SERVICE CODE: 529201034

TEXAS Health and Human Services

Crisis Stabilization Unit License Renewal Application

Name of CSU: _____

CSU License Number: _____ **Status:** ☐ Profit ☐ Non-Profit

Renewal Fee Submitted ☐ By Mail ☐ Online *(See Renewal Notice for Fee Amount)*

CSU within a hospital: ☐ Yes ☐ No

Type of Ownership:

☐ City
☐ Corporation
☐ County
☐ Hospital
☐ LTD
☐ State
☐ Other: _____

☐ Hospital District/Authority
☐ Limited Liability Company (LLC)
☐ Limited Liability Partnership (LLP)
☐ Limited Partnership (LP)
☐ Partnership
☐ Sole Owner/Proprietorship

1. 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)*

2. 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.

3. FEES: *(Fees paid to the Commission are not refundable)*

Total number of licensed beds: _____

Total fee due is $200.00 per bed + $20.00 (Texas.gov Subscription Fee) with a minimum total due of $6,020.00.

Amount paid: $_____

(The fee should include a Texas.gov subscription fee of $20 (authorized by Senate Bill 1152, 78th Regular Legislative Session 2003) which must be paid whether or not you renew online.

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4. FIRE SAFETY SURVEY:

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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5. MEDICARE CERTIFICATION

Is the CSU currently certified to participate in the Title XVIII Medicare Program?
☐ Yes ☐ No
If YES, please provide the facility's CCN Number: _____

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6. ACCREDITATION
(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

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7. EQUIPMENT AND FACILITIES:

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

☐ 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.

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. 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 E-mail Address

10. CSU ADMINISTRATOR:

_____ _____
Onsite Administrator in charge of day-to-day operations 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: _____/_____/_____