APPLICATION FOR LICENSE TO OPERATE A HOSPITAL

TO: South Dakota Department of Health
Office of Health Care Facilities Licensure & Certification
615 East 4th Street
Pierre, SD 57501-1700 Telephone No. 605-773-3356 Fax No. 605-773-6667

The undersigned hereby makes application for a license to operate a hospital as required by SDCL 34-12

I. NAME AND LOCATION OF FACILITY

Name of Facility_____
Address of Facility_____
(Street and Number) (City)
List Off-Site Addresses and Services Provided_____
_____
County_____ Zip Code (9 digit)_____ Telephone No._____ Fax No._____
Mailing Address (if different from above)_____
E-Mail Address _____

II. CAPACITY AND CLASSIFICATION OF FACILITY: (Check type of institution for which application is made:

A. _____ Total number of beds requested for licensure (to include psychiatric, intensive care, self-care, postpartum (LDRP) and coronary care units). DO NOT include bassinets, labor, or surgical recovery rooms. Number of swing beds _____.
B. _____ General Hospital (provides [check] [ ] medical, [ ] surgical, [ ] obstetrical, and [ ] emergency services.)
C. _____ Specialized Hospital (provides [check] [ ] medical, [ ] surgical, [ ] obstetrical, and [ ] emergency services.)
D. _____ Critical Access Hospital (provides [check] [ ] medical, [ ] surgical, [ ] obstetrical, and [ ] emergency services.)
List referral hospital_____
E. Accredited by _____; Date_____ Attach current accreditation reports, correspondence; if previously submitted, give date_____.

III. CONTROL OF FACILITY:

A. Check below the one which applies:

[ ] Sole Proprietorship
1. If sole proprietorship, list name of owner:
_____

[ ] Partnership
[ ] Limited Liability Partnership (LLP)
2. If partnership, list name of partnership and **attach** a list of names and addresses of partners:_____
_____
_____

[ ] Corporation [ ] Non-profit [ ] Profit
3. If corporation, give name and address of corporation: Phone_____
_____
_____
4. If corporation, give state under which laws the corporation is organized:
_____

[ ] Limited Liability Company (LLC)
5. If LLC, give name of company and **attach** a list of names and addresses of members:_____

[ ] Political Subdivision (Specify):_____
[ ] Other (Specify):_____

B. Governing Body Organization:
Attach list of governing board members including profession, address, and board position.
C. Staffing:
Attach list of department heads, managers and consultants, if applicable, and **Executive Committee of the Medical Staff**. Include license, certification or registration numbers and expiration date.
D. Management Group, if applicable:_____
(Organization) (Address)
E. Affiliation Agreement_____

(Hospital) (Address)

F. Person in Charge of Institution:_____ Title_____

G. Do you operate a licensed pharmacy? [ ] Yes [ ] No License No._____
State Controlled Substances Registration No._____ DEA No._____

H. Ownership of Building:_____ Address_____
[ ] Individual; [ ] Partnership; [ ] L.L.P.; [ ] Non-profit Corporation; [ ] Profit Corporation; [ ] LLC; [ ] Political Subdivision. **Attach** list Board of Directors, if corporation, List LLC members, Partners or Individual, including profession and address, if different from B.

I. Lease: [ ] Yes [ ] No; If yes_____
(Organization) (Address)
[ ] Individual; [ ] Partnership; [ ] LLP; [ ] Non-profit Corporation; [ ] Profit Corporation; [ ] LLC; [ ] Political Subdivision. **Attach** list of Board of Directors, if corporation; List LLC members, Partners or Individual, including profession and address, if different from B.

J. Sub-lease [ ] Yes [ ] No. If yes_____
Attach separate page, if needed. (Organization) (Address)

K. **Attach** organization charts for all above that are applicable, plus copies of existing leases, subleases, management contracts or applicable supporting documentation that indicates legal sequence from ownership to actual operation of the facility. If the requested documents were submitted previously, give date:_____.

IV. BUILDING AND SERVICES

A. Complete attached list of services offered and other information.

B. Address of buildings in which services are provided _____;
Number of licensed beds in each _____; Number of unlicensed beds _____. Co-located Services [ ] Yes [ ] No; Describe_____
_____

C. Is facility engaged in or planning to build, remodel, or add a new service? Yes ____ No ____. If yes, have plans been submitted? [ ] Yes [ ] No. Anticipated date of completion _____ Scope of project _____
_____

D. Automatic sprinkler system annual inspection_____by_____
(date)

E. Testing of standby power system under load monthly [ ] Yes [ ] No.

V. APPLICANT

I verify the information contained in this application is true and complete, and I consent to allow inspections of the hospital facility by authorized department representatives upon the presentation of identification during hours of operation.

Signed_____ Date_____
(Owner, Administrator, or other individual authorized to act on behalf of facility)
Title or Position_____

Subscribed and sworn to before me this _____ day of _____, 20_____. (Seal)

Notary Public	My commission expires:

APPLICATIONS MUST BE COMPLETE, SIGNED AND NOTARIZED TO BE PROCESSED

VI. LICENSE FEE

The license fee in the amount of $_____, (1 to 25 Beds - $1,000, 26 to 50 Beds - $1,500, 51 to 100 Beds - $2,000, 101 to 150 Beds - $3,000, 151 to 200 Beds - $4,000, or 201 + Beds - $5,000) is attached to this application. Make check, money order, or postal note payable to the South Dakota Department of Health.

Note: Please submit original and retain one copy for your files. Attach all required documentation to the original application.

FOR HEALTH DEPARTMENT USE ONLY

Fee received $_____ Receipt No._____ License No._____
The department will issue or renew a license only after payment of the proper fee, ascertainment that the facts set forth in the application are true and complete, and satisfactory evidence of the applicant's ability to comply with the provisions of SDCL Chapter 34-12 and the rules promulgated thereunder.

Hospital License Application

Facility_____Address_____
(Name)

Check services offered as of the date of application: (If not provided directly, list name of contractor.)

[ ] Acute Renal Dialysis Stations _____
[ ] Alcohol and/or Drug Services
[ ] Ambulance Services (Owned)
[ ] Anesthesia
[ ] Audiology
[ ] Blood Bank
[ ] Burn Care Unit _____ Beds _____
[ ] Cardiac Catheterization Laboratory (Suites) _____
[ ] Cardiac Rehab
[ ] Cardiac – Thoracic Surgery
[ ] Chemotherapy Service
[ ] Chiropractic Service
[ ] Critical Care Unit – Beds _____
[ ] CT Scanner
[ ] Dental Service
[ ] Dietetic Service
[ ] Dietetic Service – Contracted
[ ] Dietetic Service – In-house
[ ] Emergency Department (Dedicated)
[ ] Emergency Services – Beds _____
[ ] Extracorporeal Shock Wave Lithotripter
[ ] Gerontological Specialty Services
[ ] Home Health Services
[ ] Hospice
[ ] ICU – Cardiac (non-surgical) Beds _____
[ ] ICU – Medical-Surgical Beds _____
[ ] ICU – Neonatal Beds _____
[ ] ICU – Pediatric Beds _____
[ ] ICU – Surgical Beds _____
[ ] Laboratory – Anatomical
[ ] Laboratory – Clinical
[ ] LDR Beds _____
[ ] LDRP Beds _____
[ ] Long Term Care (swing-beds) Beds _____
[ ] Magnetic Resonance Imagining (MRI)
[ ] Mammography
[ ] Negative or Positive Air Pressure Rooms (Isolation) Total Negative _____ Total Positive _____
[ ] Neonatal Nursery
[ ] Neurosurgical Services
[ ] Newborn Nursery Bassinets _____
[ ] Nuclear Medicine Services
[ ] Obstetric Service
[ ] Occupational Therapy Services
[ ] Oncology Services
[ ] Operating Rooms – Total _____
[ ] Ophthalmic Surgery
[ ] Optometric Services
[ ] Organ Bank
[ ] Organ Transplant Services
[ ] Orthopedic Surgery
[ ] Outpatient Department Services
[ ] Patient / Community Health Services
[ ] Pediatric Services
[ ] Pharmacy

[ ] Physical Therapy Services
[ ] Positron Emission Tomography Scan
[ ] Post-Operative Recovery Rooms Total _____
[ ] Psychiatric – Child/Adolescent
[ ] Psychiatric – Forensic
[ ] Psychiatric – Geriatric
[ ] Psychiatric – Inpatient
[ ] Psychiatric – Outpatient
[ ] Psychiatric Services – Emergency
[ ] Radiology Services – Diagnostic
[ ] Radiology Services – Therapeutic
[ ] Reconstructive Surgery
[ ] Rehab – Inpatient
[ ] Rehab – Outpatient
[ ] Renal Dialysis (Acute Inpatient)
[ ] Respiratory Care Services
[ ] Respitx
[ ] Seclusion Rooms
[ ] Social Services
[ ] Speech Pathology Services
[ ] Surgical Services – Inpatient
[ ] Surgical Services – Outpatient
[ ] Surgical Services – Operating Rooms (Suites) _____ Recovery Beds _____
[ ] Telemedicine
[ ] Transplant Services
[ ] Trauma Center (Certified)
[ ] Urgent Care Center Services

List: Diagnostic Imagine Services _____
_____

I hereby authorize the Department of Health to make the list of services available to requesters unless prohibited as noted below:
_____
_____

Signature_____ Date_____