fire inspection report conducted within the last 12 months indicating approval by the ***local*** fire authority.

- Change of Ownership Applications - Include a copy of a fire inspection report conducted within the last 12 months and one from the year prior indicating approval by the ***local*** fire authority.

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11. SIGNATURE AND ATTESTATION:

The administrator attests that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 131, Freestanding Emergency Medical Care Facilities. 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. The administrator attests that at least one physician licensed in the State of Texas and at least one registered nurse licensed in the State of Texas are on site during all hours of operation.

______________________________	______________________________
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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12. CONTACT PERSON:

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

PHYSICIAN OWNERSHIP N/A ☐

Texas Administrative Code, Chapter 131.25(d)(4) requires the facility to submit the names, license numbers, and expiration dates of those licenses of any physician licensed by the Texas Medical Board who has a financial interest in the facility or in any entity that has an ownership interest in the facility.

Name: ____
Texas Medical Board License Number: ______________________________
Expiration Date of License: ______________________________________

Name: ____
Texas Medical Board License Number: ______________________________
Expiration Date of License: ______________________________________

Name: ____
Texas Medical Board License Number: ______________________________
Expiration Date of License: ______________________________________

Name: ____
Texas Medical Board License Number: ______________________________
Expiration Date of License: ______________________________________

Name: ____
Texas Medical Board License Number: ______________________________
Expiration Date of License: ______________________________________

Name: ____
Texas Medical Board License Number: ______________________________
Expiration Date of License: ______________________________________

Name: ____
Texas Medical Board License Number: ______________________________
Expiration Date of License: ______________________________________

Name: ____
Texas Medical Board License Number: ______________________________
Expiration Date of License: ______________________________________

Name: ____
Texas Medical Board License Number: ______________________________
Expiration Date of License: ______________________________________

MEMORANDUM OF TRANSFER

Section A (To be filled out by Transferring Freestanding Emergency Medical Care Facility)

1. Name of Transferring Facility:___________________
____
Address:_______________________________________
Phone Number:__________________________________

2. Patient's Full Name (If Known):__________________
____
Address:_______________________________________
Phone Number:__________________________________
Sex: M F Age:________________
National Origin:_____ Race:______________
Religion:___________ Physical Handicap:____________
____

3. Next of Kin Name (If Known):___________________
____
Address:_______________________________________
Phone Number:__________________________________
Next of Kin notified? Yes No

4. Date of Arrival:___/___/___ Time:_______

5. Initial contact with Receiving hospital administration
Date:___/___/___ Time:______
Name of contact person at Receiving hospital:____________________________________
____

6. Transferring physician secured Receiving physician
Date:___/___/___ Time:__________
Name of Receiving physician:_______________________
____

7. Transferring physician's signature:
____
Name of Transferring physician:_____________________
Address:_______________________________________
Phone number:__________________________________

8. Accepting hospital secured by Transferring facility
Date:___/___/___ Time:___________

9. Transferring facility administration who contacted the receiving hospital
Signature:_____________________________________
Title:________________________________ Time:________

10. Type of vehicle and company used:_____________________
____
Equipment needed:______________________________
Personnel needed:______________________________

11. Name of hospital to which patient was transported:________
____
City:____

12. Diagnosis:__________________________________
____

13. Attachments:
X-Rays____ Physician Progress Notes___
Lab Reports___ Nurse Progress Notes___
H&P___ Medication Record___
Other___

PHYSICIAN CERTIFICATION: Based on the information available at the time of the transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at a hospital outweigh the increased risks to the patient and, in the case of labor, the unborn child from affecting the transfer.
Summary of Risks and Benefits:
____
____

____
Transferring Physician's Signature

Section B (To be filled out at Receiving Hospital)

1. Name of Receiving Hospital:_______________________
____
Address:_______________________________________
____
Phone Number:__________________________________

2. Date of Arrival:___/___/___ Time:_______

3. Receiving Hospital Administration
Signature:_____________________________________
Title:____
Date:___/___/___ Time: _____________

4. Receiving Physician assumed Patient responsibility:
Date:___/___/___ Time:________
Signature:_____________________________________
Name:____
Address:_______________________________________
____
Phone number:__________________________________

5. If response to the transfer request was delayed beyond thirty (30) minutes, document the reason(s) for the delay, including any agreed time extensions. Use additional sheet if necessary.________________________________
____

SAMPLE