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| **Section 1: Licensing Action (Must Be Completed)** |
| **[ ]  Service Action at the Main Campus** | **[ ]**  |
| **[ ]  Service Action at Offsite Campus** | **[ ]**  |

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| **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:**  |

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| **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** |

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

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| **Section 5: Offsite Contact Information (Complete only if service action is at offsite- [ ]  Not applicable)** |
| Offsite Campus Name: |   |
| Offsite Campus Address: |   |
| Offsite Campus Parish: |   |
| Offsite Campus Phone Number: |   |
| Offsite Campus Fax Number: |   |

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| **Section 6: 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 |
| LDH Licensing FeePO Box 734350Dallas, TX 75373-4350 | HSS-Hospitals@la.gov |

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| **Section 7: Service Action Questionnaire (Must Be Completed)** |
| 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** |

Name of Hospital:

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| 1. If you answered yes to question #1, 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 in detail what the service action is that is occurring and how the area is being changed by either function, service type or structure:

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| 1. Please check any of the areas below that will be impacted by this service action:

**[ ]** Inpatient rooms/beds[ ]  Outpatient Services[ ]  Surgical Services[ ]  Special Procedures[ ]  Radiology/Imaging[ ]  Laboratory [ ]  Emergency Services [ ]  Psychiatric Services[ ]  Sterile ProcessingIf you checked yes to any of the areas above, please explain how these areas will be impacted by this service action:  |
| 1. Will this service be known by any name other than the licensed DBA name of the hospital and if so, what name:

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| 1. If you answered yes, this area will be known by another name in #5, a CMS 855A will be required:

 **[ ]  855A included in packet submission** **[ ]  855A not required** |
| 1. What is the address where the service action will occur?
 |
| 1. In #7, if the address is different from the address of the main campus or offsite location, a CMS 855A will be required:

 **[ ]  855A included in packet submission** **[ ]  855A not required**  |
| 1. Is this area located inside another licensed health care facility?

**[ ]  Yes Name of Facility:** **[ ]  No**  |

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| **Section 8a: Rooms/Beds Counted As Licensed Rooms/Beds ([ ]  Not Applicable)** |
| **[ ]** Included HSS-HO-016a Worksheet for Hospital Beds & Rooms |

Name of Hospital:

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| **Section 8b: Rooms/Beds Not Counted As Licensed Rooms/Beds ([ ]  Not Applicable)** |
| **[ ]** Included HSS-HO-016b Worksheet for Hospital Beds & Rooms |

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| **Section 9: Attestation & Signature (Must Be Completed)** |
| 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:** |

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| **Section 9: 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** | **Service Action at Main Campus-No Plan Review** | **Service Action at Main Campus-Plan Review Required** | **Service Action at Offsite Location-No Plan Review** | **Service Action at Offsite Location- Plan Review Required** |
| 1. **HSS-HO-56 Service Action Application**
 | X | X | X | X |
| 1. **DH Plan Review Released to HSS**
 |  | X |  | X |
| 1. **DH Plan Review Attestation**
 |  | 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 hospital and geographical address**
 | X | X | X | X |
| 1. **OPH Walk Through Inspection showing the dba name of the hospital and geographical address**
 | X | X | X | X |
| 1. **OPH Retail Food Permit showing the dba name of the hospital and geographical address**
 | X | X | X |  |
| 1. **HSS-HO-016a Worksheet for Hospital Beds & Rooms**
 | X | X | X | X |
| 1. **HSS-HO-016b Worksheet for Hospital Beds & Rooms**
 | 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 |