Ohio Department of Health

Health Care Facility

Ambulatory Surgical Facility, Freestanding Dialysis Center, Freestanding Birthing Center, Freestanding Inpatient Rehabilitation Facility

Initial Application

General Information and Instructions

The Ohio Administrative Code requires all health care facilities (HCF) to be licensed. There are six types of health care facilities: ambulatory surgical facilities; freestanding dialysis centers; freestanding inpatient rehabilitation facilities; freestanding birthing centers; freestanding radiation therapy centers and freestanding or mobile diagnostic imaging centers.

You may visit our website at www.odh.ohio.gov to review and print rules 3701-83-01 through 3701-83-14 and:

Ambulatory Surgical Facilities	3701-83-15 to 3701-83-22
Freestanding Dialysis Centers	3701-83-23 to 3701-83-24
Freestanding Inpatient Rehabilitation Facilities	3701-83-25 to 3701-83-32
Freestanding Birthing Centers	3701-83-33 to 3701-83-42

You may also obtain the licensure application from our website, titled Health Care Facility Licensure Application. To be considered for licensure, you must submit a completed application and an application fee of $300.00 and mailed to the address below. The check or money order is made payable to **Treasurer, State of Ohio #3500**. A complete application includes the submission of a copy of the following documents pertaining to the facility: Use and Occupancy Permit; floor plan; and State Fire Marshal's report.

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

If your fire inspection has not been conducted by the State Fire Marshal, our office will submit the necessary documents to the State Fire Marshal's office requesting an inspection.

Submission of an incomplete application, may delay the processing of your application. Please be advised that Ohio Administrative Code rule 3701-83-06 provides for an inspection fee of $1750.00.

To obtain 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 our office at (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 #

Please Print Legibly in Ink or Type

1. Application Type ☐ Initial ☐ Change of Ownership	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 _____
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			
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	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.

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