

Hospital Initial Licensure APPLICATION

Hospital licenses expire 12/31 of each year

Section 1: TYPE of HOSPITAL

Type of HOSPITAL: Choose ONE.

- General Acute Hospital
- Critical Access Hospital
- Long Term Care Hospital
- Rehabilitation
- Psychiatric

Section 2: APPLICATION TYPE

1. Choose ONE:

- Initial License
- Change of Location
- Change of Ownership

Section 3: PROVIDER INFORMATION

1. The preferred name/position of person to receive official notices from the Department:

2. Facility DBA name (if applicable):

3. Legal name and physical address of facility:

4. Generic e-mail address for official notices from Department:

5. Administrator Name:

6. Facility phone number:

7 Facility fax number:

8. Date you would prefer
to begin services:

9. Number of INPATIENT
beds:

10. Is the facility planning on being accredited?

- Y
- N

If YES, which Accrediting Organization is the facility utilizing?

- Joint Commission (TJC)
- American Osteopathic Association/Healthcare Facilities Accreditation Program (HFAP)
- Institute for Medical Quality (IMQ)
- DNV GL (DNV GL)

Facility Name:

-----Section 4: OWNERSHIP INFORMATION-----

1. Please enter the legal name and mailing address of the **OWNER** of the facility below:

A) If a CORPORATION, LIMITED LIABILITY COMPANY or GOVERNMENTAL, enter the company name and mailing address:

B) If an INDIVIDUAL, enter the owner's personal name and mailing address:

2. What is the facility's ownership type?

Governmental Individual/Sole

Limited Liability Company

Proprietorship

Corporation

3. What is the facility's Federal Employer Identification Number:

4. Is the facility? Check **ONE**:

Non-profit

For-profit

5. If identified as a CORPORATION - List the names of the CORPORATE OFFICERS:

(As specified on the Secretary of State website - i.e, President, Vice President, Secretary, Treasurer):

6. If identified as a GOVERNMENTAL UNIT - List the name of the head of the Governmental unit having jurisdiction over the facility:

7. If identified as a LIMITED LIABILITY COMPANY - List the members of that company.

-----Section 5: REQUIRED SIGNATURES-----

Neb. Rev. Stat. Section 71-433 REQUIRES the application to be signed by: (Please refer to your responses to Section 3 above):

1. **INDIVIDUAL/SOLE PROPRIETORSHIP:** the individual owner

2. **LIMITED LIABILITY COMPANY:** two of the members of that company

3. **CORPORATION:** two of the officers of the CORPORATION

4. **GOVERNMENTAL:** the head of the governmental unit having jurisdiction over the facility or a person with written authorization to sign (if this is applicable, please include written documentation indicating the authorization with this renewal form)

-----Section 6: ACCEPTANCE/SIGNATURES OF THE OWNER(S) AS THE LICENSEE-----

I/we agree to comply with the rules and regulations issued by the Department of Health & Human Services, Title 175 Chapter 9 licensure regulations for Hospitals. I/we accept responsibility for compliance with these regulations. I/we certify to the best of my/our knowledge that the information and statements on or attached to this application are true and correct, and hereby apply for a license:

Printed name/title of authorized person(s) as identified in Sections 3 and 4:

SIGNATURE:

DATE:

Printed name/title of authorized person(s) as identified in Sections 3 and 4 (IF APPLICABLE):

SIGNATURE:

DATE:

-----Section 7: SUBMIT THE FOLLOWING WITH YOUR APPLICATION-----

The following information is required to be submitted and received by our office before your application can be processed:

1. **FEE(s):**

- (A) For 1 – 50 beds, the fee is: \$1,750
- (B) For 51 – 100 beds: \$1850
- (C) For 101 or more beds: \$1950

Please make the check payable to **DHHS Licensure Unit** and **MAIL** it with your initial licensure documents to the address on the top of this renewal form.

2. **OCCUPANCY CERTIFICATE/PERMIT.** This must come from the State Fire Marshall's Office or delegated authority and be dated within the past 18 months.

Please ensure the **NAME, FACILITY TYPE, and ADDRESS** on the Certificate match the name, address and type of the facility or it will not be accepted.

3. A **LIST OF PERSONS IN CONTROL** of the facility.

4. A **COPY OF REGISTRATION AS A FOREIGN CORPORATION** filed with the Nebraska Secretary of State Office, if applicable.

5. A **FLOOR PLAN or SCHEMATIC DRAWING** of the facility identifying all operating/procedure rooms, hand washing stations, treatment rooms, medication storage rooms, entrances and exits.

Name and contact information of person to contact if the Department has questions about this application

E-mail

Phone