Hospital Licensure Applications: Process for Submissions

For Ohio Hospitals

August 28, 2024

September 4, 2024

11 a.m. – 12:30 p.m.

via Teams

Department of Health

Bureau of Regulatory Operations

Presenters:

Lisa Lang, Project Manager

Debra Walsh, Health Service Policy Supervisor

Jayson Rogers, Administrative Officer

Andrea Denning, Bureau Chief

Ohio Department of Health

Housekeeping

- If you are experiencing difficulty accessing the application, ensure you are following these steps:
    - Download the zip file to your computer and open it from your downloads folder.
    - Open the PDF within the folder using an updated PDF reader.
- If this does not resolve the issue, troubleshooting steps will briefly be discussed following the presentation.

Ohio Department of Health

Overview of Application Process

Ohio Department of Health

Complete Application

Department of Health

Application Form

- Complete the application for licensure.
  - Form HEA 1925.
  - https://odh.ohio.gov/know-our-programs/hospitals/resources/hospitallicenseapplication

Ohio Department of Health

Required Sections and Documents

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HOSPITAL LICENSURE APPLICATION

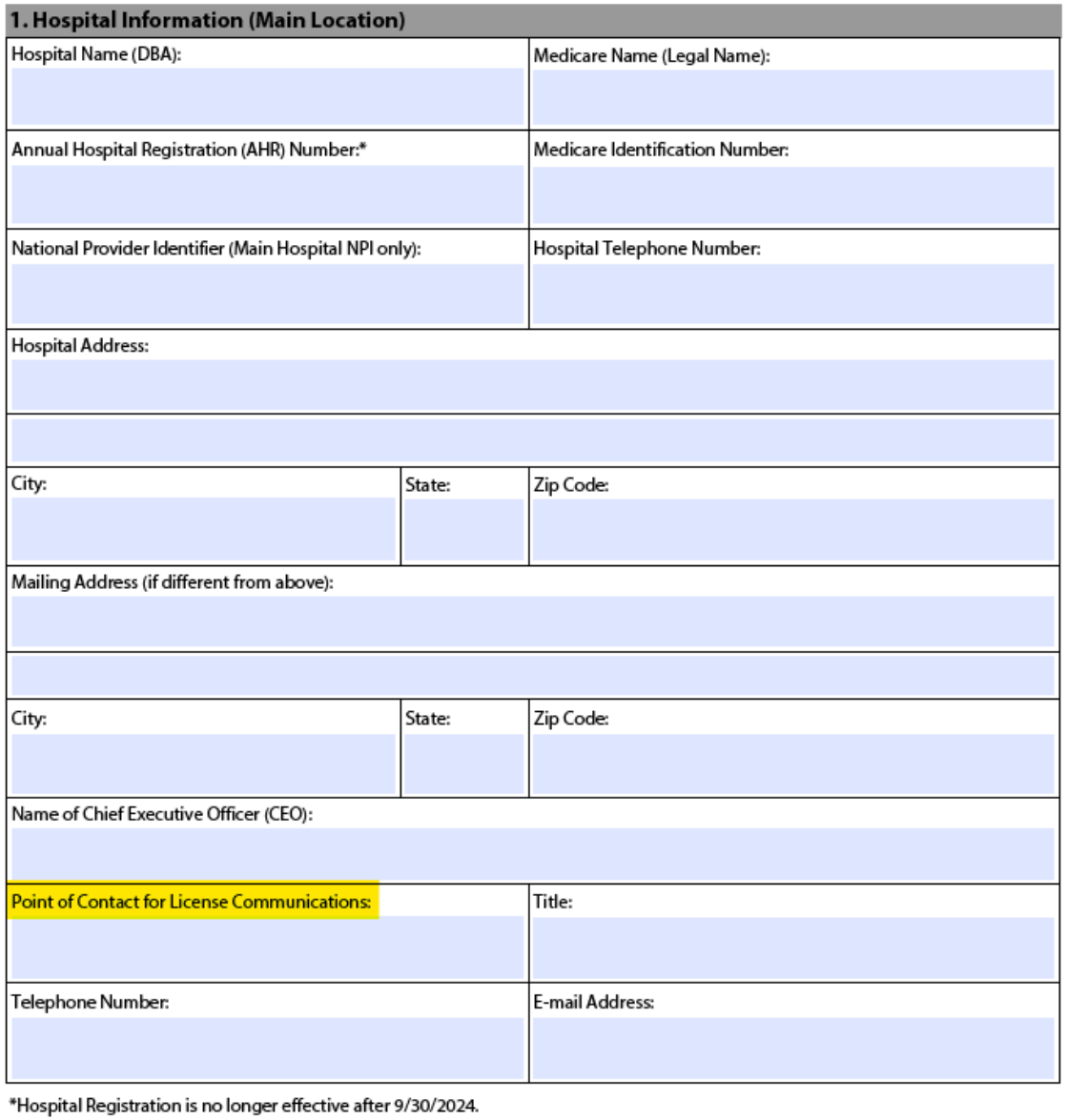
Licensure Activity Type

	Required Form Sections and Documents
☐ Initial Hospital Licensure Application (Hospitals registered prior to 9/30/2024)	• Form Sections 1 - 7 and all applicable attachments • A copy of the most recent accreditation survey • A copy of the applicant's occupancy permit • A copy of the current state fire marshal inspection report documenting that the applicant is in compliance with the state fire code
☐ Temporary Hospital Licensure Application (Hospitals opened after 9/30/2024)	• Form Sections 1, 2, 5, 6, 7 and all applicable attachments • A copy of the applicant's occupancy permit • A copy of the current state fire marshal inspection report documenting that the applicant is in compliance with the state fire code
Is this a Rural Emergency Hospital? ○ Yes ○ No	• Form Sections 1-3, 4(a) - (b), 5, 6, 7
☐ Change of Owner	• Form Sections 1 - 7 and all applicable attachments

Ohio Department of Health

Section 1

- Complete all demographic information for the main location.
- List one Point of Contact for License Communications.



1. Hospital Information (Main Location)		
Hospital Name (DBA):		Medicare Name (Legal Name):
Annual Hospital Registration (AHR) Number:*		Medicare Identification Number:
National Provider Identifier (Main Hospital NPI only):		Hospital Telephone Number:
Hospital Address:		
City:	State:	Zip Code:
Mailing Address (if different from above):		
City:	State:	Zip Code:
Name of Chief Executive Officer (CEO):		
Point of Contact for License Communications:		Title:
Telephone Number:		E-mail Address:

*Hospital Registration is no longer effective after 9/30/2024.

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Section 2

- Provide accreditation and/or certification status.
- Provide most recent inspection report.
  - This is confidential, not a public record.

2. Accreditation/Certification Status*

Accrediting/Certifying Organization	Date of Last Accreditation Survey (mm/dd/yyyy)
☐ The Joint Commission	
☐ Accreditation Commission for Health Care (ACHC)	
☐ Det Norske Veritas (DNV)	
☐ Center for Improvement in Healthcare Quality (CIHQ)	
☐ Other Medicare Approved Accrediting Organization	
Name:	
☐ Medicare Certification (if not accredited by other entities)	Date of Last Certification Survey

*** Submit copy of most recent accreditation survey. Section 3722.05(A) of the Ohio Revised Code requires submission of most recent final survey report to avoid inspection. Submissions are confidential and not considered a public record under Section 149.43 of the Ohio Revised Code.**

Ohio Department of Health

Section 3

- Provide ownership information.
    - As filed with the Ohio Secretary of State.
- Attach Section 5 of the CMS 855(A) Form.

3. Ownership Information*

Registration Name Filed with the Ohio Secretary of State:

Is the hospital in active status with the Ohio Secretary of State? ☐ Yes ☐ No

*** Attach Section 5 of the CMS 855(A) Form evidencing ownership information.**

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Section 4a

4. Classification

a. Indicate the type of organization responsible for establishing policy concerning overall operation of your hospital.

Government	Non-Government	This hospital is:

Government	Non-Government	This hospital is:
State County City City-County Hospital District or Authority Not Applicable	Corporation Limited Liability Company Partnership Sole Proprietor Other (specify by typing here) Not Applicable	For Profit Not For Profit

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Section 4b

b. Hospital System	
Is this hospital part of a multi-hospital system? ☐ Yes ☐ No	Name of System:

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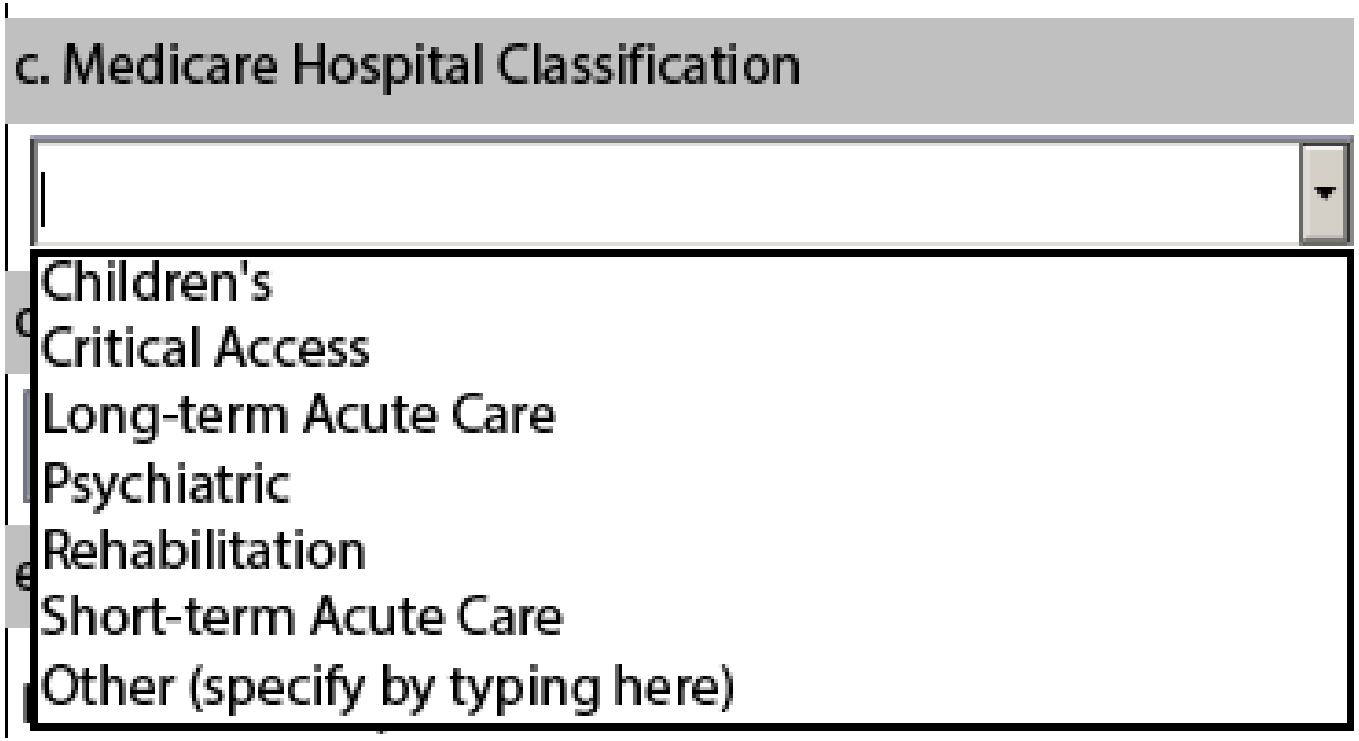
Section 4c



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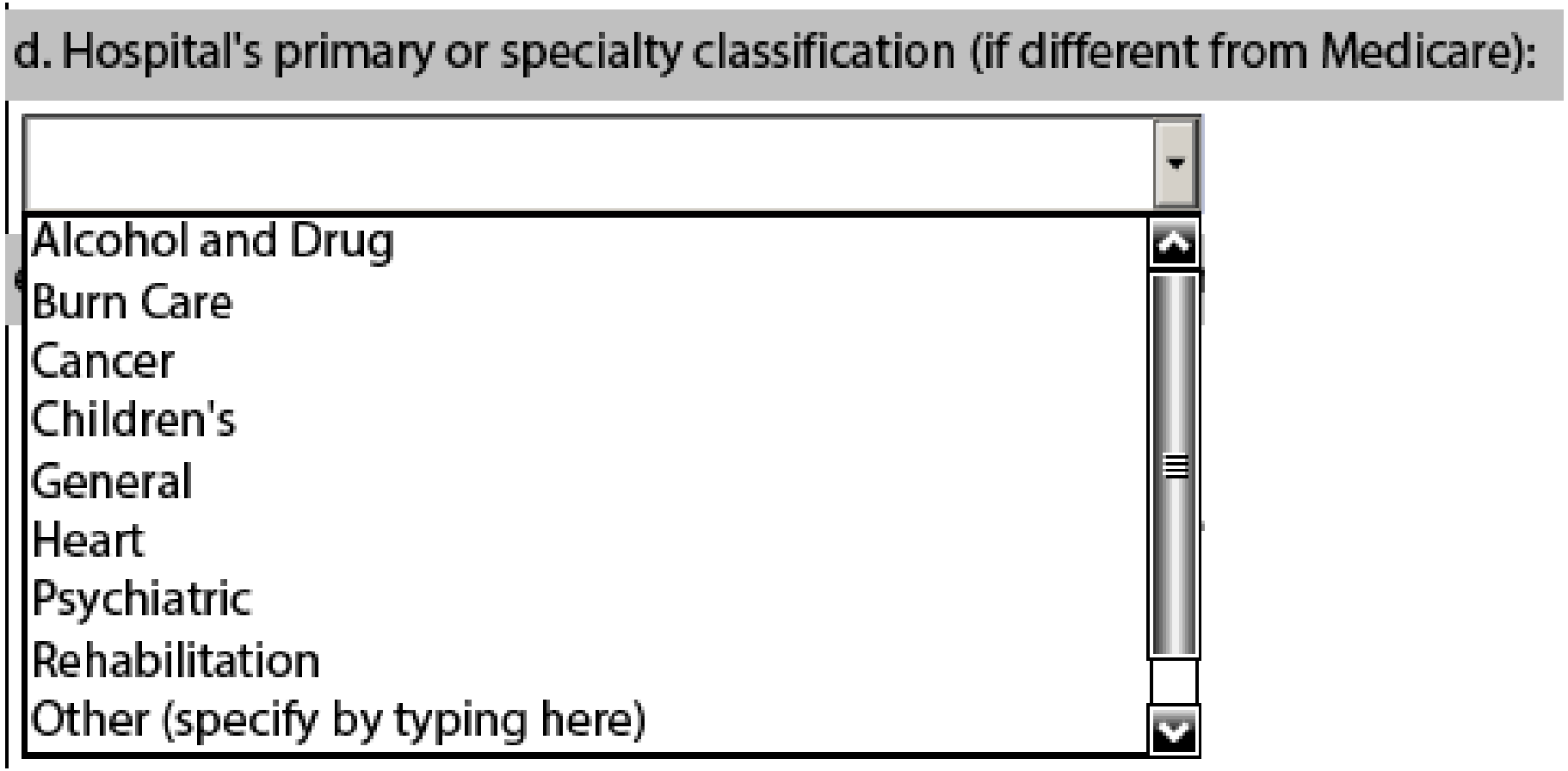
Section 4d



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Section 4e

e. Medicare identification number or state license number if entities below are contained within the main hospital system:	
Distinct-Part Psychiatric Unit:	
Ohio Department of Mental Health and Addiction Services (MHAS) License Number:	
Distinct-Part Rehabilitation Unit	
Transplant Center:	

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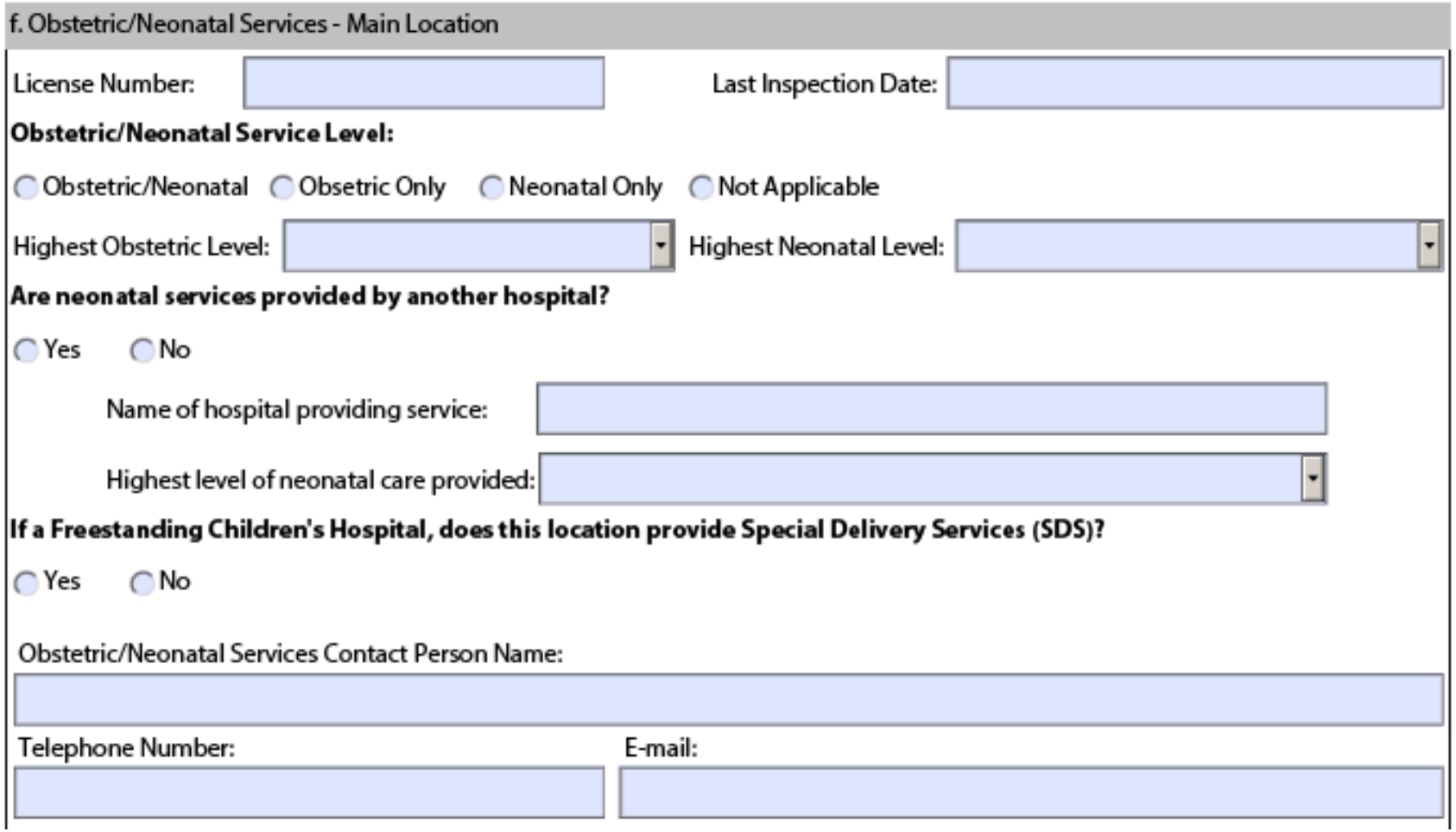
Section 4f


f. Obstetric/Neonatal Services - Main Location

License Number: Last Inspection Date:

Obstetric/Neonatal Service Level:

Obstetric/Neonatal Obsetric Only Neonatal Only Not Applicable

Highest Obstetric Level: Highest Neonatal Level:

Are neonatal services provided by another hospital?

Yes No

Name of hospital providing service:

Highest level of neonatal care provided:

If a Freestanding Children's Hospital, does this location provide Special Delivery Services (SDS)?

Yes No

Obstetric/Neonatal Services Contact Person Name:

Telephone Number: E-mail:

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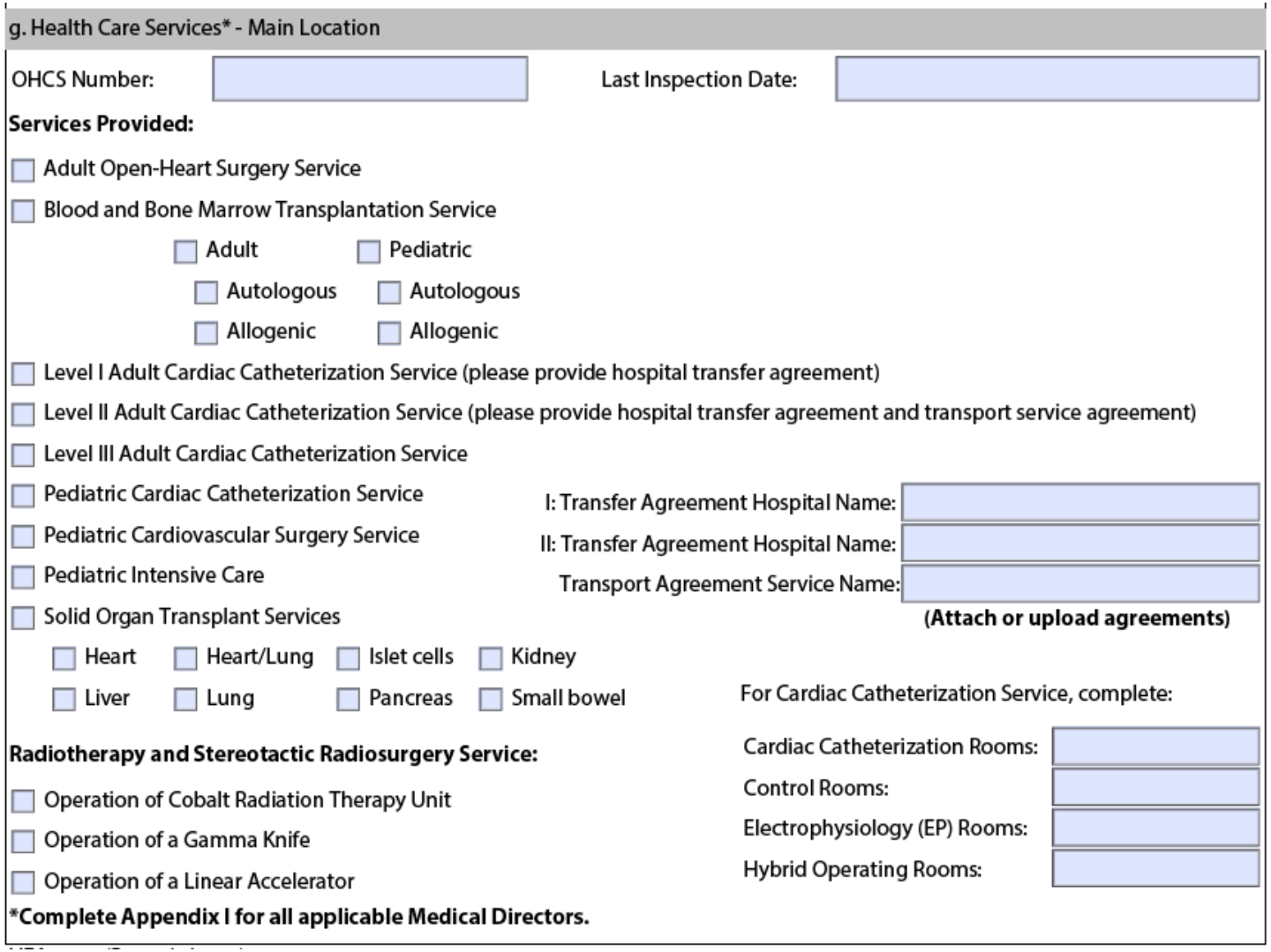
Section 4g



g. Health Care Services* - Main Location

OHCS Number: _____ Last Inspection Date: _____

Services Provided:

- ☐ Adult Open-Heart Surgery Service
- ☐ Blood and Bone Marrow Transplantation Service
  - ☐ Adult ☐ Pediatric
  - ☐ Autologous ☐ Autologous
  - ☐ Allogenic ☐ Allogenic
- ☐ Level I Adult Cardiac Catheterization Service (please provide hospital transfer agreement)
- ☐ Level II Adult Cardiac Catheterization Service (please provide hospital transfer agreement and transport service agreement)
- ☐ Level III Adult Cardiac Catheterization Service
- ☐ Pediatric Cardiac Catheterization Service
- ☐ Pediatric Cardiovascular Surgery Service
- ☐ Pediatric Intensive Care
- ☐ Solid Organ Transplant Services
  - ☐ Heart ☐ Heart/Lung ☐ Islet cells ☐ Kidney
  - ☐ Liver ☐ Lung ☐ Pancreas ☐ Small bowel

I: Transfer Agreement Hospital Name: _____

II: Transfer Agreement Hospital Name: _____

Transport Agreement Service Name: _____

(Attach or upload agreements)

For Cardiac Catheterization Service, complete:

Cardiac Catheterization Rooms: _____

Control Rooms: _____

Electrophysiology (EP) Rooms: _____

Hybrid Operating Rooms: _____

Radiotherapy and Stereotactic Radiosurgery Service:

- ☐ Operation of Cobalt Radiation Therapy Unit
- ☐ Operation of a Gamma Knife
- ☐ Operation of a Linear Accelerator

***Complete Appendix I for all applicable Medical Directors.**

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Section 4h

h. Other Services - Main Location		
Are any other services provided to patients by another hospital within this hospital?	◯ Yes ◯ No	
If yes,	Service(s) provided:	
	Providing hospital(s):	

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Section 5

5. Beds - Main Hospital	
Bed Category	**Current Number of Beds**
Adult Medical/Surgical	
Adult Special Care (ICU/CCU)	
Alcohol or Drug Abuse Rehabilitation	
Burn	
Emergency Service Beds*†	
Hospice	
LTAC - LTA less than 30 days stay	
Pediatric - General	
Pediatric Intensive Care (PICU)	
Physical Rehabilitation	
Psychiatric - Not Licensed by MHAS	
Psychiatric - MHAS Licensed*	
Any other inpatient bed not listed above	
Long Term Care	
Skilled Nursing Facility (SNF) - Not Licensed*	
Nursing Facility (NF) - Not Licensed*	
SNF/NF Not Licensed*	
Special Skilled (3702.521)*	

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Section 5 (cont.)

Obstetric/Neonatal	
Obstetric Capacity	
Level I	
Level II	
Level III	
Special Delivery Beds	
Level IV	
Special Delivery Beds	
Total Obstetric Capacity	
Neonatal Capacity	
Level I	
Well Baby Beds	
Level II	
Well Baby Beds	
Special Care Nursery Beds	
Level III	
Well Baby Beds	
Special Care Nursery Beds	
Neonatal Intensive Care Unit Beds	
Level IV	
Well Baby Beds	
Special Care Nursery Beds	
Neonatal Intensive Care Unit Beds	
Total Neonatal Capacity	
Total All Bed Categories*	

***Emergency Service Beds, Psychiatric - MHAS Licensed Beds, and Long Term Care Beds are not included in Total All Bed Categories Calculation.**
† How many total emergency service beds at the time of your licensure application.

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Bed Reporting Updates

Current Reported Maternity Bed Types	Hospital Licensure Application Obstetric/Neonatal Bed Types
OBSTETRIC	
Triage	Obstetric Level (I, II, or III) Capacity
Labor	Obstetric Level (I, II, or III) Capacity
Labor, delivery, Recovery	Obstetric Level (I, II, or III) Capacity
Labor, delivery, Recovery, Postpartum	Obstetric Level (I, II, or III) Capacity
Recovery	Obstetric Level (I, II, or III) Capacity
Postpartum	Obstetric Level (I, II, or III) Capacity
Antepartum	Obstetric Level (I, II, or III) Capacity
Special Delivery Services	Obstetric Level (III or IV) Special Delivery Bed Capacity
NEONATAL	
Rooming In	Well Baby Beds
Well Baby Nursery	Neonatal Level (I, II, III, or IV) Capacity
Holding Nursery	Well Baby Beds
Special Care Unit	Neonatal Level (II, III, or IV) Capacity
Neonatal Intensive Care Unit	Neonatal Level (III, or IV) Capacity

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Section 6

- Off campus location types to be captured in full on the expandable PDF section of the application are:
  - Remote locations.
  - Satellite.
  - Department(s) of a Provider.
  - Free-standing emergency departments.
  - Outpatient surgical service locations.

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Section 6 (cont.)

- Licensed ambulatory surgical facilities that submitted a provider-based entity statement with their previous ASF applications:
    - Become part of the hospital's license.
    - Provide information on these entities in Section 6 of hospital application.
- Once licensed, the hospital must surrender the ASF license(s).

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Section 6 (cont.)

- All other provider-based entities can be listed in a simple chart on the application or attached/uploaded on a separate list with your application.

- Definitions of these location types can be found defined at 42 Code of Federal Regulations 413.65.

    - https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-E/section-413.65

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Section 6 (cont.)

6. Provider-Based Locations:

Complete sections a. - d. for each provider-based location that falls into a location type listed below in 6. a. Select "Add Provider-Based Location" at the bottom of page 9 to add locations. All other reportable locations operated by the main hospital can be listed in section e. below.

a. Provider-Based Location Type:

◯ Remote Location ◯ Satellite ◯ Free-Standing ED ◯ Outpatient Surgical ◯ Department of a Provider

b. Provider-Based Location Information:

Name of Facility:	Medicare Name (Legal Name):	
Medicare Identification Number:	National Provider Identifier (Main Hospital NPI only):	
Telephone Number:	Annual Hospital Registration Number (if applicable):	
Facility Address:		
Facility Address Line 2:		
City:	State:	Zip Code:

Ohio Department of Health

Section 6 (cont.)

c. Services Provided - Provider-Based Location

Obstetric/Neonatal Services

License Number (if applicable): | Last Inspection Date:

Obstetric/Neonatal Service Level:

○ Obstetric/Neonatal ○ Obstetric Only ○ Neonatal Only ○ Not Applicable

Highest Obstetric Level: | Highest Neonatal Level:

Are neonatal services provided by another hospital?

○ Yes ○ No

Name of hospital providing service:

Highest level of neonatal care provided:

If a Children's hospital, does this location provide Special Delivery Services (SDS)?

○ Yes ○ No

Obstetric/Neonatal Services Contact Person Name:

Telephone Number: | Email:

Ohio Department of Health

Section 6 (cont.)

Health Care Services

OHCS Number: _____ Last Inspection Date: _____

Health Care Services Provided:

- ☐ Adult Open-Heart Surgery
- ☐ Blood and Bone Marrow Transplantation Service
  - ☐ Adult
    - ☐ Autologous
    - ☐ Allogenic
  - ☐ Pediatric
    - ☐ Autologous
    - ☐ Allogenic
- ☐ Level I Adult Cardiac Catheterization Service — I: Transfer Agreement Hospital Name: _____
- ☐ Level II Adult Cardiac Catheterization Service — II: Transfer Agreement Hospital Name: _____
- ☐ Level III Adult Cardiac Catheterization Service — Transport Agreement Service Name: _____
- ☐ Pediatric Cardiac Catheterization Service

(Attach or upload agreements)

- ☐ Pediatric Cardiovascular Surgery Service
- ☐ Pediatric Intensive Care
- ☐ Solid Organ Transplant Services
  - ☐ Islet cells
  - ☐ Heart
  - ☐ Pancreas
  - ☐ Liver
  - ☐ Kidney
  - ☐ Heart/Lung
  - ☐ Small bowel
  - ☐ Lung

For Cardiac Catheterization Service, complete:

Cardiac Catheterization Rooms: _____

Control Rooms: _____

Electrophysiology (EP) Rooms: _____

Hybrid Operating Rooms: _____

Radiotherapy and Stereotactic Radiosurgery Services

- ☐ Operation of a Cobalt Radiation Therapy Unit
- ☐ Operation of a Gamma Knife
- ☐ Operation of a Linear Accelerator

***Complete Appendix I for all applicable Medical Directors.**

Other Services

Are any other services provided to patients by another hospital within this hospital?

◯ Yes ◯ No

If yes,

Service(s) provided: _____

Providing hospital(s): _____

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Section 6 (cont.)

e. Other Provider-Based Locations:

This hospital has:

- ○ No other Provider-Based Locations
- ○ Other Provider-Based Locations that are listed in the table below
- ○ Other Provider-Based Locations that are listed on a separate and attached document

Facility Name	Facility Address	Facility Type	Add Row	Delete Row
			+	-

Alcohol and drug rehabilitation
Alcohol detoxification
Audiology
Consultation and education
CT
DEXA bone density
Diagnostic radiology
Family planning services
Family practice

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Section 7

7. Attestation of Compliance

Based on personal knowledge and belief, I attest to all of the following:

- ☐ I have submitted a complete application, which includes identifying the main hospital location and any location operated by the hospital pursuant to 42 C.F.R. 413.65 and will pay the fee specified in rules adopted under Section 3722.06 of the Ohio Revised Code;
- ☐ My hospital is certified under Title XVIII of the "Social Security Act," 42 U.S.C. 1395aa, or accredited by a national accrediting organization approved by the federal centers for Medicare and Medicaid services in accordance with 42 U.S.C. 1395bb(a), or, in the case of a new hospital, eligible under rules adopted under Section 3722.06 of the Ohio Revised Code;
- ☐ My hospital complies with standards established in rules adopted under section 3722.06 of the Revised Code.

Signature of Hospital Authorized Representative:	Date (mm/dd/yyyy)
Printed Name:	**Title:**

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Section 8

Bed Fee

Number of Beds	Fee
1 - 50	$4,425.00
51 - 100	$8,850.00
101 - 150	$13,250.00
151 - 300	$17,675.00
301 - 500	$26,500.00
501 - 750	$35,350.00
751 - 1000	$44,175.00
1001 - 1500	$53,000.00
1501+	$61,850.00

Service Fee

Service	Fee
Maternity Unit	$3,000.00
Newborn Care Nursery	$3,000.00
Health Care Service	$3,000.00

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Section 8 (cont.)

Total Beds at Main Hospital:	
Total Beds at Off-Campus Locations:	
Total Beds – All Locations:	
Bed Fee:	$0.00
Total Services at Main Hospital:	0
Total Services at Off-Campus Locations:	0
Total Services – All Locations:	0
Service Fee:	$0.00
Total License Fee:	$0.00
I am paying the hospital licensure fee:	○ In Full ○ In Thirds
Amount Due:	$0.00

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Appendix I

- Complete this table for each hospital facility, as indicated by Sections 4g and 6c.

- Provide the names of the Medical Director, Service Manager, and contact information for each healthcare service.

Hospital Name: ( ) Main Hospital ( ) Off-Campus

Health Care Service	Medical Director	Service Manager	Telephone Number	E-mail
Adult Cardiac Catheterization				
Adult Open-Heart Surgery				
Blood and Bone Marrow Transplantation				
Pediatric Cardiac Catheterization				
Pediatric Cardiovascular Surgery				
Pediatric Intensive Care				
Solid Organ Transplant (SOT)				
SOT: Heart				
SOT: Lung				
SOT: Heart/Lung				
SOT: Liver				
SOT: Islet cells				
SOT: Pancreas				
SOT: Kidney				
SOT: Small bowel				
Radiotherapy and Stereotactic Radiosurgery Rules				
Operation of a Gamma Knife				
Operation of a Linear Accelerator				
Operation of a Cobalt Radiation Therapy Unit				

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Appendix II

APPENDIX II

Index of Off-Campus Locations

Off-Campus Location Name	Street Address	# of Beds	# of Services	Page
			0	7

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Required Documents

- Copy of most recent accreditation survey.
    - If the hospital is Medicare-only certified, evidence of Medicare certification.
- Section 5 of the CMS 855(A) Form showing ownership information.
- Certificate of Occupancy (main hospital location).
- Current state fire marshal inspection report (main hospital location).

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Submit Fee

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Payment Options

- License fee is based on number of beds and services.
- Appropriate fee will be auto-calculated by the form.

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Submit Application and Required Documents

- Option 1
  (for faster processing)

  E-Form available on the ODH website.

- Option 2

  Ohio Department of Health
  Revenue Processing #1241
  PO Box 15278
  Columbus, OH 43215

Ohio Department of Health

Payment Options (cont.)

- The final fee can be paid in one sum or in thirds.
- If electing to pay in thirds (i.e., annual payments), the first of three payments is due with the application submission.
- Confirmation of the second and third payment amounts will be sent via an invoice from the ODH Licensure Section.
    - Ensure the licensure point of contact to receive an invoice has accurate contact information listed on the application.

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Additional Considerations

- Hospitals recently charged for a maternity licensure fee:
  - This will be considered in review of your application.
  - The ODH will be in communication if you are eligible for a reimbursement.

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Electronic Forms

Ohio Department of Health

Hospital License Application

Hospitals

WELCOME

IMPORTANT: After you click the Download button on this page, you must open the compressed file and save the PDF to your computer, in order to preview and complete the application.

Options for sending the completed initial hospital licensure application:

Option 1

If you wish to submit the completed application electronically and pay by credit card or electronic check, you may go to the Ohio Department of Health's Electronic Forms website. Select the "CertLicensure" tile and then the "Hospital Licensure Application" tile.

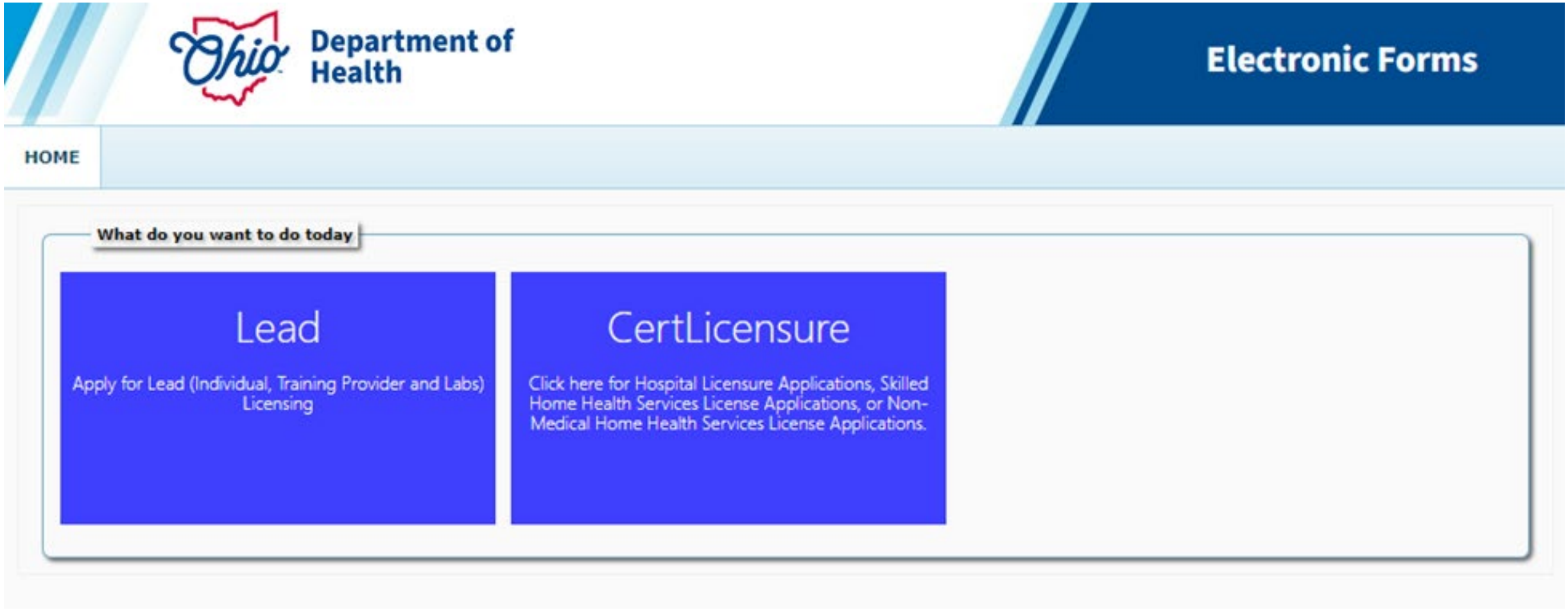
Once you have provided basic demographic information and uploaded your completed application, you can then complete your electronic payment.

Attachment

IMPORTANT: After you click the Download button, you must open the compressed file and save the PDF to your computer, in order to preview and complete the application.

DOWNLOAD

Share this



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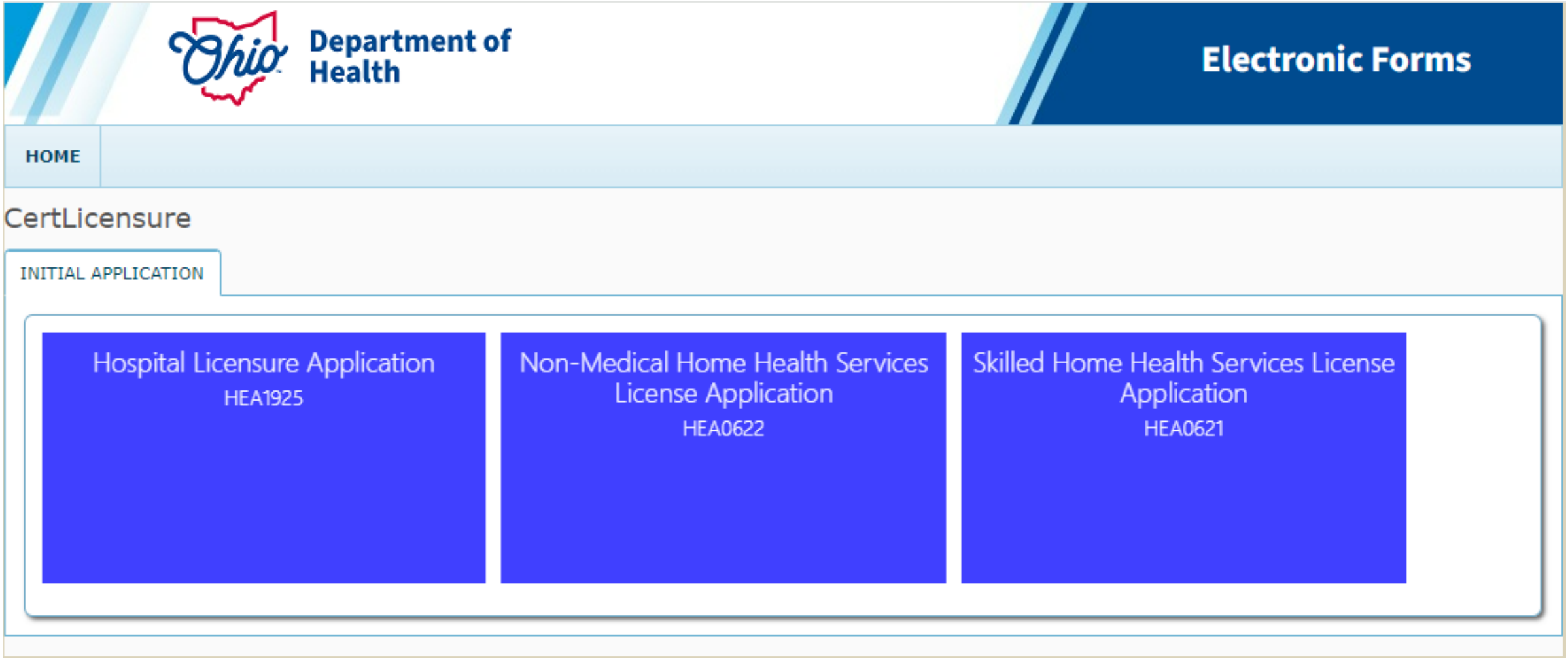

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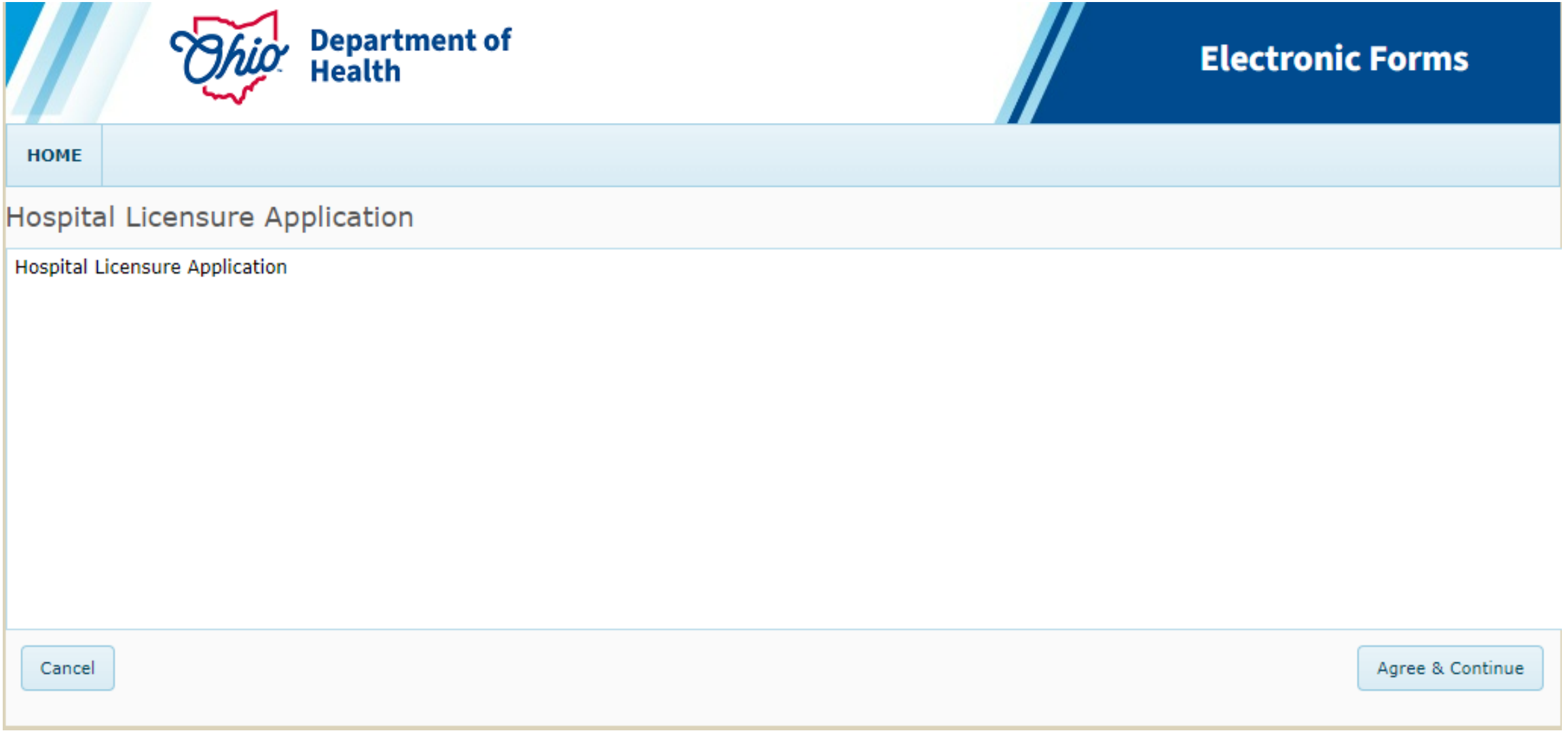

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Hospital Licensure Application

Add to Cart

General Information

APPLICATION

GENERAL INFORMATION

Ohio Department of Health
Initial Hospital License

General Information and Instructions
The Ohio Revised Code (ORC) requires each hospital operating in this state to be licensed by the director of health.
To be considered for an initial license, you must submit a completed application, applicable documents and an application fee in the amount specified based upon the completion of your application. Please obtain and fill out the pdf application for submission at our website:https://odh.ohio.gov/know-our-programs/hospitals/resources/hospitallicenseapplication. You may combine your pdf application and required documents into one pdf to upload within this electronic form. Otherwise, there are designated fields for applicable documents.

NOTE: If you choose to apply for initial licensure via the electronic forms route, please have your electronic payment ready upon submission of your application. Once your application is submitted, you have approximately 10 minutes to submit your payment or else your application process will time out, no longer allowing you to be able to submit payment.

Your **initial hospital licensure** application and the associated application fee can be submitted through:
1. This electronic forms route or;
2. By mail to:

Ohio Department of Health
Revenue Processing #1241
P.O. Box 15278
Columbus, OH 43215

The check or money order is made payable to **Treasurer, State of Ohio**

If you are applying for a **temporary hospital license** or applying for a **change of owner**, please submit the application by:
1. Email to:liccert@odh.ohio.gov or;
2. Mail to:

Ohio Department of Health
Bureau of Regulatory Operations
246 N. High St., 2nd Floor
Columbus, OH 43215-2412

Submission of an incomplete application may delay the processing of your application.

To obtain online information regarding the hospital licensure process, e.g. forms, rules (OAC and ORC), visit the Ohio Department of Health website at https://odh.ohio.gov/know-our-programs/hospitals.

Questions regarding the licensure process may be submitted by email to, liccert@odh.ohio.gov or by calling our office at (614) 466-7713.

HEA1925 06/2024

Save | Save & Continue

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Hospital Licensure Application

Add to Cart

General Information

APPLICATION

APPLICATION

Please enter the appropriate information in the boxes below. All fields with an "*" are required for the application to be processed.

Annual Hospital Registration (AHR) ID (if you do not have an AHR ID, please enter code 0000).

Annual Hospital Registration ID*	
Point of Contact for Licensure Communications*	
Point of Contact Email*	
Hospital Address*	
Hospital City*	
Hospital Zip Code*	
Hospital County*	

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Enter the application fee amount due noted at the bottom of Section 8 in your hospital licensure application. Use numbers only when entering the application fee amount.
Each file upload size limit is 10.24 MB. Accepted upload document types are '.gif', '.jpeg', '.jpg', '.png', '.pdf', '.doc', '.docx', '.zip', '.msg', '.bmp', '.tif'.

Application Fee*	
Upload Application PDF	Select file — Drop files here to upload
Upload CMS 855	Select file — Drop files here to upload
Upload Final Survey Report	Select file — Drop files here to upload
Upload Proof of Certification/Accreditation	Select file — Drop files here to upload
Upload State Fire Marshal Report	Select file — Drop files here to upload
Upload Other Document	Select file — Drop files here to upload

Save | Save & Add to Cart

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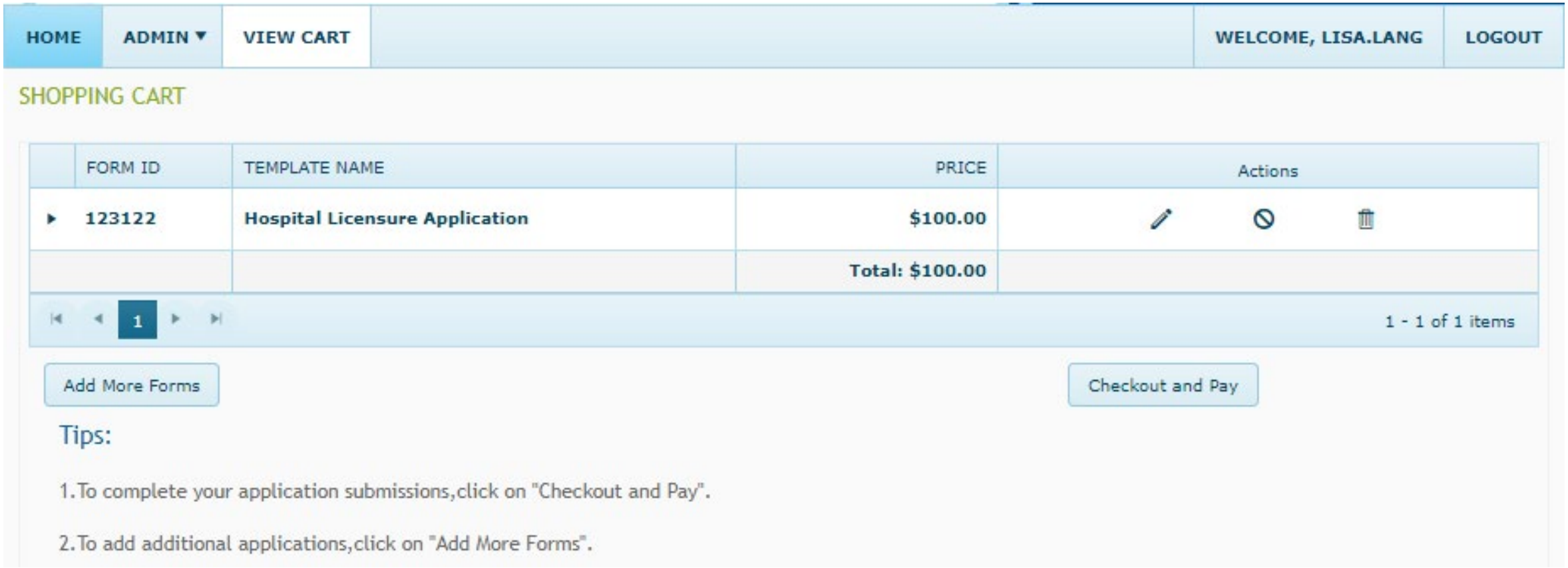
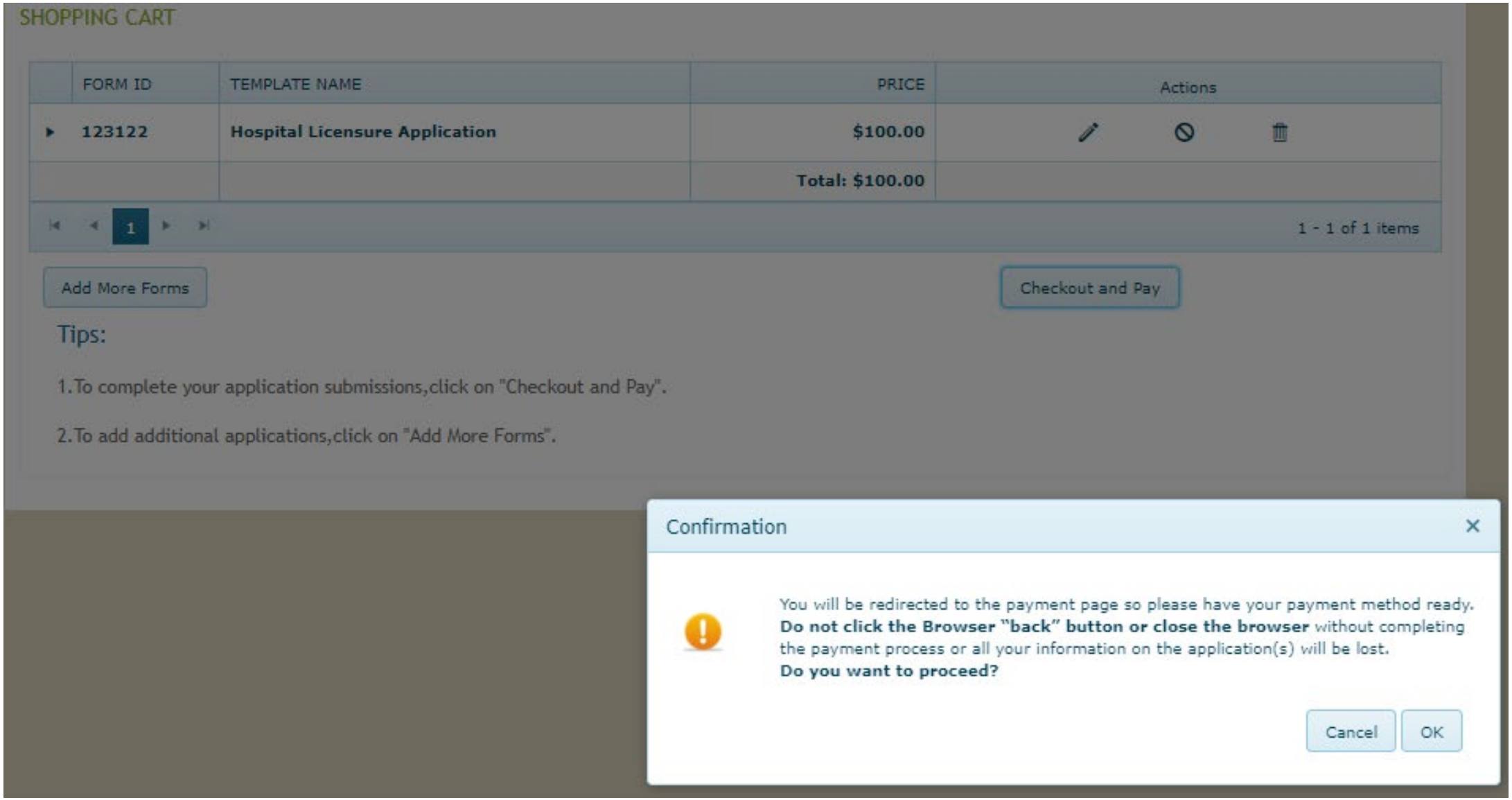


Department of Health



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Ohio | Department of Health

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Facility Payment Processing

Select Payment Method

Please select a payment method.

- ○ **Credit Card**
- ○ **Electronic Check**

Technical Support

If you need technical support for this online payment processing application, please send an email to ODHRevenue@odh.ohio.gov.

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Facility Payment Processing

Enter Payment Information

Please enter your credit card payment and billing information below. All of the fields marked with an asterisk are required.

For assistance locating the card security code, please select the following:

Locate Card Security Code

EIDC (BETA) Payment Summary

Total
$100.00

Payment Information

* Credit Card Number

* Credit Card Type

American Express
Discover
MasterCard
Visa

* Expiration Month

Card Security Code

Ohio Department of Health

Billing Information

First Name: Lisa

Middle Name:

* Last/Business Name: Lang

* Phone: 6146446220

* Address Line 1: 246 N High Street

Address Line 2:

* City: Columbus

* State/Province/Region: OH

* Zip/Postal Code: 43215

Country: United States

Email:

Email Receipt: ☐

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Technical Support

If you need technical support for this online payment processing application, please send an email to ODHRevenue@odh.ohio.gov.

Ohio Department of Health

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Facility Payment Processing

Confirm Payment Information

Please confirm that your credit card payment and billing information below is correct.

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Facility Payment Processing

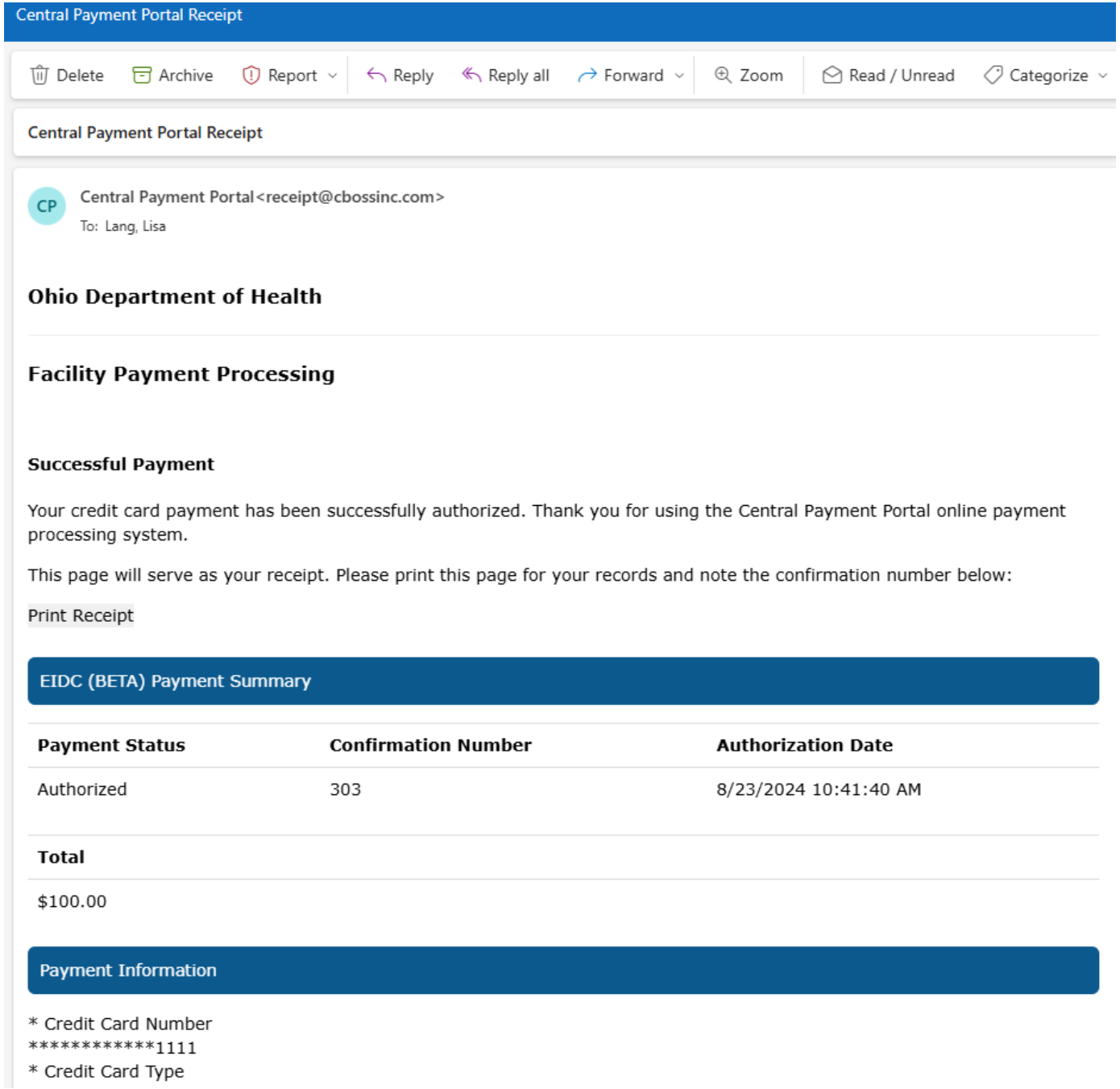
Successful Payment

Your credit card payment has been successfully authorized. Thank you for using the Central Payment Portal online payment processing system.

This page will serve as your receipt. Please print this page for your records and note the confirmation number below:

Print Receipt

Ohio Department of Health



Department of Health

From: LicCert@odh.ohio.gov <LicCert@odh.ohio.gov>
Sent: Thursday, August 22, 2024 12:03 PM
To:
Subject: 0000: ODH Confirmation of Application Submission

Dear Applicant,

Thank you for submitting your application and required documents to the Ohio Department of Health (ODH). Please understand that we will immediately begin processing your application, but due to the volume, and the amount of information that is required to be reviewed, please allow up to 90 days for processing. As we have your application, you can continue to provide services. If we need additional information, we will communicate with the responsible party listed on the application.

To view your application status, complete renewal of your license, and to receive communications from and provide information to the Ohio Department of Health, please sign up for an Enhanced Information Dissemination & Collection (EIDC) User Account here. As a hospital, please fill out all required fields and select the following:

1. Type of facility = Non Long-Term Care - Health Care Facility (HCF)
2. After the type of facility is selected, enter State ID = First four numerical digits of your Annual Hospital Registration (AHR) number.
3. Click the Search Facilities button. Select both your pending facility status (licensure) and active facility status (certification) hospital profiles and click Submit.

If you are applying for licensure and do not have an AHR number, you will be able to sign up for your EIDC User Account once you receive your license number.

As your application is being processed, you may also view your licensure status here, on our Health Care Provider Real-Time Information website. Please enter in the following information in the Health Care Provider Search:

1. Provider Type = Hospitals
2. Information Type = State of Ohio License
3. State ID = First four numerical digits of your AHR number

Please contact us at liccert@odh.ohio.gov if you have any questions.

Regards,
Licensing Unit
Bureau of Regulatory Operations

Ohio Department of Health

Receive License

Ohio Department of Health

Timeline

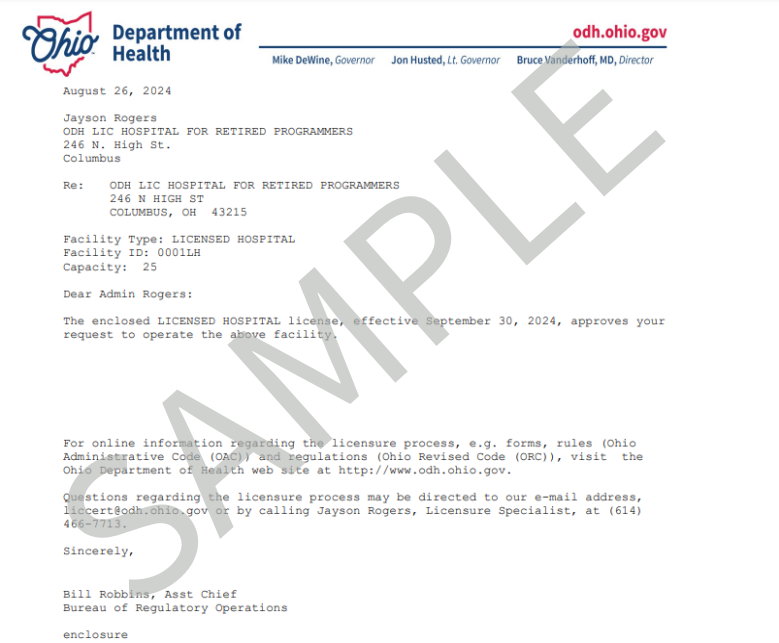
- Upon receipt of a complete application, required documents, and fee, Licensure Unit staff will review submission.

- Director of Health approves applications as recommended by Licensure Unit.

Department of Health

Timeline (cont.)

- Staff creates licensure packet, including certificate, for mailing.
  - Once mailed, expect receipt of packet within 10 – 14 days.



Department of Health

odh.ohio.gov

Mike DeWine, *Governor* Jon Husted, *Lt. Governor* Bruce Vanderhoff, MD, *Director*

August 26, 2024

Jayson Rogers
ODH LIC HOSPITAL FOR RETIRED PROGRAMMERS
246 N. High St.
Columbus

Re: ODH LIC HOSPITAL FOR RETIRED PROGRAMMERS
246 N HIGH ST
COLUMBUS, OH 43215

Facility Type: LICENSED HOSPITAL
Facility ID: 0001LH
Capacity: 25

Dear Admin Rogers:

The enclosed LICENSED HOSPITAL license, effective September 30, 2024, approves your request to operate the above facility.

For online information regarding the licensure process, e.g. forms, rules (Ohio Administrative Code (OAC)) and regulations (Ohio Revised Code (ORC)), visit the Ohio Department of Health web site at http://www.odh.ohio.gov.

Questions regarding the licensure process may be directed to our e-mail address, liccert@odh.ohio.gov or by calling Jayson Rogers, Licensure Specialist, at (614) 466-7715.

Sincerely,

Bill Robbins, Asst Chief
Bureau of Regulatory Operations

enclosure

SAMPLE

STATE OF OHIO
OHIO DEPARTMENT OF HEALTH

LICENSED HOSPITAL LICENSE

Hereby issued in accordance with Chapter 3722. of the Ohio Revised Code and Chapter 3701-20 of the Ohio Administrative Code to :

ODH LIC HOSPITAL FOR RETIRED PROGRAMMERS
246 N HIGH ST
COLUMBUS, OH

Facility ID #: **0001LH**

Effective Date: **September 13, 2024**

Expiration Date: **September 13, 2027**

In witness thereof

Bruce Vanderhoff, MD, MBA
Director of Health

This is a non-transferable license and must be posted in a conspicuous place in the facility.

SAMPLE

Department of Health

Your License

- Licenses are valid for 36 months.
- Details forthcoming related to other requests and applications.

Ohio Department of Health

Resources

Ohio Department of Health

Contact the Licensing and Certification Unit

- By phone, 8 a.m. to 5 p.m. daily:
  - 614-466-7713.
- By email:
  - LICCERT@odh.ohio.gov.
- Review our website's Hospital Licensure page:
  - https://odh.ohio.gov/know-our-programs/hospitals/hospitals

Ohio Department of Health

Ohio Laws and Administrative Rules

- Chapter 3722 of the Ohio Revised Code.
    - https://codes.ohio.gov/ohio-revised-code/chapter-3722
- The rules will be updated in the Ohio Administrative Code in advance of the law's effective date of September 30.

Ohio Department of Health

View Hospital Licensure Application Status

- Healthcare Provider Real-Time Information:
  - https://publicapps.odh.ohio.gov/eid/Provider_Search.aspx
- Healthcare Provider Online Business Processing – Enhanced Information Dissemination & Collection.
  - Apply for an EIDC account:
  - https://publicapps.odh.ohio.gov/EID/UserAccountRequest/UserAccountRequest.aspx?RequestType=EIDC

Ohio Department of Health

QUESTIONS?

ODH.OHIO.GOV

614-466-7713

LICCERT@odh.ohio.gov

Department of Health

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