Office of Health Assurance and Licensing

Health Care Facility
Initial License Application Instructions

General Information and Instructions

Section 3702.30 of the Revised Code (RC) and Chapter 3701-83 of the Ohio Administrative Code (OAC) require all health care facilities (HCFs) to be licensed, and also set forth the conditions for licensure. Rules 3701-83-01 through 3701-83-14 pertain to all HCFs; in addition, rules 3701-83-15 through 3701-83-22 pertain specifically to ambulatory surgical facilities (ASFs).

For timely processing, you should submit your application along with the fee and the required documents no more than six months (180 days) and no less than two months (60 days) before the projected opening date recorded on your application.

A check or money order, made payable to the Treasurer, State of Ohio in the amount of $300 must accompany your application.

Required Documents

The following documents must be submitted with your "Health Care Facility Licensure Application" and fee:

1. A copy of the Certificate of Occupancy Permit
2. 8 ½" x 11" schematic drawing (floor plan) of the facility that clearly shows the operating rooms and procedure rooms
3. A copy of a current State Fire Marshal Inspection report documenting the facility is in compliance with the state fire code
4. Transfer Agreement with a local hospital that specifies an effective procedure for the safe and immediate transfer of patients from the ASF to the hospital when care beyond the care that can be provided at the ASF is necessary, including when emergency situations occur or medical complications arise. This agreement must be updated every two years. A transfer agreement is not needed if the ASF is a provider based entity of a hospital.

Application Submission

Submit the completed application form, check or money order in the correct amount, and the required documents listed above to the following address:

Ohio Department of Health
Revenue Processing #3500
PO Box 15278
Columbus, Ohio 43215

If the application is incomplete or is not accompanied with the fee and required documents listed above, licensure approval may be delayed, your application may be returned

to you or your application may be denied. Deposit of your fee does not mean that your application has been accepted and/or declared complete.

Medicare and/or Medicaid Participation

An ambulatory surgical facility must be licensed before it can be certified to participate in the Medicare and/or Medicaid programs.

If you have any questions regarding your ambulatory surgical facility licensure application, please e-mail the Bureau of Regulatory Operations in the Office of Health Assurance and Licensing, Ohio Department of Health at liccert@odh.ohio.gov or call (614) 466-7713.

Health Care Facility Licensure Application

As defined in section 3702.30 of the ORC and 3701-83-04 of the OAC

ODH Use Only ID # OHL #

Print Legibly in Ink or Type

1. Application Type ☐ Initial ☐ Change of Ownership ☐ Initial/Replacing existing facility, ID#	2. Date of operation or projected opening date or date of change of ownership.

3. Licensure Type √ only one

☐ **Ambulatory surgical facility**	☐ **Freestanding dialysis center**
# of operating rooms ☐	# of hemodialysis stations ☐
# of procedure rooms ☐	# of peritoneal stations ☐
	# of training stations ☐
Is this facility located in a building that houses in-patient care? ☐ No ☐ Yes	
☐ **Freestanding inpatient rehabilitation facility**	☐ **Freestanding birthing center**
# of patient care beds ☐	# of birthing rooms ☐

4. Facility name (DBA)		Telephone number
6. Previous facility name, if applicable		
7. Address		
City	Zip	County
8. E-mail address		

9. Mailing address, if different from above

Name		
Address		
City	State	Zip

10. Days and hours of operation for this facility

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M.							
P.M.							

11. Is this health care facility accredited or certified? ☐ No ☐ Yes If yes, type If yes, enclose a copy the current accreditation inspection report with this application.

12. This business is a/an ☐Individual ☐Partnership ☐Limited Liability Company ☐Corporation ☐Association ☐Other:

Individual owner: Skip questions 19 through 29 **only**.

More than one owner, partnership, corporation, limited liability company or association, skip questions 13 through 18 **only**.

13. Owner's name		
14. Address		
City	State	Zip
15. Phone number	16. Owner's occupation	

17. Owner's business address, if different from question #7

Address			
City	State	Zip	18. Phone number

Multiple Owners, Partnership, Limited Liability Company, Corporation, Association, Other

19. Business entity name (Legal name as registered with the Secretary of State)			
20. Address			
City	State	Zip	21. Phone number
22. Business Activity			
23. This business is a ☐ For profit ☐ Not for Profit ☐ Government	24. Date of incorporated or registration	25. Charter/registration number	

26. List the **name of each person** who has an ownership interest of 5% or more in the business (attach additional sheets if necessary).

Name	Name
Name	Name
Name	Name

27. Officers names, titles, addresses and phone numbers

Title	Name	Address	Phone Number

28. Statutory agent's name (As Registered with the Secretary of State)	Address	Phone Number

29. If state agency or local government, the name, address and phone number of individual authorized to enter into agreement on behalf of state agency or local government. ☐ **Not Applicable**

Name	Address	Phone Number

30. On-site administrator's name	
31. Medical director's name or individual responsible for the provision of health care services	32. License/Certification #

33. Has the new owner(s), administrator or medical director been affiliated through ownership or employment with any of the facilities listed in rule 3701-83-04(A)(1)(c) of the OAC within five years prior to the date of this application?

☐ No ☐ Yes *If "yes", provide in writing the individual's name(s) and address(es) of the facilities.*

34. Has the owner(s), administrator or medical director been convicted of any criminal conviction, civil judgment or administrative adjudication related to the provision of care or bearing a direct or substantial relationship to the job responsibilities he/she is to carry out?

☐ No ☐ Yes *If "yes", provide in writing the individual's name, full explanation stating the charge(s), date(s) and disposition(s).*

I affirm that to the best of my knowledge and belief, the answers provided herein and all accompanying materials are true and correct. I understand that section 3702.30 of the Ohio Revised Code and paragraph (E) of rule 3701-83-04 of the Ohio Administrative Code require the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership set forth in the initial application and any change in accreditation status, no later than 30 days after the occurrence of the change. ☐ Affirm

Any owner named herein may sign the application. That owner's name must appear in question #13 or #26. If the signatory is not an owner, attach a notarized affidavit that the individual is the authorized representative of the owner.

Print/Type owner's/representative's name & title	Signature	Date
Print/Type administrator's name	Signature	Date
Print/Type medical director's name	Signature	Date