SERVICE CODE: 529201034
DEPT ID: ZZ101 FUND: 150

Psychiatric Hospital License Renewal Application

Name of Hospital: ______________________________

Hospital License Number: ____________________ **Status:** ☐ Profit ☐ Non-Profit

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

Hospital 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

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1. HOSPITAL SERVICES:

☐ **PRIVATE PSYCHIATRIC** - The term "private psychiatric" means an establishment offering inpatient services, including treatment facilities, and beds for use beyond 24 hours, for the primary purpose of providing psychiatric assessment and diagnostic services and psychiatric inpatient care and treatment for mental illness. Such services must be more intensive than room, board, personal services, and general medical and nursing care. Although substance abuse services may be offered, a majority of beds must be dedicated to the treatment of mental illness in adults and/or children. Services other than those of an inpatient nature are not licensed or regulated by the department and are considered only to the extent that they affect the stated resources for the inpatient components.

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 hospital location? ____________
Total bed design capacity of this hospital only.
A change in the bed design capacity requires prior approval and possible fees.

b. How many emergency treatment room beds are at this hospital 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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3. FEES: *Fees paid to the department are not refundable – Make checks payable to Health and Human Services Commission.*

Total number of licensed beds: _____________
Include all licensed beds at all locations under a common license.

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: $______________________

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4. FIRE SAFETY SURVEY:

Annual fire safety inspections are required for continued licensure status. Include a copy of a fire inspection report conducted within the last 12 months & a second report conducted within the last 13 to 24 months indicating approval by the local fire authority. **The fire inspector must be certified by the Texas Commission of Fire Protection in order to conduct the inspection.**

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5. MEDICARE CERTIFICATION:

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

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6. ACCREDITATION:
(Check the appropriate category)
Attach a copy of the most recent hospital letter or certificate of accreditation.

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

7. 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

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8. EQUIPMENT AND FACILITIES:

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

☐ 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.

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9. HOSPITAL DATABASE WORKSHEET:

Complete the Hospital Database Worksheet for all hospital locations. You can access the worksheet at the following address:
http://www.dshs.texas.gov/facilities/hospitals/forms.aspx

10. 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

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11. HOSPITAL 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: __________/__________/___________