TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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

DAVID L. LAKEY, M.D.
COMMISSIONER

How to Become a Licensed General or Special Hospital

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.

(Revised October 31, 2006)

Texas Department of State Health Services

DAVID L. LAKEY, M.D.
COMMISSIONER

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1-888-963-7111 • http://www.dshs.state.tx.us

Remittance list date:
Remittance #:
Remittance Amount:

Budget: ZZ101
Fund: 152

Office Use Only

License Effective _____ License Expires _____
License Number _____ Serial Number _____
Date Checked _____ Initials_____

APPLICATION FOR A STATE LICENSE TO OPERATE A HOSPITAL

_____ Change of Ownership _____ Initial License
_____ Effective Change Date

1. **NAME OF HOSPITAL** _____

STREET ADDRESS _____
Street City Zip Code County

MAILING ADDRESS _____
Street City Zip Code County

2. **TELEPHONE:** _(____)_____ **FAX:** _(_____)_____

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

OWNER/OPERATOR ADDRESS _____
Street City Zip Code

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

____ Individual ____ County ____ Limited Liability Company
____ Corporation ____ City ____ Hospital District
____ Partnership ____ City-County ____ Hospital Authority
____ General ____ Limited ____ Other: _____
(check one (specify)

Check one: Profit ____ Non-Profit ____

NAME of HOSPITAL: _____
License Number: _____

5. **TYPE OF HOSPITAL**: (Please check either GENERAL or SPECIAL)

____ **GENERAL** - The term "general hospital" means any establishment offering services, facilities, and beds for use beyond twenty-four (24) hours for two (2) or more non-related individuals requiring diagnosis, treatment or care for illness, injury, deformity, abnormality, or pregnancy, and regularly maintaining at least clinical laboratory services, diagnostic x-ray services, treatment facilities which would include surgery and/or obstetrical care, and other definitive medical or surgical treatment of similar extent. PLEASE CHECK THE SERVICES OFFERED:

____ Surgery ____ Obstetrics ____ Emergency Services ____Pediatric Services (if 15 or more beds)
____ Comprehensive Medical Rehabilitation Services ____ Mental Health Services in an identifiable part of the hospital
____ Chemical Dependency in an identifiable part of the hospital ____ ESRD - Acute Services

____ **SPECIAL** - The term "special hospital" means any establishment offering services, facilities and beds for use beyond twenty-four (24) hours for two (2) or more non-related individuals who are regularly admitted, treated and discharged and require services more intensive than room, board, personal services and general nursing care and which has clinical laboratory facilities, diagnostic x-ray facilities, treatment facilities and/or other definitive medical treatment.

PLEASE CHECK THE SERVICES OFFERED:

____ Medical Only ____ Comprehensive Medical Rehabilitation Services ____ Emergency Services
____ Mental Health Services in an identifiable part of the hospital (Minimum of an emergency treatment room)
____ Chemical Dependency in an identifiable part of the hospital
____ Pediatric Services (only if 15 or more beds)

_____ **NICHE -** (not a license category) – The term "Niche Hospital " means that, (A) two-thirds of the hospital's Medicare patients or all patients are classified in no more than two major diagnosis related groups (DRG) or surgical diagnosis-related groups; **OR** (B) specializes in one or more of the following areas: cardiac, orthopedics, surgery, or women's health and is not a public hospital, one with the majority of inpatients are for DRG related to rehabilitation, psychiatry, alcohol and drug treatment or children or newborns, or has fewer than 10 claims per bed per year.

6. **NUMBER OF EMERGENCY TREATMENT ROOM BEDS AT THIS LOCATION**: _____ This count is not included in the licensed bed count and will not affect fees.

7. **NUMBER OF LICENSED BEDS AT THIS LOCATION**: ___ (Design bed capacity of this facility only).
A change in the design bed capacity requires Department approval. If the application is not pre-printed, please mark the number of beds in each category of service offered. **Do not change the number of beds, which may have been pre-printed on the application.**

___ 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	

*********Submit a Multiple Location Addendum Application form for each building under the common license.*********

8. **TOTAL NUMBER OF LICENSED BEDS: ____ Include all the designed capacity beds at all locations under a common license.**

9. **LICENSING FEE**: (All fees paid to the Department are nonrefundable). Please pay $39.00 per bed. License is for a 2 year period. The fee shown includes a Texas Online subscription fee of $20 (authorized by Senate Bill 1152, 78th Regular Legislative Session 2003) which must be paid whether or not you renew online, unless this is an initial or change of ownership (CHOW) application.

GENERAL OR SPECIAL HOSPITAL: $ _____

MAIL LICENSE FEE AND COMPLETED APPLICATION TO:
ZZ101 – 152
Facility Licensing Group/ MC 2835
TEXAS DEPARTMENT OF STATE HEALTH SERVICES
P.O. BOX 149347, MC 2003
AUSTIN, TEXAS 78714-9347

Make check payable to DSHS. Please reference ZZ101-152 on your check.

10. **TRANSFER POLICY, MEMORANDUM OF TRANSFER, AND AGREEMENTS**: **SUBMITTED ONLY FOR INITIAL (NEW) HOSPITALS OR CHANGE OF OWNERSHIP APPLICATIONS FOR GENERAL AND SPECIAL HOSPITALS LICENSED UNDER HEALTH AND SAFETY CODE (HSC) CHAPTER 241.**
DO NOT submit policies or agreements with Renewal Applications.

(a) Attach a copy of the hospital's Memorandum of Transfer form and the Patient Transfer Policy developed in accordance with the rules governing hospital patient transfer policies and agreements which is signed by both the chairman and secretary of the hospital's governing body attesting to the date of adoption of the policy and the policy's effective date; and

(b) Attach copies of all patient transfer agreements between the hospital and another hospital **licensed under HSC Chapter 241** developed in accordance with the rules governing hospital patient transfer policies and agreements unless you have a written waiver granted by the hospital licensing director. If you have a written waiver signed by the hospital licensing director, please attach a list of hospitals with which the hospital has agreements and include the effective dates of the agreements. **Only submit agreements between hospitals that are licensed under HSC Chapter 241.**

11. **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/Year. (DO NOT SUBMIT THE CERTIFICATE)

____ Accredited by the American Osteopathic Association (AOA).
ATTACH A COPY OF THE MOST RECENT ACCREDITATION LETTER.

____ Certified to participate in the Title XVIII Medicare Program. Medicare Provider Number _____
____ Not accredited or certified.

12. **ADMINISTRATOR'S SIGNATURE:**

GENERAL OR SPECIAL HOSPITAL – CERTIFICATION OF MEDICAL STAFF AND INFORMATION PROVIDED ON THIS APPLICATION:

In compliance with the Health and Safety Code §241.022(c)(1) and the hospital licensing rules, this is to certify that the physicians on the medical staff of this hospital are currently licensed by the Texas State Board of Medical Examiners and are qualified legally, professionally and ethically for the positions to which they are appointed. I acknowledge that all information contained in this document is true and correct.

_____ _____
Chief Executive Officer or Administrator Signature Date Signed
(The CEO must sign if licensed for multiple locations.)

_____ _____
Printed Name of CEO or Administrator and Official Title E-Mail Address

13. **CONTACT PERSON:**

Name of the person completing this application _____ Phone: (____)_____

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 the appropriate 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.

ADDENDUM to the Ownership Disclosure

☐ **Niche Hospital - the names and license numbers of any physicians licensed by the Texas Medical Board who have any financial interest in the applicant or any entity which has an ownership interest in the applicant.**

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number: _____

Print Name: _____ Percent Ownership _____%

Texas Medical Board License Number**:** _____

An Equal Employment Opportunity Employer and Provider

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:

Texas Department of State Health Services

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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. **NUMBER OF EMERGENCY TREATMENT ROOM BEDS AT THIS LOCATION**: _____ This count is not included in the licensed bed count and will not affect fees.

7. **DO YOU CURRENTLY PROVIDE ACUTE DIALYSIS (ESRD) TO YOUR PATIENTS? Yes___ No___**
If yes, what patient populations are served: pediatric _____ adult _____.
If yes, how many hemodialysis stations do you provide? _____This count is not included in the licensed bed count and will not affect fees.

DO YOU PROVIDE PERITONEAL DIALYSIS? Yes___ No___

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

9. 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	

Name of Main Hospital: _____

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

10. Check the services provided at this multiple location site.
___ Surgery ___ Diagnostic X-Ray ___ Emergency Services
(Minimum of an emergency treatment room)
___ Obstetrics

___ **NICHE -** (not a license category) – The term "Niche Hospital " means that, (A) two-thirds of the hospital's Medicare patients or all patients are classified in no more than two major diagnosis related groups (DRG) or surgical diagnosis-related groups; **OR** (B) specializes in one or more of the following areas: cardiac, orthopedics, surgery, or women's health and is not a public hospital, one with the majority of inpatients are for DRG related to rehabilitation, psychiatry, alcohol and drug treatment or children or newborns, or has fewer than 10 claims per bed per year.

11. 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

12. _____ _____
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:

13. 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.
14. 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
PO 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.

(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.)

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: _____

    Facility transported to: _____
    City: _____

1 Diagnosis: _____
  _____

1 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.

Revised 1/26/2007