TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
P.O. Box 149347• Austin, Texas 78714-9347
1-888-963-7111 • http://www.dshs.state.tx.us

How to Become a Licensed Psychiatric Hospital or CSU

Attached is an application packet for an Initial Hospital License or Change of Ownership (CHOW) License for a General, Special, or Private Psychiatric Hospital & Crisis Stabilization Unit. The packet contains a license application form and other informational materials. The application, fees and other documents must be submitted as required by 25 Texas Administrative Code, Chapter 133 Hospital Licensing Rules, §133.22 Application and Issuance of an Initial License or, Chapter 134 Private Psychiatric Hospitals & Crisis Stabilization Units, §134.22 Application and Issuance of an Initial License. Information regarding licensure for health care facilities, including contact information for the zone office for your location is located on the department's web site: www.dshs.state.tx.us/hfp

The following documents, fees, and actions must be completed, received, and approved before a license will be issued:

- Applicant shall not submit documents to the department earlier than 60 calendar days prior to the projected opening date of the facility.
- An accurate and complete application form.
- If the applicant is a sole proprietor, partnership with individuals as a partner, or a corporation in which an individual has an ownership interest of at least 25% of the business entity, the names and social security numbers of the individuals.
- A multiple hospital location application form for multiple hospitals to be licensed under a single license number, if applicable.
- Fees. All initial hospital licenses are for a two-year licensing period and fees are nonrefundable. Please submit, $39.00 per bed for General and Special hospitals, or $200.00 per bed (with a $6000 minimum) for Private Psychiatric hospitals and Crisis Stabilization Units.
- Verification of accreditation by the Joint Commission on accreditation of Healthcare Organizations (JCAHO); or accreditation by the American Osteopathic Association (AOA) and/or; Medicare Provider Number.
- A copy of the hospital's Patient Transfer Policy that is in accordance with §133.44 Hospital Patient Transfer Policy or §134.43 Patient Transfer Policy, and signed by the chairman & secretary of the governing body. Please submit to Julie.long@dshs.state.tx.us or fax to 512/834-4514 for approval.
- A copy of the hospital's Memorandum Of Transfer form that is in accordance with §133.44(b)(11)(B) or §134.43(d)(10)(B). Please submit to Julie.long@dshs.state.tx.us or fax to 512/834-4514 for approval.
- Patient Transfer Agreements. If the application is for a Special Hospital license, a copy of a written agreement the Special Hospital has entered into with a General Hospital which provides for the prompt transfer to and the admission by the General Hospital of any patient when special services are needed but are unavailable at the Special Hospital. For General Hospitals, provide copies of any patient transfer agreements voluntarily entered into between the hospital and another hospital in accordance with §133.61. Patient transfer agreements for Private Psychiatric Hospitals & Crisis Stabilization Units are not required to be submitted to the department for approval.
  Please submit to Julie.long@dshs.state.tx.us or fax to 512/834-4514 for approval.
- For existing facilities, a copy of a fire safety survey report indicating approval by the local fire authority in whose jurisdiction the facility is based that is dated no earlier than one year prior to the opening date. For new construction, additions, and renovation projects, written approval by the local building department and local fire authority shall be submitted at the time of the final construction survey by the department. Submit a fire safety survey report for each location when submitting multiple location applications.
- For Private Psychiatric Hospitals, in accordance with §134.22(a)(5), submit documentation of accreditation if the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- The applicant or the applicant's representative shall attend a presurvey conference at the office designated by the department. The designated survey office may waive the presurvey conference requirement. Please contact the applicable Zone office (www.dshs.state.tx.us/hfp/pdf/zonelist.pdf) to schedule the pre-survey conference.
- Change of Ownership. In addition to the documents required in §133.22 for General and Special Hospitals and §134.22 for Private Psychiatric Hospitals & Crisis Stabilization Units, the applicant shall include evidence of the effective date of the change of ownership.
- Architectural Projects. Approval for occupancy must be obtained from the Texas Department of State Health Services, Architectural Review Group for hospitals with architectural projects (phone 512/834-6649, fax 512/834-6620, or web www.dshs.state.tx.us/hfp/arch_review.shtm). Additional documentation for new hospitals or conversions from nonhospital buildings must be completed prior to the issuance of a hospital license to newly constructed hospitals or hospitals from conversions of nonhospital buildings.

Medicare Provider Certification information may be obtained from the zone office for your location (www.dshs.state.tx.us/hfp). The Social Security Act directs the Secretary of the Department of Health and Human Services to use the help of State health agencies or other appropriate agencies to determine if health care entities meet Federal standards. This task is one of the Department of State Health Services' responsibilities. For information on gaining provider certification contact department Zone Office staff. Using your city, find the associated zone number on the list at: www.dshs.state.tx.us/hfp/pdf/zonelist.pdf . Then find the associated zone office contact information at: www.dshs.state.tx.us/hfc/pdf/address.pdf .

CLIA information is located on the department's web site: www.dshs.state.tx.us/hfp. For more information, contact the zone office for your location.

The hospital licensing staff is dedicated to assist you through this process and is available to answer your questions. If you have any questions, please contact the Hospital Licensing Section: phone 512/834-6648, fax 512/834-4514, or email vyki.robbins@dshs.state.tx.us.

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Remittance list date:
Remittance #:
Remittance Amount:

Budget ZZ101
Fund 150

Office Use Only

License Effective _____ License Expires _____
License Number_____ Serial Number _____
Date Checked _____ Initials _____

APPLICATION FOR A STATE LICENSE TO OPERATE A PRIVATE PSYCHIATRIC HOSPITAL OR A CRISIS STABILIZATION UNIT

_____ Change of Ownership _____ Initial License
_____ Effective Change Date

1. **NAME OF HOSPITAL**:_____

   STREET ADDRESS: _____
   Street City Zip Code County

   MAILING ADDRESS:_____
   (If different) Street City Zip Code County

2. **TELEPHONE:**_____ **FAX:**_____

3. **APPLICANT:** _____
   (Name of entity legally responsible for the operation of the hospital, whether by lease or ownership)

   OWNER/OPERATOR ADDRESS:_____

4. **TYPE OF OWNERSHIP**: **Check one:**

____ Individual	____ County	____ Limited Liability Company
____ Corporation	____ City	____ Hospital District
____ Partnership	____ City-County	____ Hospital Authority
____ General	____ Limited	____Other _____ (specify)

Check one: Profit ____ Non-Profit____

NAME of HOSPITAL: _____

License Number: _____

5. TYPE OF HOSPITAL: PLEASE CHECK THE SERVICES OFFERED

PRIVATE PSYCHIATRIC - The term "private psychiatric hospital" 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.

____ Psychiatric ____ Chemical Dependency

6. **TOTAL NUMBER OF BEDS**: ____ (Design bed capacity) DO NOT CHANGE NUMBER OF BEDS. Please list the number of beds in each category of service. **A change in the design bed capacity requires Department approval. DO NOT CHANGE THE NUMBER OF BEDS THAT HAVE BEEN PRE-PRINTED ON THE APPLICATION.**

____ Psychiatric ____ Chemical Dependency

7. LICENSING FEE: _____ [All fees paid to the Texas Department of State Health Services are nonrefundable. he license fee is 200.00 per bed (per «BILLCYCLE» 24 months). The minimum fee is six thousand dollars (per 2 year Bill Cycle 24 months). **The fee shown includes a Texas Online subscription fee of $20 (authorized by Senate Bill 1152, 78th Regular Session, 2003), which must be paid whether or not you renew online unless this is an Initial or Change of Ownership (CHOW application).**

MAIL LICENSE FEE AND COMPLETED APPLICATION TO:

ZZ101 - 150
TEXAS DEPARTMENT OF STATE HEALTH SERVICES
P.O. BOX 149347, MC 2003
AUSTIN, TEXAS 78714-9347

8. ACCREDITATION/CERTIFICATION STATUS: (Please check the category or categories that apply.)

___ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
ATTACH A COPY OF THE MOST RECENT ACCREDITATION LETTER showing the 3 year effective date from the Month/Day/Tear. (DO NOT SUBMIT THE CERTIFICATE).

___ Medicare certified. (Certified to participate in the Title XVIII Medicare Program). Medicare provider number: _____

___ Not accredited or certified.

9. MEDICAL AND PROFESSIONAL STAFF: (Required by Health and Safety Code, Chapter 577.004.)

Please complete the information requested below (ATTACH ADDITIONAL PAGES, IF NECESSARY):

(a) The name and address of the physician(s) in charge of the hospital care and treatment of the patients admitted to the private psychiatric hospital:

_____
Printed Name of Physician and Title

_____
Address City State Zip Code

NAME of HOSPITAL: _____

9. MEDICAL AND PROFESSIONAL STAFF (continued): Required by Health and Safety Code, Chapter 577.004.

(b) The profession and number of the professional staff (i.e., Ph.D., RN, LVN, etc.) excluding M.D.'s:

Profession	Number	Profession	Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(c) Description of the Equipment and Facilities of the Psychiatric Hospital. _____

_____

_____

(d) Plan of the psychiatric hospital premises. Describe the buildings (by name) and grounds and the various parts of the premises intended use: _____

_____

_____

Please submit a campus map indicating the different buildings, the name of the buildings, the licenses held by each building, the number of beds in each building, etc.

10. ADMINISTRATOR'S SIGNATURE:

I hereby affirm and declare that all information submitted on this form is true and correct. I understand that false statements or information on this application may be considered as sufficient cause for denial of the license.

_____ _____

Administrator's Signature Date Signed

_____

Printed Name of Administrator and Official Title

11. CONTACT PERSON:

Name of the person who completed this application _____ Phone number _(____)_____

Title of the person who completed this application _____

E-Mail Address_____

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Regulatory Licensing Unit
Facility Licensing Group
ADDENDUM TO HOSPITAL LICENSING APPLICATION

NAME of HOSPITAL: _____

LICENSE NUMBER: _____

Check only ONE box, fill in the required information, and attach additional pages if necessary*:*

The applicant is a:

☐ **Sole proprietor -**

Print Name: _____

Social Security Number: _____/_____/_____

☐ **Partnership - List each general partner who is an individual.**

Print Name: _____

Social Security Number: _____/_____/_____

Print Name: _____

Social Security Number: _____/_____/_____

☐ **Corporation - List any individual who has an ownership interest of 25 percent or more in the corporation that is the applicant or any part of an application.**

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

Print Name: _____ Percent Ownership _____%

Social Security Number: _____/_____/_____

☐ **Hospital District/Authority**

Print Name: _____

Social security numbers will be kept confidential under Government Code Section 552.147.

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Regulatory Licensing Unit/Facility Licensing Group
1100 West 49th Street
Austin, Texas 78756

Fire Safety Survey Report for Hospitals and Crisis Stabilization Units

A completed Fire Safety Survey Report form must be submitted with an Initial or Change of Ownership License Application for a hospital or CSU. Annual fire safety inspections are required for continued licensure status. Two annual Fire Safety Survey Report forms must be submitted with Renewal License Applications (one report for each year).

Name of Hospital:
License No.: Physical Address:
Type of Building Construction_____ No. of Stories_____ Date of Inspection_____

EXITS

	Yes	No
1. Are exits and egress corridors and exits unobstructed?		
2. Is car parking at least 10 feet from exit door?		
3. Are exit signs operative and on emergency generator?		
4. Do exit doors swing outward and equipped with panic hardware?		

HEATING EQUIPMENT

	Yes	No
1. Are doors to furnace room equipped with automatic closers and are they kept closed?		
2. Are flues, pipes and steam lines--In good condition and properly insulated?		
3. Date of last boiler inspection: From _____ To_____		
4. Is there a gas cut-off outside the building?		

KITCHENS

	Yes	No
1. Is there a steel range hood over cooking equipment?		
2. Are the hood and listed filters clean?		
3. Is hood properly insulated and vented to open air?		
4. Is cooking equipment protected with a fire extinguisher?		
(a) Does discharge of automatic extinguisher sound the fire alarm signal or at least ring a local alarm?		
(b) Do nozzles cover all cooking surfaces?		
(c) Are gas or electricity automatically cut off?		
(d) Does automatic extinguisher have remote manual pull near egress?		
(e) Date of last automatic extinguisher inspection _____.		
(f) Lights in hood have protective covers?		
5. Are doors to refrigeration machinery room kept closed?		
(a) Are motors and cooling coils clean?		
(b) Is room properly ventilated?		
(c) Are pressure relief valves and vents operative?		

LAUNDRY

	Yes	No
1. Are laundry doors to main building kept closed?		
2. Is tumbler free from lint and dust?		
3. Do electric devices and irons have operative automatic heat controls?		
4. Do safety pilot lights operate?		

LABORATORY

	Yes	No
1. Are flammable liquids stored properly?		
2. Are acids stored and handled properly?		
3. Are connections of Gas fired or open flame equipment in good condition?		
4. Are type and number of fire extinguishers proper for this area?		

OXYGEN & NITROUS OXIDE STORAGE

	Yes	No
1. Are Oxygen, Nitrous Oxide cylinders stored separately from other gases?		
(a) Are storerooms ventilated?		
(b) Are storerooms constructed as hazardous areas?		
(c) Are No Smoking signs and Nitrous Oxide warnings posted on storeroom doors?		
(d) Are cylinders stored to prevent tipping?		
(e) Are cylinders protected from the sun?		
(f) Are cylinders removed from steam pipes or radiators to prevent contact?		
(g) Is storage room equipped with automatic closed door and door kept closed?		
(h) Is light switch outside storage room 5 feet above floor, if in room?		
2. In operating and delivery rooms-- (a) Are explosive anesthetics used such as:Cyclopropane,Ethylene or Ether?		
(b) If above answer is yes, is conductive floor and other conductive equipment tested monthly?		
(c) Is a conductive shoe tester used in operating and delivery room areas?		

GENERATORS

Generator 1. Is it in good operating condition?	Yes	No
2. Is it automatic starting?		
3. Is generator tested underload monthly?		

WATER HEATERS

	Yes	No
1. Are water heaters properly vented?		
2. Are water heaters equipped with 100% safety pilots?		
3. Are water heaters equipped with pressure relief valves?		

INCINERATORS

	Yes	No
1. Is there an approved incinerator?		
2. Does incinerator appear in good repair?		

GENERAL

1. Check following locations where accumulations of waste paper, rubbish, old furniture, etc., are, and explain under "Remarks": attic, basement, furnace or boiler room, laundry, kitchen, sewing room, pharmacy, laboratory, maintenance shop, other locations.	Yes	No
2. Corridors free from storage of beds, linen carts, etc?		
3. Is space beneath stairs and elevator and dumbwaiter shafts free from storage of any materials?		
4. Are elevator, dumbwaiter, laundry and trash chute shafts made of fire resistant material?		
(a) Does each opening have a labeled frame with 1 1/2 B label fire door?		
(b) Are trash and laundry chutes sprinklered?		
5. Are covers on breaker panels and face plates in good condition?		
6. Are appliance cords in good condition?		
(a) Are appliance cords located as not to be subject to mechanical injury?		
(b) Is all permanent wiring in conduit?		
7. Are approved metal containers used for all oily waste, polishing or cleaning materials?		
8. Are ether and acetone kept in approved metal cans?		
9. Are all other combustible liquids kept in approved metal cans?		
10. Is refuse removed from premises or burned daily?		
11. Are grounds free from trash and weeds?		

If Code Violations are noted, has a Re-inspection been scheduled? YES ____ NO ___

PROTECTION

	Yes	No
1. Are all building sections of combustible and/or non-fireproof construction provided with automatic sprinklers?		
2. Where sprinklers are installed: (a) Are heads unobstructed?		
(b) Nothing is stored within 18" of heads (measured vertically)?		
(c) Sprinkler valves open?		
(d) Date of last fire sprinkler inspection _____.		
(e) Are water flow indicating devices connected to fire alarm system and alarm bell?		
3. All employees know location of fire extinguishers and know how to use them?		
4. Date of last fire drill you attended _____.		
5. Are fire alarm devices on each floor in each section of building operative?		
6. Are signs giving location of pull stations properly maintained?		
7. Are pull stations unobstructed and plainly marked?		
8. Date system last fire alarm tested _____.		
9. Plan for evacuation of patients?		
10.Interior fire hose in good condition?		
11.Are waste containers in designated smoking areas, metal or listed approved materials?		
12.Are privacy curtains and drapes fire-retardant?		
13.(a) Does all the carpeting in corridors and exits pass the flame-spread test		
(b) or the radiant panel test?		
14. Are portable heaters used?		

THIS FACILITY MEETS LOCAL FIRE AND BUILDING CODES FOR A HEALTH CARE FACILITY

YES ____ NO ____

_____ _____

Signature of Local Fire Authority **Date**

Printed Name of Local Fire Authority

_____

Badge/License #

Local fire authority phone number (____)_____

COMMENTS:

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Regulatory Licensing Unit
Facility Licensing Group

Name of Main Hospital: _____ **Budget: ZZ101**

Medicare Provider Number: _____ ___ **General/Special Hospital Fund: 152**

Hospital License Number: _____ ___ **Private Psychiatric Hospital Fund: 150**

Multiple Hospital Location Application
For Hospitals Licensed Under A Single License Number

1. Place a check beside the hospital license type: ___General Hospital ___Special Hospital ___Private Psychiatric Hospital

2. Name of Multiple Location Hospital : _____
(Separate Hospital Building Sharing a Common License Number)

3. Physical Address: _____
Street City Zip Code County

4. Main Telephone Number: _____ FAX: _____

5. Applicant (Owner/Operator): _____
(Name of entity legally responsible for the operation of the hospital, whether by lease or ownership)

6. Total number of licensed beds at this location (Design bed capacity of this building only): _____

7. Enter the number of beds in each bed category:

___ Medical/Surgical (May include Pediatric if Pediatric bed count is less than 15 beds)

___ ICU/CCU ___ Intermediate Care ___ Universal Care

___ Neonatal ICU ___ Continuing Care Nursery ___ Antepartum

___ Labor/Delivery/Recovery/Postpartum ___ Post Partum ___ Adolescent

___ Pediatric (if 15 or more beds) ___ Skilled Nursing ___ Comprehensive Medical Rehabilitation

___ Psychiatric ___ Mental Health and Chemical Dependency

(Please contact Facility Licensing Group 512-834-6648, if the pre-printed number on the application differs from the number of design bed capacity patient beds in use. A change in the design bed capacity requires Department approval.)

Name of Main Hospital: _____

Medicare Provider Number: _____ **Hospital License Number:** _____

8. Check the services provided at this multiple location site.

___ Surgery ___ Diagnostic X-Ray ___ Emergency Services
___ Obstetrics (Minimum of an emergency treatment room)

9. There are multiple buildings under this license number and the requirements for the definition of a "Premises" as described by 25 Texas Administrative Code, Chapter 133.2 (50) or Chapter 134.2 (42), have been met.

_____
Chief Executive Officer Signature This must be the CEO over all the facilities licensed under the main hospital license.

_____ _____
Printed Name of Chief Executive Officer and Official Title Date

10. _____ _____
Printed Name of Contact Person & Title Telephone Number of Contact Person

_____
E-Mail Address of Contact Person

****

In addition to the above, the following information is required for an INITIAL Multiple Hospital Location Application for a separate building:

11. If this facility is not currently licensed as a hospital, an architectural project is required. The project must be approved for licensure and occupancy by the Architectural Review Group. Any licensed bed increase fees must be submitted to Facility Licensing Group with this original Multiple Hospital Location Application form.
12. If accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO), an extension letter from the JCAHO stating that the separate building has been included in the accreditation of the common license.

MAIL TO:

Facility Licensing Group/ Mail Code 2835
TEXAS DEPARTMENT OF STATE HEALTH SERVICES
P.O. BOX 149347, MC 2003
AUSTIN, TEXAS 78714-9347

Make checks payable to DSHS.

Please reference ZZ101-152 for general or special hospital application payment.

Please reference ZZ101-150 for psychiatric hospital application payment.

MEMORANDUM OF TRANSFER (sample)

****

SECTION A (To Be Filled Out At Transferring Hospital)

1. Name of Transferring Hospital**:**
   _____
   Address**:** _____
   _____
   Phone Number: (_____) _____

2. Patient Information (If Known)
   Patient's full name: _____
   Address**:** _____
   _____
   Phone Number: (_____) _____
   Sex: _____ M _____F Age: _____
   National origin: _____Race: _____
   Religion: _____
   Physical Handicap**:**_____

3. Next of Kin:(If Known) _____
   Address**:** _____
   _____
   Phone Number: (_____) _____
   Next of Kin notified? (___) Yes (___) No

4. Date of Arrival: ___/___/_____ Time: _____

5. Initial contact with receiving hospital administration:
   Date: __/___/_____ Time:_____
   Name of contact person at receiving hospital**:**
   _____

6. Receiving physician secured by transferring physician:
   Date:___/____/_____ Time**:** _____
   Name of receiving physician**:**
   _____

7. Transferring physician's signature or signature of hospital staff acting under physician's orders: _____
   Name of transferring physician: _____
   Phone Number: (_____) _____
   Address: _____
   _____

8. Accepting hospital secured by transferring hospital:
   Date: _____/_____/_____ Time : _____
   Name of receiving hospital administration person:
   _____

9. Transferring hospital administration who contacted the receiving hospital:
   Signature:_____
   Title:_____ Time:_____

10. Type of vehicle and company used:
    _____
    Equipment needed: _____
    Personnel needed: _____

11. Facility transported to: _____
    City _____

12. Diagnosis: _____
    _____

13. Attachments:
    X-Rays _____ MD Progress Notes _____
    Lab Reports _____ Nurses Progress Notes _____
    H & P _____ Medication Record _____
    Other _____
    _____

PHYSICIAN CERTIFICATION: based upon the information available at the time of the transfer the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks of the transfer to the patient and, in the case of labor, the unborn child.

Summary of Risks and Benefits: _____
_____
_____

_____

PHYSICIAN'S SIGNATURE

SECTION B (To Be Filled Out At Receiving Hospital)

1. Name of Receiving Hospital:_____
_____

Address:_____
_____

Phone Number: (_____)_____

2. Date of Arrival: ___/____/_____ Time:_____

3. Receiving Hospital Administration Signature:

_____

Title:_____ **Date:**_____/_____/_____

4. Receiving physician assumed responsibility for the patient:

Date: _____/_____/_____ Time: _____
Receiving Physician's signature:
_____
Name: _____
Address: _____
_____
Phone Number: (_____) _____

5. If response to the transfer request was delayed beyond thirty (30) minutes, document the reason(s) for the delay, including any agreed time extensions. Use additional sheet, if necessary.
_____
_____
_____
_____
_____

DISTRIBUTION: Original to accompany patient to receiving hospital. Copy to be retained at transferring hospital.