TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Special Care Facility License Application

1. **APPLICATION SUBMISSION**: No earlier than 60 days prior to the projected opening date of the facility, complete and return the Special Care Facility (SCF) license application, and non-refundable license fee. See application for mailing address and appropriate fee.

2. **ARCHITECTURAL REVIEW:** Submission of plans and specifications may be determined by the local regulating authority, instead of the Department, refer to §125.91. If required, complete and return the Application for Plan Review available: http://www.dshs.state.tx.us/hfp/arch_plan_review_app.pdf (17KB).

   Submit construction documents: Submit one complete set of construction documents/final plans and specifications to the department for review and approval. All construction documents/final plans and specifications shall be appropriately sealed and signed by a registered architect and professional engineers licensed by the State of Texas. See TAC 125, for complete requirements. Options for special submittals include:

   - **Self-certification** - Upon your request and at the discretion of the department, you may be allowed to submit a set of final construction documents and the Self-certification form attesting that plans and specifications are based upon and comply with the requirements of state licensing rules, thereby, expediting the department review process. Download the Self-certification form: http://www.dshs.state.tx.us/hfp/Arch_Self_Cert_pkt.pdf (54KB)
   - **Fast-track project** - Usually for new facilities or major new additions. At the discretion of the department, you may be allowed to submit the project documents in two or three separate packages, allowing the department to review each package as it is received. This process allows construction to begin as soon as the department issues approval for that package. Submittal of package must be in accordance with TAC 125. A fast-track project shall be requested in writing with a brief written description and narrative of the proposed project.
   - **Minor project** - A project in a building that holds a current SCF license issued by the department and meets the specifications listed in TAC 125. A minor project shall be requested in writing with a brief written description, narrative of the proposed project, and floor plans of the areas of work.

3. **CONSTRUCTION APPROVAL**: Construction shall not commence until the department has issued a letter granting approval to begin construction. The architect of record or the facility owner/operator shall provide written notification to the department when construction will commence.

4. **REQUESTING AN INSPECTION**: You must receive written notice from the Department of State Health Services (department) indicating approval of the construction document before you are allowed to request any inspection. The architect of record or the facility owner/operator shall request an inspection by submitting**, at least three weeks in advance of the requested inspection date**, an Application for Inspection and the construction inspection fee in accordance with TAC 125 for each intermediate inspection, final inspection, and reinspection requested. Inspection requests by contractors will not be honored. Download the Application for Inspection at: http://www.dshs.state.tx.us/hfp/Arch_Inspection_App.pdf (13KB)

5. **PRE-SURVEY CONFERENCE:** All applicants are required to attend a pre-survey conference to discuss the standards for the operation of an SCF. Upon review of a complete application and fee, you will be notified, by letter, how to schedule your pre-survey conference. Department staff associated with one of the Zone Offices is responsible for conducting the pre-survey conference and making a recommendation regarding the issuance of the initial license. Contact information for Zone Office staff is available at: http://www.dshs.state.tx.us/hfp/default.shtm#zonelist.

6. **Issuance of the initial license will be made upon completion of all items listed above. Patients cannot be admitted until the facility is issued a license.**

7. **SURVEY**: During the initial licensing period, department Zone Office staff will conduct an on-site survey of the SCF to ascertain compliance with the provisions on Health and Safety Code, Chapter 248 and TAC Chapter 125. Find information about the survey components at: http://www.dshs.state.tx.us/hfp/special.shtm

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TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Remittance list date:
Remittance #:
Remittance Amount:

EDUARDO J. SANCHEZ, M.D., M.P.H.
COMMISSIONER

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

Office Use Only

License Effective _______________ License Expires _______________
License Number _______________ Serial Number _______________
Date Checked __________________ Initials ______________________

Residential AIDS hospice designation: yes ☐ no Effective Date______________

SPECIAL CARE FACILITY REQUEST FOR LICENSURE

Change of ownership Initial License
__________ Effective Change Date

1. **Name of Special Care Facility** ____
(Please Print or Type)

Mailing Address ____
Street City Zip Code County

Street Address ____
(if different) Street City Zip Code County

2. **Telephone** ___________________ **Fax** ________________________

3. **Names and Title of Facility Director** ____
(Please Print or Type) Name Title

4. **Type of Ownership**: (check one). Individual Partnership Corporation
County City Other _________________________________

Check one: Profit ☐ Non Profit

5. **Ownership and Control Interest Disclosure**: List the name(s) of the entity legally responsible for the operation of the facility and all the owners of the facility. (Attach additional pages, if necessary.) If a corporation, please list the corporation name and include a list of the Board of Directors.

Name of the Entity(s)____

SPECIAL CARE FACILITY: ____

6. Number of Beds ________

7. Licensing Fee $___________

The license application and renewal fees are computed at $70.00 per facility bed, but in no event shall the total fee be less than $600.00 or more than $5,000. The license period is 2 years. An application will not be considered as officially submitted until the applicant pays the license fee. The fee must accompany the completed application form. FEES ARE NOT REFUNDABLE. Any remittance submitted to the department in payment of a required fee must be in the form of a certified check, money order, or personal check made payable to the Texas Department of State Health Services.

8. Residential AIDS Hospice Designation:

A special care facility's designation as a residential AIDS hospice must be approved by the Texas Department of State Health Services. A license holder or person may not use the word "hospice" in a title or description of a facility, organization, program, service provider, or services, or use any other words, letters, abbreviations, or insignia indicating or implying the person holds a license to provide hospice services under the Health and Safety Code, Chapter 142, Home and Community Support Services License. Notwithstanding Chapter 142, a special care facility licensed and issued a designation as a residential AIDS hospice under the Health and Safety Code, Chapter 248, may use the term "residential AIDS hospice" or a similar term or language in its title or in a description or representation of the facility if the similar term or language clearly identifies the facility as a facility regulated under Chapter 248 and clearly distinguishes the facility from a hospice regulated under Chapter 142. A special care facility shall meet 125.6(f)(12) if the special care facility provides residential AIDS hospice services. To receive designation as a residential AIDS hospice, please check the appropriate box in this section and submit the documents listed in (a) and (b) as follows.

Please designate as a residential AIDS Hospice   No designation requested

a) A written policy relating to the facility's organized program for the provision of residential AIDS hospice services, indicating palliative care and support, counseling, and bereavement services; and

b) Documentation relating to the establishment and responsibilities of the facility's interdisciplinary team.

Office use only

Residential AIDS hospice designation: _________ approved ____________ date _____ initials

SPECIAL CARE FACILITY ______________________________________

9. **Signature of Facility Director**____

Date Signed ____

10. **Notarization**:

STATE OF TEXAS
COUNTY OF ___________________________________

Before me, the undersigned authority, on this day personally appeared, ______________________________, known to me to be the person who is the **DIRECTOR** of this special care facility, and acknowledged to me that all information contained in this document is true and correct.

Given under my hand and seal of office, this ___________ day of ____________________ in the year of___________.

____
(Notary Signature)

Place Notary Seal Below

Notary Public in and for ________________________ County, Texas

Mail license fee and the completed and notarized application to:

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TEXAS DEPARTMENT OF STATE HEALTH SERVICES
PO BOX 149200- MAIL CODE 1980/DEPT.E32000
AUSTIN TX 78714-9200

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