How to Become a Licensed Special Care Facility

Attached is an application packet for an Initial, Change of Ownership (CHOW), or Relocation License for a Special Care Facility. The application, fees, and other documents shall be submitted as required by 25 Texas Administrative Code, Chapter 125, Special Care Facility Licensing Rules, §125.12 Application and Issuance of Initial 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 $70.00 per bed shall be submitted. The total fee shall not be less than $600.00 or more than $5,000.00. **License fees are not refundable.**
- A completed 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 shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated office to schedule the presurvey conference (http://www.dshs.texas.gov/facilities/compliance-zones.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 $70.00 per bed shall be submitted. The total fee shall not be less than $600.00 or more than $5,000.00. **License fees are not refundable.**
• A completed 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 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 $70.00 per bed shall be submitted. The total fee shall not be less than $600.00 or more than $5,000.00. **License fees are not refundable.**
• A copy of two completed 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 conducted within the last 12 months and a second report conducted within the last 13 to 24 months indicating approval by the local fire authority.
• The Administrator shall attend a presurvey conference at the Health Facility Compliance Zone Office designated by the department. Contact the designated zone office to schedule the presurvey conference or to request a waiver (http://www.dshs.texas.gov/facilities/compliance-zones.aspx).
• A Bill of Sale, lease agreement, or legal/court document of the Change of Ownership shall be submitted.

**Important Items to Note:**

• The D/B/A or Assumed name of the facility is the name that will appear on the license and should match advertisements and signage 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.

The Facility Licensing Group is dedicated to assist you through this process and is available to answer your questions. If you have any questions, 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

HIGHER LEVEL
OF OWNERSHIP

EIN #

(Add Boxes as Needed)

LEGAL NAME

EIN #

DOING BUSINESS AS (D/B/A)

or ASSUMED NAME
SPECIAL 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.

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Name of Facility: ____________________

SERVICE CODE: 529201028
BUDGET: ZZ101     FUND: 141

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 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: __________________________________________

3. LICENSED BEDS AND FEES:

Total number of beds ____________
* A change in the bed design capacity requires prior Department approval and possible fees.

Total fee due is $70.00 per bed. The fee shall be no less than $600.00 or more than $5,000.00.

Amount paid: $____________________________________
(Fees paid to the Department are not refundable)
4. FACILITY DESIGNATION:

SPECIAL CARE FACILITY (SCF) - The term "special care facility" means an institution or establishment that provides a continuum of nursing or medical care or services primarily to persons with acquired immune deficiency syndrome or other terminal illnesses. The term includes a special residential care facility.

A special care facility's designation as a residential AIDS hospice must be approved by the Texas Department of State Health Services. A license holder or person may not use the word "hospice" in a title or description of a facility, organization, program, service provider, or services, or use any other words, letters, abbreviations, or insignia indicating or implying the person holds a license to provide hospice services under the Health and Safety Code, Chapter 142, Home and Community Support Services License. Notwithstanding Chapter 142, a special care facility licensed and issued a designation as a residential AIDS hospice under the Health and Safety Code, Chapter 248, may use the term "residential AIDS hospice" or a similar term or language in its title or in a description or representation of the facility if the similar term or language clearly identifies the facility as a facility regulated under Chapter 248 and clearly distinguishes the facility from a hospice regulated under Chapter 142. A special care facility shall meet §125.6(f)(12) if the special care facility provides residential AIDS hospice services.

To receive designation as a residential AIDS hospice, please check the appropriate box in this section and submit the documents listed in (a) and (b) if necessary:

☐ Request designation as a residential AIDS Hospice

☐ No designation requested

(a) A written policy relating to the facility's organized program for the provision of residential AIDS hospice services, indicating palliative care and support, counseling, and bereavement services; and

(b) Documentation relating to the establishment and responsibilities of the facility's interdisciplinary team.

5. FIRE SAFETY SURVEY:

A completed Fire Safety Survey Report form shall be submitted. Annual fire safety inspections are required for continued licensure status. Please include a copy of a fire inspection report conducted within the last 12 months indicating approval by the local fire authority. For change of ownership applications, a copy of two completed Fire Safety Survey Report forms shall be submitted; one report dated within the last 12 months and a second report dated within the last 13 to 24 months.
6. OCCUPANCY CLASSIFICATIONS – for initial applicants only:
(Please select one below)

A new facility shall be classified into one of the following two occupancy classifications:

☐ Limited Care Facility (LCF) – A LCF provides medical and nursing care, treatment and other services to residents who require staff attendance and supervision, including staff assistance to evacuate the facility. These residents are not able to participate in fire drills because they are either physically unable to respond to the fire alarm or they are incapable of following directions under emergency conditions.

☐ Residential Board and Care Facility (RBCF) – A RBCF provides medical and nursing care, treatment and other services for residents who do not require routine or continuous staff attendance and supervision, and are physically and mentally able to evacuate the facility. These residents must be able to participate in fire drills, be able to transfer and evacuate themselves and be capable of following directions under emergency conditions. A RBCF is further classified as either small or large. A small RBCF provides sleeping accommodations for up to 16 residents. A large RBCF provides sleeping accommodations for more than 16 residents.

7. Administrator’s Signature & Attestation:

I attest that the owner is capable of meeting the requirements of 25 Texas Administrative Code, Chapter 125, Special Care Facilities 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.

Administrator’s Name (Print)  Title
Person responsible for day-to-day operations at the facility

Administrator’s Signature  Date Signed

Administrator’s Email Address  Administrator’s Telephone Number

8. Contact Person:

Name of the person completing this application  Title

Telephone Number  Email Address