|  |
| --- |
| **Section 1: Licensing Action (Must Be Completed)** |
| **[ ]  Offsite Addition** | **[ ]  Offsite Relocation** |
| **[ ]  Offsite Outpatient only ED Addition** | **[ ]  Offsite RHC Addition** |

|  |
| --- |
| **Section 2: Hospital Information (Must Be Completed)** |
| **Main Campus License #**      | **State ID:H0000**       |
| **Facility(Main Campus DBA) Name and Geographical Address:**       |
| **Fiscal Intermediary:**       | **Fiscal Year End:**       |
| **Accrediting Body:**       | **Accreditation Exp:**       |

|  |
| --- |
| **Section 3: Type of Facility (Must Be Completed)** |
| **[ ]  Acute Care Hospital** | **[ ]  Long Term Acute Care Hospital** | **[ ]  Critical Access Hospital** |
| **[ ]  Psychiatric Hospital** | **[ ]  Rehabilitation Hospital** | **[ ]  Children’s Hospital** |

|  |
| --- |
| **Section 4: Administration (Must Be Completed)** |
| **Administrator** | **Designated Contact Person** |
| **Name:**       | **Name:**       |
| **Phone:**       | **Phone:**       |
| **Email:**       | **Email:**       |

|  |
| --- |
| **Section 5: Offsite Contact Information (Complete only if adding a new offsite- [ ]  Not applicable)** |
| Offsite Campus Name: |        |
| Offsite Campus Address: |        |
| Offsite Campus Parish: |        |
| Offsite Campus Phone Number: |        |
| Offsite Campus Fax Number: |        |

|  |
| --- |
| **Section 6: Offsite Relocation Contact Information (Complete only if relocating an offsite- [ ]  Not applicable)** |
| Offsite Campus Name **(before relocation)**: |        |
| Offsite Campus License # **(before relocation**):  |       |
| Offsite Campus Address **(before relocation)**: |        |
| Offsite Campus Name **(after relocation)**: |        |
| Offsite Campus Address **(after relocation)**: |        |
| Offsite Campus Parish **(after relocation):** |        |
| Offsite Campus Phone Number (**after relocation**): |        |
| Offsite Campus Fax Number **(after relocation):**: |        |

|  |
| --- |
| **Section 7: Payment Information (Must Be Completed if there is a Fee Associated with This Action** |
| Check or Money Order Number:       Check Amount:       |
| **[ ]** Mail Payment & Payment Transmittal Form To | **[ ]** Email License Application To |
| DHH Licensing FeePO Box 62949New Orleans, LA 70162-2949 | HSS-Hospitals@la.gov |

Name of Hospital:

|  |
| --- |
| **Section 8: Offsite Description (Must Be Completed)** |
| 1. Occupancy: **[ ]** Single Occupancy **[ ]**  Multi Occupancy
 |
| 1. If multi occupancy, describe the other occupants or tenants in the building.

       |
| 1. Floors: **[ ]** Single Floor **[ ]**  Multi Floor
2. If multi floors, how many floors:
3. If multi floors, number of floors occupied by the offsite campus:
4. If multi floors, are you licensing the entire floor for certain suites/rooms?
 |

|  |
| --- |
| **Section 9: Offsite Criteria (Must Be Completed)** |
| Ownership and Control | All components subject to the control of and direction of one common owner and the governance. (e.g. common bylaws operating decisions and personnel actions). The ownership structure of the offsite campus is exactly the same as the hospital ownership structure. | **[ ]  Yes** | **[ ]  No** |
| Chief Medical Officer | A single Chief Medical Officer who maintains a day-to-day reporting relationship directly to the governing body and who is responsible for all medical staff activity for all components of the hospital. | **[ ]  Yes** | **[ ]  No** |
| Total Integrated Medical Staff | Total integration of the organized medical staff as evidenced by:1. All medical staff members have privileges at all components of the hospital.
2. All medical staff committees are responsible for their respective areas of responsibility at all components of the hospital.
 | **[ ]  Yes** | **[ ]  No** |
| Chief Executive Officer | There is a single chief executive officer whom all administrative authority flows and who exercises direct control and surveillance on a day-to-day basis over all administrative activities of all components.  | **[ ]  Yes** | **[ ]  No** |
| Tax ID Number | Does this location function under the same tax ID number as the main campus? What is the tax ID #:       | **[ ]  Yes** | **[ ]  No** |
| Recognition  | Will the off-site campus be held out to the public as part of the main campus hospital so that patients recognize what hospital they are entering and being billed for? | **[ ]  Yes** | **[ ]  No** |

|  |
| --- |
| **Section 10: Offsite Questionnaire (Must Be Completed)** |
| 1. Is this offsite campus located within a 35 mile radius of the main campus? **Please attach a map showing the distance.**
 | **[ ]  Yes** | **[ ]  No** |
| 1. If your hospital is Critical Access Hospital, is this offsite campus at least 35 miles away from another hospital’s campus? (Offsite RHCs are exempt from this requirement) **[ ]  N/A**
 | **[ ]  Yes** | **[ ]  No** |
| 1. Is this offsite co-located on the campus or in the building of another hospital?

 If yes, list the name of the hospital:       | **[ ]  Yes** | **[ ]  No** |
| 1. Do any of the below bullet points apply to this project? Changes to inpatient beds, nurseries, or NICU
* Changes inclusive of, but not limited to inpatient and outpatient surgical services, labor delivery services, bronchoscopy, endoscopy, heart cath units, pre-operative services, post-operative services or intra-operative services.
* Changes to sterile processing physical environment
* Changes to psychological/behavioral health services physical environment
* Changes to the ED services functional program and/or physical environment
* Imaging centers that provide linear acceleration and proton beam therapy (if licensed to a hospital)
 | **[ ]  Yes** | **[ ]  No** |
| 1. Will this offsite location have inpatient beds?
 | **[ ]  Yes** | **[ ]  No** |

Name of Hospital:

|  |  |
| --- | --- |
| 1. If you answered yes to either question #4 or #5, please provide the Health Facility Plan Review project number. For information on this plan review, please visit our website at: <http://dhh.louisiana.gov/index.cfm/directory/detail/740>.

In order for your packet to be reviewed, your plan review must be released for our review on the Office of State Fire Marshal (OSFM) IMS website. To release the plan review for our review, you will need our first name, last name and login. **HSSHospitals** should be entered in each of these fields.Ensure your plan review includes a site map showing all buildings demarcated, a floor map with the area boundaries demarcated, floor plan with all rooms identified by purpose or patient room number and floor plans showing what the area looked like before the change. \*Please note if plan review was required, submit the plan review attestation with this packet\*. | **DH-**     **-**     **DH-**     **-**     **DH-**     **-**     **[ ]  Not applicable.** |
| 1. Please provide the OSFM Plan Review for the Life Safety/Occupancy Approval. The OSFM can exempt you from this review. If exempt, please provide the documentation showing the exemption. For information on this plan review, please visit our website at: <http://dhh.louisiana.gov/index.cfm/directory/detail/740>.

In order for your packet to be reviewed, your plan review must be released for our review on the Office of State Fire Marshal (OSFM) IMS website. To release the plan review for our review, you will need our first name, last name and login. **HSSHospitals** should be entered in each of these fields.  | **AR-**     **-**     **AR-**     **-**     **AR-**     **-**     **[ ]  Exempt.** |
| 1. Describe the Inpatient Services that will be provided:

      **[ ]  Not applicable-this offsite will not provide inpatient services.** |
| 1. Describe the Outpatient Services that will be provided:

       **[ ]  Not applicable-this offsite will not provide outpatient services.** |
| 1. What arrangements will be made for patients requiring emergency services? (Please do NOT provide an answer such as “call 911” or “transport to nearest emergency room”. You must briefly explain how your policies/procedures will be followed to provide initial care and treatment to persons experiencing emergencies).

       |
| 1. In an emergency situation, will the patient be sent to the main campus of the hospital?

(If the answer is no, where will the patient be sent)       |

|  |
| --- |
| **Section 11a: Rooms/Beds Counted As Licensed Rooms/Beds ([ ]  Not applicable)** |
| **[ ]** Included HSS-HO-016a Worksheet for Hospital Beds & Rooms  |

|  |
| --- |
| **Section 11b: Rooms/Beds Not Counted As Licensed Rooms/Beds ([ ]  Not applicable)** |
| **[ ]** Included HSS-HO-016b Worksheet for Hospital Beds & Rooms |

|  |
| --- |
| **Section 12: Adding an Offsite Emergency Department ([ ]  Not applicable)** |
| I have reviewed the CMS Survey and Cert Letter 08-08 and I comply with all of the CoPs in that letter. **[ ]  Yes [ ]  No** |

Name of Hospital:

|  |
| --- |
| **Section 13: Attestation & Signature** |
| I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership or change in geographical address. It is my responsibility to notify the Louisiana Department of Health, Health Standards Section, in writing of any changes in the information provided in this application in a separate packet. I attest that the Hospital currently complies with the requirements of the Office of State Fire Marshal, Office of Public Health and building codes. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Louisiana Department of Health. |
| **Authorized Representative’s Printed Name & Title:**       |
| **Authorized Representative’s Signature:**       | **Date:**       |

|  |
| --- |
| **Section 14: Required Licensing Information to Attach to this Application**Please attach all items denoted by “X” below for the type of application you are submitting. Please don’t attach extraneous information or information not requested for your licensing action. |
| **Item** | **Offsite Addition** | **Offsite Relocation** | **Offsite Outpatient Only ED** | **Offsite RHC** |
| 1. **HSS-HO-55 Offsite Addition Application**
 | X | X | X | X |
| 1. **DH Plan Review Released to HSS**
 | X | X | X | X |
| 1. **DH Plan Review Attestation**
 | X | X | X | X |
| 1. **OSFM Life Safety Plan Review Released to HSS or Exemption Received**
 | X | X | X | X |
| 1. **OSFM Walk Through Inspection showing the dba name of the offsite and geographical address**
 | X | X | X | X |
| 1. **OPH Walk Through Inspection showing the dba name of the offsite and geographical address**
 | X | X | X | X |
| 1. **OPH Retail Food Permit showing the dba name of the offsite and geographical address**
 | X | X | X |  |
| 1. **Map showing distance from main campus to offsite location**
 | X | X | X | X |
| 1. **HSS-HO-016a Worksheet for Hospital Beds & Rooms**
 | X | X |  |  |
| 1. **HSS-HO-016b Worksheet for Hospital Beds & Rooms**
 | X | X | X |  |
| 1. **Return original license**
 |  | X |  |  |
| 1. **If DH plan review is not required, provide a copy of a site map, floor map and floor plans**
 | X | X | X | X |
| 1. **Please refer to our website for federal documents that are required in order to process this application.**
 | X | X | X | X |
| 1. **HSS-HO-017c or HSS-HO-017d**
 |  |  |  | X |
| 1. **Offsite RHC HSS-HO-017e supplement**
 |  |  |  | X |
| 1. **Site Verification from the Bureau of Primary Care & Rural Health**
 |  |  |  | X |