DEPT. ID ZZ101/FUND 095

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:

Application for a License to Operate an End Stage Renal Disease Facility

☐ Initial
☐ Change of Ownership – Effective Date: _____
☐ Relocation (Treated as an Initial) – Date the facility will open: _____
Previous address: _____

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

_____ _____
Mailing Address City/State/Zip

_____
Name of Facility Administrator

Application revised 10/5/05

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

☐ Individual ☐ Corporation * ☐ Partnership (Provide a list of limited and general partners)
☐ Limited Liability Company ☐ Hospital/Hospital District ☐ State of Texas
☐ Local Government Type (e.g., city, county): _____ ☐ Other (Specify): _____

** 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 ESRD 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: (Fee not applicable if this facility is owned/operated by the State of Texas)

Initial/Relocation/Change of Ownership	**0-10 stations**	**=**	**$3,500.00**
	11-20 stations	**=**	**$4,300.00**
	21-30 stations	**=**	**$5,100.00**
	31-40 stations	**=**	**$5,900.00**
	41 or more stations	**=**	**$6,700.00**

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

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4. Fire Inspection Report
A facility must submit a copy of an approved fire safety inspection report from the local fire authority in whose jurisdiction the facility is based that is dated no earlier than 12 months prior to the date of the application (§117.12(a)(2)).

☐ Report Attached

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5. Dialysis Services:

a. Number of stations _____ *An increase requires prior written TDH approval (§117.11(e)(2))*

b. Patient Census and Services Provided (check all that apply, including census for each category)

Current Total Patient Census (#) _____

☐ Adult Only
☐ Pediatric and Adult
☐ Pediatric Only

c. Services (***All facilities, including those applying to provide only PD services, are required to meet all applicable licensing rules, including the water treatment system. No requests for exemption will be accepted or considered at this time.)***

☐ In-center Hemodialysis (# Patients) _____ ☐ In-center Peritoneal (# Patients) _____

☐ Home Hemodialysis (# Patients) _____ ☐ Home Peritoneal (# Patients) _____

d. Dialysis Delivery (check one): ☐ Single-station delivery system ☐ Multi-station delivery system ☐ None ☐ Bicarbonate ☐ Acetate

e. Reuse: ☐ Yes (check all that apply below) ☐ No

☐ Multi-Facility Centralized ☐ Manual ☐ Formalin ☐ Other germicide
☐ Single Facility On-site ☐ Automated ☐ Renalin (specify): _____

6. Ownership and Control Interest Disclosure:

a. 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 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 _____**

b. The owner must disclose the following data concerning the applicant, the applicant's affiliates, and the managers of the applicant. Check yes or no to each question. If yes is checked, provide details on a separate sheet, including all ownership and facility information, circumstances, dates and final action.

1. Denial, suspension, or revocation of end stage renal disease license or any health agency in any state or any other enforcement action? **Yes _____ No _____**
2. Denial, suspension or revocation or other enforcement action against a health care facility license 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 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_____**

7. Personnel:

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

a. Name of Medical Director: _____
Name License # Expiration Date

b. Is the Medical Director Board <u>certified</u> ☐ or Board <u>eligible</u> ☐ in nephrology/pediatric nephrology?

c. Physician(s) _____
Total Number: _____ Name License # Expiration Date

d. Physician Assistant(s) _____
Total Number: _____ Name License # Expiration Date

e. Advanced Practice Nurses _____
Total Number: _____ Name License # Expiration Date

8. Nursing Services:

a. Name of Supervising nurse (a.k.a. Director of Nurses): The supervising nurse is a registered nurse (RN) with at least 18 months experience as an RN with at least 12 months experience in dialysis obtained within the previous 24 months. An RN who holds a current certification from a nationally recognized board in nephrology nursing or hemodialysis may substitute the certification for the 12 months experience in dialysis obtained within the previous 24 months.

_____ _____

Name License # Expiration Date

Check one ☐ 12 months experience in dialysis ☐ 2 – 5 years experience in dialysis
☐ 12 months – 2 years experience in dialysis ☐ 5 or more years experience in dialysis

Check one if applicable ☐ Certified Nephrology Nurse ☐ Certified Hemodialysis Nurse

b. Registered nurses: Number of Full-Time Equivalents (# FTEs) _____
(please fill in all blanks) # FTEs qualified to function in the charge role (See §117.44(c)) _____

c. Licensed vocational nurses: Number of Full-Time Equivalents (#FTEs) _____
(please fill in all blanks) # FTEs qualified to function in the charge role (See §117.44(c)) _____

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9. Social Services:

Please provide the information below as it applies to your facility.

In accordance with §117.44(e), each social worker shall:
(A) be licensed as a social worker under the Human Resources Code, Chapter 50, and hold a masters degree in social work from a graduate school of social work accredited by the Council on Social Work Education (MSW); or
(B) have worked for at least 2 years as a social worker, one year of which was in a dialysis facility or transplantation program prior to September 1, 1976, and have established a consultative relationship with a social worker who has a masters degree in social work from a graduate school of social work accredited by the Council on Social Work Education.

Total Number Social Worker #FTEs: _____

a. Number contracted: #FTEs _____ *and/or* Number On-staff: #FTEs _____

b. Number of MSWs **(A)**: #FTEs _____ *and/or* Number "Grandfathered" **(B)**: #FTEs _____

c. Are BSWs used to provide discrete services? ☐ Yes - #FTEs _____ ☐ No

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10. Dietitians Services:

Please provide the information below as it applies to your facility.

a. Number on staff: #FTEs _____ *and/or* Number contracted: #FTEs _____

b. Of the number above, how many are Registered by the Commission on Dietetic Registration of the American Dietetics Association (CDR/ADA): #FTEs _____

c. If (b) above is 0, how many are eligible for registration by the CDR/ADA: #FTEs _____

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11. Dialysis Technicians:

Please provide the information below as it applies to your facility.

A dialysis technician is defined in §117.2 as an individual who is not a registered nurse or physician and who provides dialysis care under the direct supervision of a registered nurse or physician. If unlicensed, this individual may also be known as a patient care technician (PCT).

PCTs: #FTEs _____ Mechanical/Reuse Techs: #FTEs _____

PCT Trainees: #FTEs _____ Mechanical/Reuse Tech. Trainees: #FTEs _____

Check the appropriate box and submit a notarized statement for one of the following:

☐ I have attached a notarized statement that each dialysis technician on staff in the facility has completed the training and competency evaluation programs described in §117.62 and 117.63.

☐ I have attached a notarized statement that this facility will not/does not use dialysis technicians as defined in §117.2 to provide patient care.

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

☐ A list of management and supervisory personnel.
☐ 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.)*

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13. Administrator's Signature:

_____ _____
Administrator's Signature Date

_____ _____
Printed Name Administrator's Email Address

_____
Official Title (e.g. CEO, Administrator, Owner)

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14. Notarization (Important – The notary date must match the date signed by the Administrator in #13)

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 §117.1-§117.86, and that all copies submitted (#12 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)

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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 095)
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)