TEXAS Health and Human Services

How to Become a Licensed Crisis Stabilization Unit (CSU)

Attached is an application packet for an Initial, Relocation, or Change of Ownership (CHOW) License for a Crisis Stabilization Unit (CSU). The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 134, Private Psychiatric Hospitals and Crisis Stabilization Units Licensing Rules, §134.22 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/.

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

Initial Application

- A CSU application form submitted approximately 90 calendar days prior to the projected opening date of the CSU.
- A license fee of $200.00 per bed shall be submitted. ***License fees are not refundable.***
- Patient Transfer Documents:
  - A copy of the CSU's Patient Transfer Policy that is in accordance with §134.43 Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
  - A copy of the CSU's Memorandum of Transfer form that is in accordance with §134.43(d)(10)(B) shall be submitted.
  - Patient transfer agreements for CSUs are not required to be submitted to the department for approval.
- 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 Health and Human Services Commission, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or http://www.dshs.texas.gov/facilities/architectural-review.aspx).
- The applicant 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-zones.aspx). ***(Note: It is required that an individual listed on the license application attend the conference).***

Relocation Application

- A CSU application form submitted approximately 90 calendar days prior to the projected opening date of the CSU.
- A license fee of $200.00 per bed shall be submitted. ***License fees are not refundable.***
- Patient Transfer Documents:
  - A copy of the CSU's Patient Transfer Policy that is in accordance with §134.43 Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
  - A copy of the CSU's Memorandum of Transfer form that is in accordance with §134.43(d)(10)(B) shall be submitted.
  - Patient transfer agreements for CSUs are not required to be submitted to the department for approval.
- A copy of the letter or certificate of accreditation from an authorized accrediting agency which includes effective dates of accreditation.
- 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 Health and Human Services Commission, Architectural Review Group (phone (512) 834-6649, fax (512) 834-6620 or http://www.dshs.texas.gov/facilities/architectural-review.aspx).

Change of Ownership (CHOW) Application

- A CSU application form submitted prior to the date of the change of ownership or not later than 10 calendar days following the date of the change of ownership.
- A license fee of $200.00 per bed shall be submitted. ***License fees are not refundable.***
- Patient Transfer Documents:
  - A copy of the CSU's Patient Transfer Policy that is in accordance with §134.43 Patient Transfer Policy, and signed by the Chairman and Secretary of the Governing Body shall be submitted.
  - A copy of the CSU's Memorandum of Transfer form that is in accordance with §134.43(d)(10)(B) shall be submitted.
  - Patient transfer agreements for CSUs are not required to be submitted to the department for approval.
- A copy of the letter or certificate of accreditation from an authorized accrediting agency which includes effective dates of accreditation.
- 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.
- The applicant shall attend a presurvey conference at the zone office designated by the department. The designated zone office may waive the presurvey conference requirement for a Change of Ownership. Please contact the designated zone office to schedule the presurvey conference or to request a waiver. (http://www.dshs.texas/gpv/facilities/compliance-zones.aspx). ***(Note: It is required that an individual listed on the license application***

attend the conference).

- 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 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.

Additional Information:

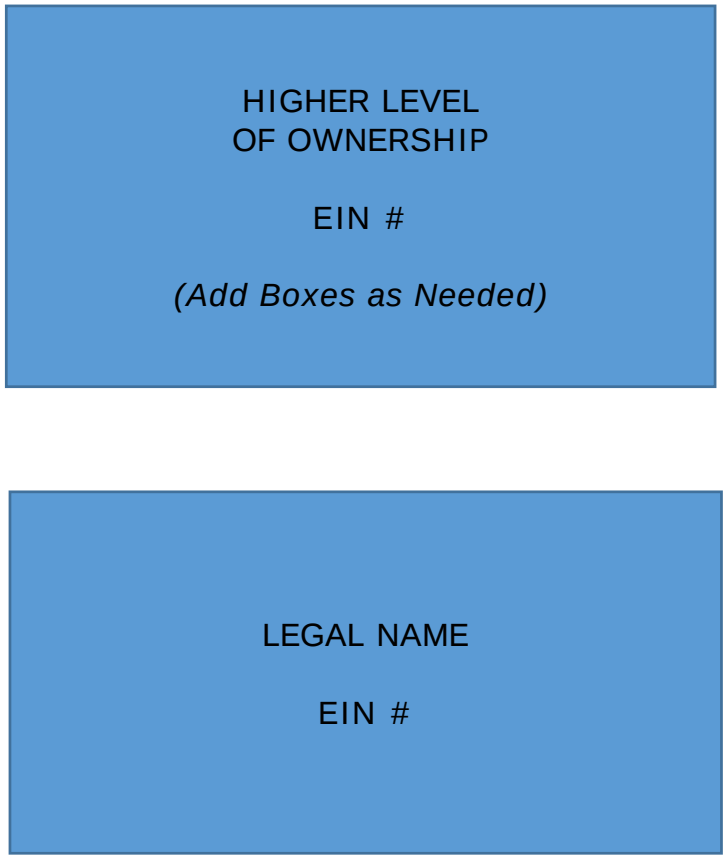
Medicare certification information may be obtained from the zone office for your location (http://www.dshs.texas.gov/facilities/compliance-zones.aspx). The Social Security Act directs the Secretary of the Department of Health and Human Services to use the help of State health agencies or other appropriate agencies to determine if health care entities meet Federal standards. This task is one of the Health and Human Services Commission's responsibilities. For information on obtaining provider certification, please contact zone office staff.

CLIA information is located on the department's website at http://www.dshs.texas.gov/facilities/. For more information, please contact the Zone Office for your location http://www.dshs.texas.gov/facilities/compliance-zones.aspx.

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



TEXAS Health and Human Services

APPLICATION FOR A LICENSE TO OPERATE A CRISIS STABILIZATION UNIT

☐ 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 #: _____

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1. CSU INFORMATION:

a. Located within a hospital: ☐ Yes ☐ No

b. 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.

c. Street Address:

_____
Street

_____
City/State/Zip County

d. Mailing Address (if different):

_____
Street or P.O. Box Number City/State/Zip

e. Telephone Number (include area code) **f.** Fax Number

_____ _____

Leave blank if numbers are unknown at this time.

2. OWNERSHIP INFORMATION:

a. Legal Name ***(Name of direct owner legally responsible for the day to day operation of the facility, whether by lease or ownership)***

_____

b. Mailing Address City/State/Zip

_____ _____ _____

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

f. Status: ☐ Profit ☐ Non-Profit

g. Type of Ownership:

☐ 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: _____

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

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

j. Attach an organizational chart showing the ownership structure. *See Example.*

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3. CSU SERVICES:

CRISIS STABILIZATION UNIT (CSU) - The term "crisis stabilization unit" means a mental health facility operated by a community center or other entity designated by the Texas Department of Mental Health and Mental Retardation in accordance with Texas Health and Safety Code, §534.054, that provides treatment to individuals who are the subject of a protective custody order issued in accordance with Texas Health and Safety Code, §574.022.

Services: *(Please check all services offered)*

☐ Psychiatric
☐ Chemical Dependency
☐ Laboratory Services (*Onsite or Contracted*)
☐ Emergency Treatment Room *(Required)*

4. LICENSED BEDS:

a. How many total licensed beds are at this location? _____

A change in the bed design capacity requires prior approval and possible fees.

b. How many emergency treatment room beds are at this location? _____

This count is not included in the licensed bed count above and will not affect fees. A minimum of one bed is required.

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5. FEES: *Fees are not refundable – Make checks payable to Health and Human Services Commission.*

Total number of licensed beds: _____

Total fee due is $200.00 per bed with a minimum total due of $6,000.00.
Amount paid: $_____

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6. MEDICARE CERTIFICATION (CHOWS and RELOCATIONS ONLY)

Is the facility certified to participate in the Title XVIII Medicare Program?
☐ Yes ☐ No

If YES, provide the facility's CCN Number: _____

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7. ACCREDITATION (CHOWS and RELOCATIONS ONLY)
(Check the appropriate category)
Attach a copy of the most recent letter or certificate of accreditation.

☐ Joint Commission (JC)
☐ American Osteopathic Association (AOA)
☐ DNV GL
☐ Center for Improvement in Healthcare Quality (CIHQ)
☐ Not accredited

8. MEDICAL AND PROFESSIONAL STAFF:

Provide the name of the physician in charge of the care and treatment of the patients.

_____ _____
Name of Physician Title

_____ _____
License Number Expiration Date

Provide the numbers of all professional staff below. On a separate sheet include an explanation of the duties and qualifications of the professional staff.

_____ Licensed Counselors
_____ Registered Nurses
_____ Master Social Workers
_____ Licensed Vocational Nurses
_____ PhDs
_____ Other: _____

_____ MDs
_____ Recreational Therapists
_____ Occupational Therapists
_____ Activity Therapists
_____ Psychiatric Technicians

9. EQUIPMENT AND FACILITIES:

☐ Attach a description of any major medical equipment and facilities used by the facility.

☐ Attach a plan (campus map) of the premises that describes the buildings and grounds and the manner in which the various parts of the premises are intended to be used. The plan should also include the names of the buildings, the licenses held by each building, and the number of beds in each building.

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.

11. PATIENT TRANSFER POLICY and MEMORANDUM OF TRANSFER:

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

12. SIGNATURE AND ATTESTATION:

I attest that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 134, Private Psychiatric Hospitals and Crisis Stabilization Units Licensing Rules. I attest that all information contained in this application is true and correct. I attest that all copies submitted with the application are original copies or copies of the original documents.

_____ _____
Chief Executive Officer Signature Date Signed

_____ _____
Printed Name of CEO Title

_____ _____
Telephone Number Email Address

13. CSU ADMINISTRATOR (onsite administrator in charge of day-to-day operations at the facility):

_____ _____
Administrator Title

_____ _____
Telephone Number Email Address

OWNERSHIP ADDENDUM

Complete if the owner is a Partnership or a Corporation. Attach additional pages if necessary.

The owner is a: **N/A** ☐

☐ **Partnership - List each general partner who is an individual.**

Print Name: _____
Social Security Number: _____/_____/_____

Print Name: _____
Social Security Number: _____/_____/_____

Print Name: _____
Social Security Number: _____/_____/_____

Print Name: _____
Social Security Number: _____/_____/_____

Print Name: _____
Social Security Number: _____/_____/_____

☐ **Corporation - List any individual who has an ownership interest of 25% or more in the corporation.**

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

MEMORANDUM OF TRANSFER (sample)

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SECTION A (To Be Filled Out At Transferring Hospital)

1. Name of Transferring Hospital:
   _____
   Address: _____
   _____
   Phone Number: (_____) _____

2. Patient Information (If Known)
   Patient's full name: _____
   Address: _____
   _____
   Phone Number: (_____) _____
   Sex: _____ M _____F Age: _____
   National origin: _____Race: _____
   Religion: _____Physical Handicap:_____

3. Next of Kin:(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. Receiving physician secured by transferring physician:
   Date:___/____/_____ Time: _____
   Name of receiving physician:
   _____

7. Transferring physician's signature or signature of hospital staff acting under physician's orders: _____
   Name of transferring physician: _____
   Phone Number: (_____) _____
   Address: _____
   _____

8. Accepting hospital secured by transferring hospital:
   Date: _____/_____/_____ Time : _____
   Name of receiving hospital administration person:
   _____

9. Transferring hospital administration who contacted the receiving hospital:
   Signature:_____
   Title:_____ Time:_____

10. Type of vehicle and company used:
    _____
    Equipment needed: _____
    Personnel needed: _____

11. Facility transported to: _____
    City: _____

12. Diagnosis: _____
    _____

13. Attachments:
    X-Rays _____ MD Progress Notes _____
    Lab Reports _____ Nurses Progress Notes _____
    H & P _____ Medication Record _____
    Other _____

PHYSICIAN CERTIFICATION: based upon the information available at the time of the transfer the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks of the transfer to the patient and, in the case of labor, the unborn child.
Summary of Risks and Benefits
_____
_____
_____

_____
PHYSICIAN'S SIGNATURE

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*

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:_____/_____/_____

4. Receiving physician assumed responsibility for the patient:
   Date: _____/_____/_____ Time: _____
   Receiving Physician's 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.
   _____
   _____
   _____
   _____
   _____

DISTRIBUTION: Original to accompany patient to receiving hospital. Copy to be retained at transferring hospital.