DEPT. ID ZZ101/FUND 170

Texas Department of State Health Services
Regulatory Licensing Unit - Facility Licensing Group
Delivery Code 2835
PO Box 149347, MC 2003 **(512) 834-6646**
Austin, Texas 78714-9347 **(512) 834-4514 FAX**

Official Use Only

License #:

Remittance Number:

Remittance Date:

Remittance Amount:

Survey Date:

Application for a License to Operate an Abortion Facility

☐ Initial
☐ Change of Ownership – Effective Date: ____________________

1. Facility Information

a. Name the facility will be doing business as (d.b.a.):

____

b. Street Address: ____
Street Number

____
City/State/Zip County

c. Mailing Address: ____
(if different) Street or P.O. Box Number

____
City/State/Zip

d. Telephone Number (include area code) Fax Number (include area code)

( ) ______________________ ( ) ______________________

2. Owner:

a. Name & Address of Owner:

______________________ ______________________
Name SS# or Tax ID Number

______________________ ______________________
Date of Birth (Applies to Individual Owner Only) Drivers License # (Individual Owner Only) State

______________________ ______________________
Mailing Address City/State/Zip

b. Type of Ownership: ☐ Profit ☐ Non-Profit

☐ Individual ☐ Corporation * ☐ Partnership (Provide a list of limited and general partners)
☐ Limited Liability Company ☐ Hospital/Hospital District ☐ Other

** Attach a diagram of the corporation's organizational structure and a list of the name(s) and business address(es) of each director(s), officer(s), or partner(s) with 5% or more interest in the ownership.*

c. Has the Owner had or currently have any affiliation with another licensed abortion facility?
Yes ______ **No** ______
If the answer is yes, attach a separate sheet that includes the name and current or last address of the facility and the date such relationship commenced and if applicable the date it was terminated.

d. Does the Owner subcontract with any business(es) in which they hold any percentage of ownership?
Yes ______ **No** ______
If the answer is yes, attach a separate sheet that includes name, address, Tax ID#, relationship, and start date.

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3. Licensing Fee: ☐ Initial $5,000.00
☐ Change of Ownership $5,000.00

Fees paid to the Department are not refundable. Application will not be processed without the appropriate fee.

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4. Ownership and Control Interest Disclosure:

a. The owner named in item 2 (page 1), must disclose the following data concerning the applicant, the applicants affiliates, and the managers of the applicant. Check yes or no to the following questions. If yes is checked, you must provide details, including all ownership and facility information, circumstances, dates and final action, on a separate sheet with this application.

1. Denial, suspension, or revocation of an abortion facility license or any health agency, or enforcement action such as court, civil or criminal action, in any state? **Yes** ______ **No** ______
2. Denial, suspension or revocation of or other enforcement action against an abortion facility license or any health agency in any state, which is or was proposed by the licensing agency and the status of the proposal? **Yes** ______ **No** ______
3. Surrendered a license before expiration of the license or allowing a license to expire in lieu of the department proceeding with enforcement action? **Yes** ______ **No** ______
4. Federal or state (any state) criminal felony arrests or convictions? **Yes** ______ **No** ______
5. Federal or state Medicaid or Medicare sanctions or penalties relating to the operation of a health care facility? **Yes** ______ **No** ______
6. Operating a health care facility or agency that has been decertified with Medicare or Medicaid? **Yes** ______ **No** ______
7. Debarment, exclusion, or contract cancellation from Medicare or Medicaid in any state? **Yes** ______ **No** ______

b. The owner must disclose for the two-year period preceding the application date, the following date concerning the applicant, the applicants affiliates, and the managers of the applicant. Check yes or no to the following questions. If yes is checked, you must provide details, including ownership and facility information, circumstances, dates and final action, on a separate sheet with this application.

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

5. Personnel:

Submit names, addresses, license numbers and expiration dates of all licensed professionals who provide services at the abortion facility. *(Use a separate sheet if necessary.)*

Name	Address	License #	Expiration Date
Name	Address	License #	Expiration Date
Name	Address	License #	Expiration Date

6. Other – The following documents are required and must be attached in order to complete the application:

☐ Organizational structure of the staffing for the facility.
☐ Agreement to sale. *(Change of Ownership Only.)*

7. Administrator's Signature:

Administrator's Signature	Date
Printed Name	Administrator's Email Address
Official Title (e.g. CEO, Administrator, Owner)	Phone Number where Administrator can be reached when facility is closed

8. Notarization (Important – The notary date must match the date signed by the Administrator in #7)

Before me, the undersigned authority, on this day personally appeared, ________________________________, known to me to be the administrator of this facility, and acknowledged to me that all information contained in this application is true and correct. The administrator attests that the applicant is capable of meeting the requirements of §139.1-§139.46, and that all copies submitted (#6 of the application) with the application are original copies or copies of the original documents.

Given under my hand and seal of office, this ________ day of ___________________________ in the year of ________.

____
Signature of Notary Public

Notary Public in and for ___________________________________ County, Texas.
(Name of County)

MAIL LICENSE FEE AND COMPLETED, NOTARIZED APPLICATION WITH ATTACHMENTS TO:

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
REGULATORY LICENSING UNIT- FACILITY LICENSING GROUP
(DEPT ID ZZ101-FUND 170)
DELIVERY CODE 2835
P.O. BOX 149347, MC 2003
AUSTIN, TEXAS 78714-9347
PHONE 512-834-6646
FAX 512-834-4514

PRIVACY NOTIFICATION/NOTIFICACION SOBRE PRIVACIDAD

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023, 559.003, and 559.004)

Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la informacion que el Estado de Texas reune sobre usted. A usted se le debe conceder el derecho de recibir y revisar la informacion al requerirla. Usted tambien tiene el derecho de pedir que la agencia estatal corrija cualquier informacion que se ha determinado sea incorrecta. Dirijase a http://www.dshs.state.tx.us para mas informacion sobre la Notificacion sobre privacidad. (Referencia: *Government Code*, seccion 552.021, 522.023, 559.003 y 559.004)