DHHS Public Health Licensure Unit PO
Box 94669
Lincoln, NE 68508
402-471-3484
DHHS.acutecarefacilities@nebraska.gov

Hospital Initial Licensure APPLICATION

Hospital licenses expire 12/31 of each year

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Section 1: TYPE of HOSPITAL

Type of HOSPITAL: Choose ONE.

- ☐ General Acute Hospital
- ☐ Critical Access Hospital
- ☐ Long Term Care Hospital
- ☐ Rehabilitation
- ☐ Rural Emergency Hospital
  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 Proprietorship
- ☐ Limited Liability Company
- ☐ 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 4 and 5:

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. **Rural Emergency Hospitals**
   Initial licensure fee: $650

2. **Initial Licensure Fee for all other hospital types:**

(A) For 1 – 50 beds, the fee is:	$1750
(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