BUREAU OF FACILITY STANDARDS
Division of Licensing & Certification
Idaho Department of Health and Welfare
3232 Elder Street | P.O. Box 83720
Boise, ID 83720-0009
(208) 334-6626

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DO NOT FAX RETURN BY MAIL ONLY

APPLICATION FOR HOSPITAL LICENSE

Hospital Name: _____

Physical Address: _____
Street and number or RFD

_____, Idaho _____ _____
City Zip Code County

Mailing Address: _____
Street and number or RFD

_____ _____
City State Zip Code

Phone (208)_____ **E-mail** _____ **FAX** (208) _____

I. CLASSIFICATION AND OWNERSHIP

A. **Facility Control or Ownership:** Check the entity which has legal responsibility for operation of the facility. *(Check only one.)*

Check which entity has legal responsibility for operation of the agency (check only one):

For Profit	NonProfit	Government	
☐ Individual	☐ Church Related	☐ State	☐ City/County
☐ Partnership	☐ Nonprofit Corporation	☐ County	☐ Hospital District
☐ Corporation	☐ Other Nonprofit	☐ City	☐ Federal

Name of Legal Entity: _____

B. **Management Contract:** Does the controlling organization plan, through a contract, to place responsibility for the administration of the hospital with another organization?

☐ No. ☐Yes. If yes, give the name of the organization that manages the hospital:

_____

C. **Owners:** If "for profit", please list the names and addresses of persons with ownership interests of five percent (5%) or more (attach separate sheet if necessary).

_____

_____

D. **Lease (if applicable):** If the hospital is leased by the owner to a second party for the operation of the facility, Please include a copy of the lease agreement clearly describing the responsibilities of both parties.

E. **Disclosure:** Has anyone identified on this application or associated with it ever been 1) denied a license 2) had a license suspended or revoked, or 3) owned or operated an entity involuntarily terminated from the Medicare or Medicaid program? No:____ Yes:____ If yes, identify who, what, and where:

_____

_____

I. CLASSIFICATION AND OWNERSHIP (continued)

F. Facility Categorization. Which best categorizes your facility? *(Check only one.)*

☐ Critical Access Hospital (CAH) ☐ Rehabilitation ☐ General Medical and Surgical

☐ Long Term Care Hospital ☐ Psychiatric

II. FACILITIES AND SERVICES TO BE OFFERED

A. Hospital Units

Please note the number of beds anticipated in each area or unit named below. **List each bed only once according to its primary designation.**

	Beds
Medical and/or Surgical	_____
Obstetric.....	_____
Pediatric.....	_____
Intensive care	
mixed or other intensive care.....	_____
cardiac intensive care	_____
pediatric intensive care	_____
neonatal intensive care.....	_____
Rehabilitation	_____
Alcohol/Drug Dependency	_____
Psychiatric.....	_____
Any other unit(s): (specify; do not include SNF)	_____
_____	_____
_____	_____
_____	_____
Total Beds….......	_____

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newborn bassinets (do not include in above total) ..... ….. _____

recovery (do not include in above total)…… _____

II. FACILITIES AND SERVICES TO BE OFFERED (Continued)

B. Services Offered. Check each service below that the facility will offer.

___01 audiology services
___02 blood bank
___03 burn care unit
___04 cardiac catheterizations
___05 clinical psychology services
___06 continuing care nursery
___07 CT scanners
___08 dental services
___09 electroconvulsive therapy
___10 electroencephalography
___11 emergency department
___12 genetic counseling services
___13 hemodialysis (inpatient)
___14 hemodialysis (outpatient)
___15 histopathology laboratory
___16 laboratory
___17 MRI
permanent MRIs: _____
mobile MRIs: _____
mobile unit provided by: _____
_____
_____
_____
_____
___18 nuclear medicine

___ 19 obstetrics
___ 20 occupational therapy department
___ 21 open heart surgery department
___ 22 organ/tissue bank
___ 23 organized outpatient department
___ 24 outpatient surgery
___ 25 pediatrics
___ 26 pharmacy with full-time registered pharmacist
___ 27 pharmacy with part-time registered pharmacist
___ 28 physical therapy department
___ 29 podiatric services
___ 30 post-operative recovery rooms
___ 31 prenatal medicine (outpatient)
___ 32 psychiatric emergency services
___ 33 psychiatric inpatient services
___ 34 psychiatric outpatient services
___ 35 psychiatric partial hospitalization program
___ 36 radiation therapy
___ 37 rehabilitation outpatient services
___ 38 respiratory therapy department
___ 39 social work department
___ 40 speech pathology services
___ 41 surgical services
___ 42 transplant services
___ 43 trauma center

C. Off-Campus Sites. For each anticipated off-campus hospital-based location, please provide the following information:

Address:

_____

Services Provided:_____

(If more space is needed for off-campus hospital-based location information, include it on additional sheets of paper.)

IF THERE ARE QUESTIONS ABOUT INFORMATION IN THIS REPORT, WHO SHOULD BE CONTACTED?

Name: _____

Title: _____

Telephone: _____

E-mail address: _____

I CERTIFY THAT THE STATEMENTS MADE IN THIS REPORT ARE TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____
Signature of Administrator

_____
Printed Administrator Name

_____
Date

_____
Administrator's E-mail Address

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