|  |  |
| --- | --- |
|  | **APPLICATION FOR LICENSE TO OPERATE AN**  **INPATIENT CARE FACILITY** BUREAU OF HEALTH FACILITIES LICENSING |

In accordance with §44-7-260 and §44-71-10, of the South Carolina Code (as amended) and Regulations 61-13, 61-16, 61-17, 61-78, 61-93 and 61-103, licensees and prospective licensees must file an application under oath prior to operating a health care facility, and annually thereafter. Licenses are generally effective for a 12-month period following the date of issue unless otherwise determined by state statute or regulation.

1. **REASON FOR APPLICATION**:

A.  New Inpatient Care Facility (Initial License) Skip Lines 1.B and 1.C.

B.  Renewal of License Number:       Expiring On:

C.  Change to Licensing Information for License Number:

(1)  Change of Owner (See instructions before completing).  Ownership Change  Name Change Only

Enter the current name on the first space and the new name on the second space.

From

To

(2)  Change of Facility Name on Line 2.A. (See instructions before completing).

From

To

(3)  Increase/Decrease in Number of Licensed Units From:     To:     Description of units (Patient or Resident Rooms):

(4)  \*Change or  Correction of Address for Location of Facility listed on Line 2:

From

To

\*[NOTE: Relocation of Facility requires prior approval from Department before occupying the new location]

(5)  Addition/Change in Service or Modification (attached document describing the addition or change)

2. **FACILITY INFORMATION (Location where facility provides care to patients or residents)**:

A.

(Name of the facility. See instructions regarding the naming of a facility)

B.

(Physical Location Address to include City, State and Zip Code)

C.

(Mailing Address, if different)

D.

(County in which the facility is physically located)

E. Phone Number at Location:       Emergency Contact Number:

F. \*E-Mail Address:

\*[NOTE: E-mail is our primary means of communicating with the Facility. Please ensure the e-mail address is accurate and monitored.]

3. **LICENSEE OR OWNER(S)**: (1) is an organization or partnership as registered with the South Carolina Secretary of State; or (2) it is the individual names of partners in an agreement that has no organization title and is not required to be registered; or (3) it is an individual that is the sole-proprietor and is not a member/owner of an organization that has an interest in the facility.

A.

(Name of Organization as Registered with the SC Secretary of State or, Name of Individual(s) if this is a Sole-proprietorship or Partner Agreement)

B.

(Location Address to include City, State and Zip Code)

C.

(Mailing Address, if different)

D.

(Phone Number)

E.

(Name and title of presiding officer of the Registered Organization’s Governing Body)

F. Entity named on Line 3.A is a (check one of following characteristics in each of the three categories that applies):

(1)  For Profit  Non-Profit (Registered with the Internal Revenue Service as a 501.c organization)

(2) Sole proprietorship  Partnership  Limited Partnership Corporation

Limited Liability Company  Other:

(3)  State Government  County Government  District Government

Religious  Commercial  None of these categories apply

4. **LOCATION CONTACT (Administrator/Director**): **Prefix**:Mr.  Mrs.  Ms.  Dr.  Other:

|  |  |  |
| --- | --- | --- |
| Line **First Name**: | **MI**: | Line**Last Name**: |

**Generation:** Sr.  Jr.  III  Other:       **Suffix:** MD  Ph.D.  RN  Other:

5. **TYPE OF FACILITY FOR WHICH APPLICATION IS MADE**: (**Check only one category per application**)

A.  **Hospice Facility (Regulation 61-78)** Number of Beds:

B.  **Nursing Home (Regulation 61-17)**

(1)  Nursing Home Number of Beds:

(2)  Institutional Nursing Home Number of Beds:

###### Total Number of Beds:

Does the facility provide or offer to provide Alzheimer’s special care services?  Yes ⁫ No

Total number of Alzheimer patients diagnosed as such by a physician:

Does the facility have a designated area or Alzheimer Special Care Unit?  Yes ⁫ No

If yes, how many licensed beds are located in the area or unit where the Alzheimer patients reside?

Name of Designated Area:

C.  **Intermediate Care Facilities for Persons with Intellectual Disability (Regulation 61-13)**

Number of Beds:

D.  **Residential Treatment Facility for Children & Adolescents (Regulation 61-103)**

Number of Beds:

Educational Program Provided By:  School District  Other: ­­­

E.  **Hospital or Institutional General Infirmary (Regulation 61-16)**

(1)  General Hospital

(2)  Institutional General Hospital

(3)  Institutional General Infirmary

(4)  Privately-owned Educational Institutional Infirmary

(5)  Specialized Hospital (Specialty):

Certified to perform abortions?  Yes;  No (If you checked “Yes”, request to Health Licensing must be on file.)

Number of beds to be licensed: General      ; Psychiatric      ; Rehabilitation      ;

Substance abuse      ; **Total Number of Beds:**

Do you operate a swing bed unit?  Yes;  No. Number of Beds:

Does your hospital provide perinatal (obstetrics and newborn) services?  Yes;  No.

If yes, indicate the appropriate level:  I;  II;  III;  III Regional Center.

If licensed at Level II or III, how many NICU and Neonatal Special Care (Intermediate and Continuing Care) neonates are you capable of caring for? NICU       Neonatal Special Care

JCAHO accredited?  Yes;  No. Date of Last JCAHO Inspection:

Trauma Center?  Yes;  No.  If yes, what level is your designation?  I;  II; or  III

F.  **Inpatient Treatment Facility for Psychoactive Substance Abuse or Dependence (Regulation 61-93)**

      Number of Medical Detoxification Beds (Requires CON Approval)

      Number of Social Detoxification Beds

      Number of Residential Treatment Program Beds

      Total Number of Beds to be Licensed

6. **BUILDINGS & PATIENT/RESIDENT ROOMS INFORMATION (Initial Licensure Only)**:

A. In how many buildings are patient/resident rooms located?

|  |  |  |  |
| --- | --- | --- | --- |
| Name of building: |  | No. of beds: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of building: |  | No. of beds: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of building: |  | No. of beds: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of building: |  | No. of beds: |  |

Check this block if you have additional buildings in which patient/resident rooms are located other than the four identified above and attach a sheet with similar information as requested above for each additional building.

B. If any facility services or functions are located in buildings other than those named above, attach a description of the functions and name of building(s) (and location if at an address other than that of the hospital).

C. Attach a brief description of any construction or renovations in progress; identify location, percent of completion, expected completion date, and the Certificate of Need (if applicable).

7. **REQUIRED ATTACHMENTS (Annual Renewal and Initial)**:

A. **Administrator’s License** - attach a copy of the license (or “other proof”) issued by the Board of Long Term Health Care Administrators, Department of Labor Licensing & Regulation for the person identified on Line 4 if:

(1) 5.B has been marked or;

(2) 5.C has been marked and the person possesses an administrator’s license.  N/A  Attached

B. **Physician Supervisor** – If you marked Line 5.A, 5.E or 5.F and are required by regulation to have a Medical Director or Chief of Staff, attach a copy of the license issued by the South Carolina State Board of Medical Examiners or other proof that the physician is currently authorized to practice medicine in South Carolina.  N/A  Attached

C. **Nursing Supervisor** – If you marked Line 5.A, 5.B, 5.E, or 5.F and are required by regulation to have a Director of Nursing or Nursing Services Supervisor, attach a copy of the registered nurse license issued by the South Carolina State Board of Nursing or other proof that the person is authorized to practice as a registered nurse in South Carolina.  N/A  Attached

D. **Pharmacist** – If you marked Line 5.C or 5.F and are required by regulation to have a Pharmacist or you currently have a pharmacist that oversees a drug room, attach a copy of the pharmacist license issued by the South Carolina State Board of Pharmacy or other proof that the person is authorized to practice as a pharmacist in South Carolina.  N/A

Attached

E. **Licensee or Owner Documents Required**:

(1) If the licensee is a corporation or partnership, attach a list identifying all officers.  N/A  Attached

(2) If the licensee or owner is a corporation or partnership, attach a list with the name, address and percentage of all owners that possess 5% or more ownership of the company or partnership.  N/A  Attached

(3) If any person or other legal entity can claim liabilities of the licensee or of the facility or service for which this license is requested, attach a list identifying the name, address, percent, and type of claim.  N/A  Attached

F. **Real Property Ownership** – If the land and/or building on/in which the facility or service is conducted are owned by an individual or organization other than the licensee indentified on Line 3.A:

(1) Attach a copy of the current executed lease or rental agreement.  N/A  Attached

(2) Attach a list with the name, address and percentage of all owners that possess 5% or more ownership of the company or partnership that owns the land or building(s).  N/A  Attached

(3) Attach a list identifying all officers of the corporation or partnership that own the land or building(s).  N/A

Attached

(4) If any person or other legal entity (other than the licensee or owner of the land/building(s) can claim liabilities of the licensee or of the facility or service for which this license is requested, attach a list identifying the name, address, percent, and type of claim.  N/A  Attached

G. **Management Agreement** – If the licensee has engaged an entity other than an employee of the licensee to manage or operate the facility, attach a list providing information similar to that required in Line 3 and a copy of the current executed management agreement.  N/A  Attached

H. **Additional Ownership Information** - If applicable, attach a copy of any agreement, contract, option, understanding, intent or other arrangement that will effect a change in any of the information requested and/or provided in Line 7.E, 7.F, and 7.G.  N/A  Attached

8. **VERIFICATION**

**[NOTE: For nursing homes, the owner(s) or person(s) authorized to sign the application must have a criminal background check result on file with our office. Licenses will not be issued if the result is not on file or there is a conviction that would preclude us from issuing the license.]**

|  |  |
| --- | --- |
| State of: |  |

|  |  |
| --- | --- |
| County of: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| I, |  | and |  |
| being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with standards set forth in South Carolina Regulation 61-13, 61-16, 61-17, 61-78, 61-93, or 61-103 (as applicable to the license applied for herein) and that non compliance with these standards may result in the Department pursuing enforcement actions as provided in the applicable regulation 61-13, 61-16, 61-17, 61-78, 61-93, or 61-103. | | | |

|  |  |  |
| --- | --- | --- |
|  |  |  |

(Signature)\* (Title)

|  |  |  |
| --- | --- | --- |
|  |  |  |

(Signature)\* (Title)

An application must be signed by the owner if an individual; or in the case of a limited liability company, the head of the limited liability company; or two of the owners if a partnership; or, in the case of a corporation, by two of its officers; or, in the case of a governmental unit, by the head of the governmental department having jurisdiction over the facility.

Subscribed and sworn to before me this \_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_.

(Month) (Year)

NOTARY PUBLIC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My commission expires \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NOTARY SEAL

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 9. |  |  |  |  |  |
| (Name and title of person preparing this application) (Telephone Number) (Date Prepared) | | | | | |
|  | | | | | |
|  |  | | |  | |
|  | (E-mail address) | | |  | |

|  |
| --- |
| ***NOTICE:*** *Your license must be renewed prior to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or bed increases/decreases) from the Department that are in progress at the time the license is due for renewal. To avoid a lapse in your license we recommend you submit an application to renew the current license and a second application to effect the changes. Please read the attached instructions regarding pending changes for Line 3* |

**Instructions for Completing DHEC Form 0207**

**Application for License to Operate an Inpatient Care Facility**

**PURPOSE:** In accordance with §44-7-260 and §44-71-10, of the South Carolina Code Ann. (Suppl. 2001) and Regulations 61-13, 61-16, 61-17, 61-78, 61-93, and 61-103, licensees and prospective licensees must file an application under oath prior to operating a health care facility, and annually thereafter. Licenses are effective for a 12-month period following the date of issue.

**INSTRUCTIONS:**

**Line 1.A:** **New Inpatient Care Facility (Initial License)** – Check this block only if this is the first time you are applying for a license with the Department. Do not check this block if this is a change of ownership for an existing licensed service/activity. Skip Lines 1.B and 1.C.

**Line 1.B.** **Renewal of License** - Checkthis block only if you are renewing your license and then enter the license number and expiration date of the license in the spaces provided.

**Line 1.C.** **Change of Licensing Information –** Check this block if you are applying for a change that will alter the information on the face of your license. Then enter the license number in the space provided and apply for the following as appropriate:

**(1) Change of Owner** – If the information regarding the owner has changed check this block. If it is a change in the ownership, check the “Ownership Change” block. If it is a legal name change only for the owner, check the “Name Change Only” block. For an ownership change, the application is to be completed by the individual or entity that will become the new licensee, as licenses are not transferable. Regardless of the party that completes the application, the signatures on Line 9 must be that of the new licensee. The Department will continue to recognize the current licensee as the owner until the change is approved. Until approval is granted and a license is issued to the new owner, the current owner is responsible for renewing the license prior to the expiration date and must submit a separate application to renew the license. If the name of the owner will change, enter the current name on the first space provided and the new name on the second space provided. If you were issued a Certificate of Need (CON) regarding this change, attach a copy approving or exempting the change from CON review.

**(2)** **Change of Facility Name** – Check this block if you are changing the name of the facility (See Line 2A. regarding the name of the facility before completing this section). Enter the current name in the first space provided and then enter the new name in the second space provided)

**(3)** **Increase/Decrease in Number of Licensed Units** – Check this block if you are increasing or decreasing the number licensed units. Enter the current number of units you are licensed for in the first space and the new number of units you are applying for in the second space. If you were issued a Certificate of Need (CON), attach a copy of the letter approving or exempting the increase/decrease from CON review. In the third space, enter a description of the type of units you will be increasing/decreasing (i.e. patients or residents).

**(4) Change or Correction of Address** – The abandonment of a facility to relocate patients/residents rooms at another address requires prior approval from the Department before patients/residents can occupy the rooms at the new location. If the location of the patient/resident rooms listed on Line 2.A. will be changing, check this block. If this a correction to information previously provided, check this block. Enter the old address in the first space and the new address in the second space.

**(5) Addition/Change in Service or Modification** – Attach a document describing the addition or change in services provided or any modifications to the building.

**Line 2.A.** **Name of Facility to be** **Licensed** - If you are renewing your license, the name of the facility must appear exactly as it did for the prior year. If changing the name, enter the current name on Line 1.C (2) where it says “From” and then enter the new name on line 1.C (2) where it says “To” and again on line 2.A. We recommend names be limited to 65 characters (including spaces) as those having more than 65 characters will be truncated due to the limitations of our database. The abbreviated name will appear on all information made available to the public and may not accurately reflect the actual name if greater than 65 characters. Regardless of our database limitations, the name on Line 2.A. should be consistent with the name that appears on other documents submitted during the initial licensure process. Afterwards, if you desire to change the name, you may submit another application for the change. This will ensure the name reflects what you intended. No facility can have the same name as another facility that is already licensed even if it is owned by the same owner.

Under circumstances where the applicant has entered the name of the facility the same as the owner, we will add an additional identifier or delete part of the name to establish a distinction between the two. For example, if the owner is ABC Nursing Home, Inc., our office will drop the “Inc.” from the facility name. Our records will then reflect ABC Nursing Home, Inc. as the licensee and the facility name as ABC Nursing Home. As another example, if ABC Nursing Home, Inc. will have more than one license, the facility name of each must be distinguishable from one another. For example ABC Nursing Home, Inc. has a license for a facility in Charleston and another license for a facility in Greenville. As such, a suggested name of each on their respective licenses might reflect the facility name as ABC Nursing Home-Charleston and the other as ABC Nursing Home-Greenville. Each license will also reflect the name of ABC Nursing Home, Inc. as owning both.

**Line 2.B.** **Facility Location Address** – Enter the street address where the facility is physically located. (Note: You cannot move the patient/resident rooms from their current licensed location to another location without prior approval from our office.)

**Line 2.C.** **Facility Mailing Address** – Enter the mailing address if it is different from the location address. If it is the same, enter “Same” on this line. The mailing address is where the Department will send all correspondence regarding the licensure, inspections, invoicing, and important notices. This will be the only mailing address we will list.

**Line 2.D.** **County Location** – Enter the county were the facility is physically located.

**Line 2.E. Telephone Numbers** – Enter telephone number of the facility in the space provided in the first space. In the second space, enter the number where the Department can call in the event of an emergency.

**Line 2.F.** **E-Mail Address** – We recommend creating a facility e-mail address that will be monitored by several staff. E-mail will be our primary means of communicating with the facility for licensure, inspections, invoicing, and important notices. If the e-mail address changes at any time, please notify the Department immediately. In the space provided, enter the e-mail that the Department can contact the facility.

**Line 3.A.** **Licensee or Owner(s)** – Enter the name according to one of the options below that best describes the owner:

(1) If the owner is an organization required to be registered with the South Carolina Secretary of State’s Office, enter the name of the organization in the space provided exactly as it appears with that office.

(2) If the owner is an organization having no title and is not required to be registered with the Secretary of State’s Office, enter the name of each individual partner with which you have entered into a written agreement.

(3) If the licensee is a sole-proprietor (an individual) and is not a member of an organization that has an ownership interest in the facility, then enter the name of the individual in the space provided.

**Line 3.B.** **Licensee or Owner Location Address** – Enter the address where the licensee is physically located. In the case of a partnership, enter the location address of only one partner identified on Line 3.A.

**Line 3.C.** **Licensee or Owner Mailing Address** - Enter the mailing address if different from the location address.

**Line 3.D. Licensee or Owner Phone Number –** Enter the phone number where we can contact the owner.

**Line 3.E. Presiding Officer** – Enter the name of the presiding officer of the organization identified on Line 1.A.

**Line 3.F.** **Entity Type** – Check one of the following characteristics in each of the three categories that best describes the licensee (owner). Only one block per category (1), (2), and (3) shall be checked. If the license is for a renewal, and you check any block different from the previous application, you must attach a full explanation and any other pertinent documentation to support the change. (Note: You cannot arbitrarily change from a sole proprietorship to any other category without an official notarized agreement if a partnership or; articles of incorporation if a limited partnership or corporation; or limited liability company. Such action may constitute an ownership change).

**Line 4** **Administrator Officer (Facility Contact)** – enter the name of the person that is the primary contact and has the authority to act on behalf of the licensee. For a nursing home, this is the person that possesses an Administrators License issued by the Board of Long Term Health Care Administrators, Department of Labor Licensing & Regulation. This also applies to a Intermediate Care Facilities for Persons with Intellectual Disability (ICFPID) if the Administrator possesses a license issued by the Board of Long Term Health Care Administrators, Department of Labor Licensing & Regulation.

**Line 5** **Type of Facility for which Application is Made** - Only one category for Line 5. (A, B, C, D, E, or F) can be checked. If the licensee is the holder of multiple licenses with our Department, you must submit a separate application for each type of license that is held or being applied for.

**Line 5.A** **Hospice Facility** - Check this block if you are being licensed for this type of facility as defined in DHEC Regulation 61-78. Enter the total number of beds in the space provided. (Do not use this application if you are applying for a license to operate an outpatient facility. You will need to complete an outpatient license application DHEC Form 0200).

**Line 5.B** **Nursing Home** - Check this block if you are being licensed for this type of facility as defined in DHEC Regulation 61-17. Then check either or both blocks (1) if you have nursing home beds and/or (2) if you have institutional nursing home beds. Enter the number of beds in the appropriate spaces provided and then the total number of beds in the space provided. Check either Yes or No if your facility provides or offers to provide Alzheimer’s special care services. If you checked “Yes”, then enter the total number of Alzheimer’s patients diagnosed by a physician. Check Yes or No if your facility has a designated area or Alzheimer’s Special Care Unit. If you checked “Yes”, enter the number of beds that are located in the area or unit where the Alzheimer’s patients reside in the space provided. Also enter the name of the designated unit or area in the space provided.

**Line 5.C** **Intermediate Care Facilities for Persons with Intellectual Disability** - Check this block if you are being licensed for this type of facility as defined in DHEC Regulation 61-13. Enter the total number of beds in the space provided.

**Line 5.D** **Residential Treatment Facility for Children and Adolescents** - Check this block if you are being licensed for this type of facility as defined in DHEC Regulation 61-103. Enter the number of beds you are being licensed for in the space provided. Check the appropriate block that describes your Educational Program, i.e., provided by the local school district or other; if other, please describe.

**Line 5.E** **Hospital or Institutional General Infirmary** - Check this block if you are being licensed as for this type of facility as defined in DHEC Regulation 61-16. Check only one category for Line 5.E. (1), (2), (3) (4) or (5). You can only check Line 5.E. (5) if you have a Certificate of Need (CON) to operate as a specialty hospital. A specialty hospital is defined in Regulation 61-16.

Check Yes or No as to whether or not your facility is certified to perform abortions. If you checked “Yes”, a request to the Bureau of Health Facilities Licensing must be on file.

For the number of beds to be licensed, enter in the space provided for each of the categories listed. The number of beds by each classification added together must equal the total number of beds in the space provided. Beds can only be licensed as general, psychiatric, rehabilitation, or substance abuse. This is normally indicated in the Certificate of Need (CON) letter that you were issued by our Department.

Indicate whether or not you operate a swing bed unit and enter the total number of swing beds in the space provide. (The number of swing beds is not related to the total number of licensed beds discussed in the paragraph above.)

Indicate by checking the appropriate block if your hospital provides perinatal (obstetrics and newborn) services. If yes, then check the box for appropriate level you are authorized to provide. Then, enter the number of neonates you are capable of caring for in the spaces provided.

Indicate whether or not you are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the date of the last JCAHO inspection.

Check Yes or No if you are a designated Trauma Center. If you checked “Yes”, then check level designation (I, II or III).

**Line 5.F** **Inpatient Treatment** **Facility for Psychoactive Substance Abuse or Dependence** - Check this block if you are being licensed for this type of facility as defined in DHEC Regulation 61-93. (Do not use this application if you are applying for a license to operate an outpatient facility. You will need to complete an outpatient license application).Enter the number of beds on the appropriate line for each type of treatment or program the facility provides. Enter the total number of beds to be licensed. (Note: You cannot have Medical Detoxification Beds without a Certificate of Need (CON) issued to the licensee from the Department.)

**Line 6.A** **Building & Patient/Resident Rooms Information (Initial Licensure Only)** – enter the total number of buildings in which patient/resident rooms are located in the space provided. Then in the spaces provided, enter the name of each building and the total number of beds for each patient/resident that is located in that specific building. If you need to list additional buildings, check the block beneath the buildings you have already listed and attach a sheet with similar information.

**Line 6.B** **Facility Services or Functions Located in Buildings other than those Described in Line 6.A.** - (Self explanatory)

**Line 6.C** **Construction or Renovations in Progress** – (Self explanatory)

**Line 7** **Required Attachments** – (Self explanatory)

**Line 8** **Verification** – In the first two spaces, enter the State and County where signatures are to be notarized. In the second two spaces, print the name of the individual(s) authorized to sign the application. The remaining portion to be completed is self-explanatory. The verification signatures shall be those of the individuals who are officers of the licensee’s governing body. Individuals belonging to a management company or other persons who are not officers of the governing body cannot sign on behalf of the licensee. In the case of a sole proprietorship, the signature shall be that of the person identified on Line 3.A. If the license application is being notarized outside of the State of South Carolina, the notary seal of that State shall be affixed to the application. The seal is not required if notarized in South Carolina by a notary registered in our State.

[NOTE: For nursing homes, the owner(s) or person(s) authorized to sign the application must have a criminal background check result on file with our office. Licenses will not be issued if the result is not on file or there is a conviction that would preclude us from issuing the license.]

**Line 9** **Name & Title of Person Preparing the Application** – (Self explanatory)

**OFFICE MECHANICS AND FILING**: Kept in accordance with records retention schedule 16327 – retain at Agency for 4 years then to State Records Center for 6 years, and then destroy.