DEPT. ID ZZ101/FUND 169

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**

Department Use Only

License #:

Remittance Number:

Remittance Date:

Remittance Amount:

Resurvey Date:

Application for a License to Operate a Birthing Center

☐ 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 birthing center?
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: ☐ $2,000.00 for Initial & Change of Ownership Application

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 a birthing center license or any health agency in any State, or documentation as a midwife; or any other enforcement action? **Yes _____ No _____**
2. Denial, suspension or revocation of or other enforcement action against a birthing center license, any health agency in any state, or documentation as a midwife 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 a birthing center/health care facility 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 who provide services at the birthing center. *(Use a separate sheet if necessary.)*

☐ Physician

Name	Address	License #	Expiration Date

☐ Certified Nurse-Midwife(wives)

Name	Address	License #	Expiration Date

☐ Licensed Midwife (Partera(s))

Name	Address	License #	Expiration Date

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

☐ A written plan for the orderly transfer of care of patients and clinical records in the event the facility is unable to maintain services under the license.
☐ 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 §137.1-§137.55, 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 169)
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)