LOUISIANA DEPARTMENT OF HEALTH

Health Standards Section
License Application
AMBULATORY SURGICAL CENTER

☐ *INITIAL* ☐ *RENEWAL* ☐ *OTHER* (Specify)_____

*LICENSE NUMBER*_____ *EXPIRATION DATE of current license* _____

**Check & Payment Transmittal Form Must be submitted to DHH Licensing Payments, P.O. Box 734350, Dallas, Texas75373-4350*

CHECK / MONEY ORDER # _____

☐ *check if any change has occurred since last application*

STATE ID# AS_____ ***NPI#***_____

I. *FACILITY (DBA) NAME* _____

GEOGRAPHICAL ADDRESS _____

*CITY / STATE / ZIP*_____*Parish:*_____

*TELEPHONE NUMBER (____)*_____ *FAX NUMBER (____)*_____*email*_____

II. *MAILING ADDRESS (IF DIFFERENT FROM ABOVE)* _____

CITY / STATE / ZIP _____

III. *ADMINISTRATOR :*_____ *DIRECTOR OF NURSING:* _____

*ADMINISTRATOR EMAIL:*_____ *DIRECTOR OF NURSING EMAIL:* _____

IF HSS was not notified, you must submit a Key Personnel Change Form if positions changed in the last year by visiting our website at http://ldh.la.gov/index.cfm/page/2988)

IV. *LOCATION:* ☐ *HOSPITAL BASED* ☐ *FREE STANDING*

V. *TYPE OF OWNERSHIP:*

NON- PROFIT	*FOR – PROFIT*	*GOVERNMENT*
☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *FEDERAL* ☐ *HOSPITAL DISTRICT*
☐ *CORPORATION*	☐ *CORPORATION*	☐ *STATE* ☐ *OTHER*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*	☐ *PARISH*
*(Specify):*_____	☐ *GROUP PRACTICE*	☐ *CITY/PARISH*
☐ *RELIGIOUS AFFILIATION*	☐ *OTHER (Specify): (i.e. LLC)*	☐ *CITY*
☐ *UNINCORPORATED ASSOCIATION*	_____	☐ *COMBINATION GOV-N-PROFIT*
☐ *OTHER (Specify):* _____		

VI. *ENTITY / CORPORATION / LEGAL NAME* _____

MAILING ADDRESS (IF DIFFERENT) _____

CITY / STATE / ZIP _____

*TELEPHONE NUMBER (____)*_____*FAX NUMBER (____)*_____*EIN#*_____

VII. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ *Yes* ☐ *No*
(Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and facility provider numbers.

NAME	*ADDRESS*	*PROVIDER NUMBER*

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225-342-0138 • http://ldh.la.gov

VIII. Has there been a change of ownership or control within the last year? ☐ *Yes* ☐ *No*
If yes, give date._____HSS must be notified in writing of all Changes of Ownership

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IX. PROGRAM OPERATIONAL INFORMATION:

ACCREDITATION: ☐ *YES* ☐ *NO* *SPECIFY:* ☐ *AAAHC* ☐ *JCAHO* ☐ *AAASF*
Must submit a copy of the accreditation letter to HSS *Deemed Status:_____Yes _____No*

FISCAL YEAR END DATE_____ *FISCAL INTERMEDIARY_____*

☐ *Check if any change has occurred since last application*

X. SERVICES PROVIDED:

☐ *CARDIOVASCULAR*	☐ *OPHTHALMOLOGY*	☐ *THORACIC*
☐ *FOOT*	☐ *ORAL*	☐ *UROLOGY*
☐ *GENERAL*	☐ *ORTHOPEDIC*	☐ *OTHER (Specify)* _____
☐ *NEUROLOGICAL*	☐ *OTOLARYNGOLOGY*	_____
☐ *OBSTETRICS / GYNECOLOGY*	☐ *PLASTIC*	

☐ *Check if any change has occurred since last application. If additions to services have occurred, written notification must be made.*

XI. OPERATION:

DAYS OF OPERATION: _____ *HOURS OF OPERATION:* _____
NUMBER OF OPERATING ROOMS: _____ *NUMBER OF PROCEDURE ROOMS:* _____

ATTESTATION: I certify that I have reviewed the Ambulatory Surgical Center (ASC) licensing requirements. I certify that the above referenced ASC meets and will continue to meet all applicable requirements for ASCs set forth in the State of Louisiana Rules, Regulations and Minimum Standards (LAC 48:I, Chapter 45), all applicable Conditions of Coverage set forth in the Code of Federal Regulations, and all applicable requirements of the Office of State Fire Marshall and Office of Public Health. I agree that if the ASC fails to meet any of these requirements, I will notify the Health Standards Section of the Louisiana Department of Health of the changes immediately in order to permit a valid determination of the ASC's compliance with the aforementioned regulations and requirements. I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership, change of location, or cessation of business. It is my responsibility to notify the Health Standards Section of the Louisianan Department of Health in writing of any changes in the information provided in this application. Documentation of the information above is available upon request by the Louisiana Department of Health and/or the Centers for Medicare and Medicaid Services (CMS). I understand that the Health Standards Section of the Louisiana Department of Health and/or the Centers for Medicare and Medicaid Services (CMS) has the right to conduct an on-site survey at any time to validate whether the information provided is true. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge.

EMERGENCY PREPAREDNESS ATTESTATION: I certify that I am in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules and regulations concerning emergency preparedness.

_____
AUTHORIZED REPRESENTATIVE NAME
(TYPED OR PRINTED)

_____ _____
AUTHORIZED REPRESENTATIVE SIGNATURE *DATE*

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