

## HEALTHCARE FACILITY LICENSE APPLICATION

FOR DEPARTMENTAL USE ONLY				
Fee Paid		Old #		Appl Approved
Check #		New #		

**If we have questions/concerns regarding the information provided on this application, whom should we contact?**

Facility Name:

Person's Name:

Phone Number:

E-Mail:

### A. GENERAL APPLICATION INFORMATION

1. Type of application: (check one)

a.  Initial (New Provider)

Desired Effective Date:

b.  Annual Renewal

c.  Change in Ownership

Accepting Assignment of the existing provider agreement  Yes  No

Desired Effective Date:

d.  Change in Facility Name

Old Name:

Desired Effective Date:

e.  Change in Beds (Stations for ESRD)

Old #:                      New #:

Desired Effective Date:

f.  Change in Main Physical Location

Old Location:

Desired Effective Date:

g.  Change or Addition of Ancillary Location

Details:

Desired Effective Date:

h.  Addition or Change in Services

Details:

Desired Effective Date:

2. Type of Facility (check one):

- a.  Adult Day Care Center (ADC)
- b.  Adult Foster Care Home (AFCH)
- c.  Assisted Living Facility (ALF)
- d.  Ambulatory Surgical Center (ASC)
- e.  Birthing Center (BC)
- f.  Boarding Home (BH)
- g.  Critical Access Hospital (CAH)
- h.  Renal Dialysis Center (ESRD)
- i.  Free-Standing Diagnostic Testing Center (FSDTC)
- j.  Health Agency (HHA)
- k.  Hospital (HOSP)
- l.  Hospice Facility (HSPC)
- m.  Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- n.  Medical Assistance Facility (MAF)
- o.  Nursing Care Facility (NH)
- p.  Psychiatric Hospital (PSYCH)
- q.  Rehabilitation Facility (REHAB)
- r.  Rehabilitation Hospital (RHOSP)

3. Facility Name: (This is how it will appear on your license.)

4. Physical Facility Address: (Main location.)

5. Mailing Address: (If different than #5.)

6. County:

7. Fiscal Year End Date: (Cost Reporting End Date)

8. Phone:

9. Fax:

10. Email: (This will be used for all official correspondences, survey results, etc. Only one address per provider.)

## B. PROVIDER DETAILS

11. Are you a Medicare/Medicaid Certified Provider?  Yes  No

a. If yes, what is your CMS Certification Number (CCN):

b. If no, are you planning on applying for Medicare/Medicaid Certification?  Yes  No

12. National Provider Identifier number (NPI):

13. Federal Employer Tax ID number (EIN):

14. Does the healthcare facility have in place a documented quality management function to evaluate and improve patient/resident/client care and services?  Yes  No

15. Provider Specific Data. Complete only the appropriate provider section below for this application.

**ADULT DAY CARE**

a. Hours of operation:

SUN	MON	TUE	WED	THU	FRI	SAT

**ADULT FOSTER CARE HOME**

a. Number of beds to be licensed:

**ASSISTED LIVING FACILITY**

a. Number of beds to be licensed:

b.  Level 1  Level 2

c. If Level 2, is this in a Secure Unit?  Yes  No

d. Admission & Occupancy Data: (Use period from April 1 previous calendar year through March 31 current calendar year. Example of calculations in Attachment A.) (Only required for renewal applications.)

i. Annual Admissions:

ii. Actual Total Patient Days of Care: (total daily census for the year)

iii. Available Total Patient Days of Care: (# of licensed beds X # of days in year)

iv. Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)

**AMBULATORY SURGICAL CENTER**

a. Number of surgical beds:

b. Number of observation beds:

c. Number of 23-hour recovery beds:

(Continued on next page)

- d. Do you currently have a “deemed” status with one of the nationally recognized accrediting organizations below?  Yes  No  
 (You can belong to an accrediting organization but not be deemed. Deemed status means you have requested and received approval from Centers for Medicare and Medicaid Services (CMS) to accept the accrediting organization’s survey process instead of using the State Survey Agency for certification.)
- e. If yes, what approved accrediting organization do you belong to:  
 (Check one:)  TJC  AOA  AAAHC  AAAASF
- f. If no, are you in the process or plan to become deemed within the next 12 months?  Yes  No
- g. Date of Last Accrediting Survey: (You must submit copy of the survey results with this application.)
- h. Hours of operations:

SUN	MON	TUE	WED	THU	FRI	SAT

- i. Services Provided: (check as appropriate)
- |  |   |
|--|---|
| <input type="checkbox"/> Dental          | <input type="checkbox"/> Orthopedic             |
| <input type="checkbox"/> Endoscopy       | <input type="checkbox"/> Pain                   |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Plastic/Reconstructive |
| <input type="checkbox"/> Ob/Gyn          | <input type="checkbox"/> Podiatry               |
| <input type="checkbox"/> Ophthalmologic  |   |
| <input type="checkbox"/> Other:          |   |
- j. Attach a listing of all surgical procedures performed at the ASC.

### **BIRTHING CENTER**

- a. Number of beds to be licensed:

### **BOARDING HOME**

- a. Number of beds to be licensed:
- b. Admission & Occupancy Data: (Use period from April 1 previous calendar year through March 31 current calendar year. Example of calculations in Attachment A.) (Only required for renewal applications.)
- Annual Admissions:
  - Actual Total Patient Days of Care: (total daily census for the year)
  - Available Total Patient Days of Care: (# of licensed beds X # of days in year)
  - Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)

**CRITICAL ACCESS HOSPITAL**

- a. Number of licensed beds:
- b. Number of observation beds:
- c. Number of operating rooms:
- d. Number of endoscopy procedure rooms:
- e. Number of cardiac catheterization procedure rooms:
- f. Do you currently have a “deemed” status with one of the nationally recognized accrediting organizations below?  Yes  No  
(You can belong to an accrediting organization but not be deemed. Deemed status means you have requested and received approval from Centers for Medicare and Medicaid Services (CMS) to accept the accrediting organization’s survey process instead of using the State Survey Agency for certification.)
- g. If yes, what approved accrediting organization do you belong to:  
(Check one:)  TJC  AOA  DNV
- h. If no, are you in the process or plan to become deemed within the next 12 months?  Yes  No
- i. Date of Last Accrediting Survey (You must submit copy of the survey results with this application.):
- j. Admission & Occupancy Data: (Use period from April 1 previous calendar year through March 31 current calendar year. Example of calculations in Attachment A.) (Only required for renewal applications.)
  - i. Annual Admissions:
  - ii. Actual Total Patient Days of Care: (total daily census for the year)
  - iii. Available Total Patient Days of Care: (# of licensed beds X # of days in year)
  - iv. Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)
- k. If you provide swing bed services, you must complete occupancy data on swing beds. (Only required for renewal applications.)
  - i. Annual Swing Bed Admissions:
  - ii. Actual Total Swing Bed Patient Days of Care: (total daily census for the year)
  - iii. Available Total Swing Bed Patient Days of Care: (# of licensed beds X # of days in year)
  - iv. Swing Bed Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)
- l. Specialized Units: (check as appropriate)
  - Alzheimer Unit  Substance Abuse Unit
  - PPS Psychiatric Unit  Special Care Unit
  - PPS Rehabilitation Unit  Other
- m. Number of provider-based off-site locations under this CCN. (See section D.)

(Continued on next page)

n. Services Provided: (Check as appropriate. See list of service description in Attachment B.)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Alcohol and/or Drug Services           | <input type="checkbox"/> Laboratory-Clinical                                | <input type="checkbox"/> Psychiatric-Geriatric                  |
| <input type="checkbox"/> Anesthesia Services                    | <input type="checkbox"/> Magnetic Resonance Imaging (MRI)                   | <input type="checkbox"/> Psychiatric-Adult Inpatient            |
| <input type="checkbox"/> Audiology                              | <input type="checkbox"/> Obstetric Services                                 | <input type="checkbox"/> Psychiatric-Outpatient                 |
| <input type="checkbox"/> Burns Care Unit                        | <input type="checkbox"/> Occupational Therapy Services                      | <input type="checkbox"/> Radiology Services-Diagnostic          |
| <input type="checkbox"/> Cardiac Catheterization Laboratory     | <input type="checkbox"/> Operating Rooms                                    | <input type="checkbox"/> Radiology Services-Therapeutic         |
| <input type="checkbox"/> Cardiac-Thoracic Surgery               | <input type="checkbox"/> Ophthalmic Surgery                                 | <input type="checkbox"/> Reconstructive Surgery                 |
| <input type="checkbox"/> Chemotherapy Services                  | <input type="checkbox"/> Optometric Services                                | <input type="checkbox"/> Respiratory Care Services              |
| <input type="checkbox"/> Chiropractic Services                  | <input type="checkbox"/> Organ Transplant Services (Non Medicare-certified) | <input type="checkbox"/> Rehab Services – Inpatient             |
| <input type="checkbox"/> CT Scanner                             | <input type="checkbox"/> Orthopedic Surgery                                 | <input type="checkbox"/> Rehab Service – Outpatient             |
| <input type="checkbox"/> Dental Services                        | <input type="checkbox"/> Outpatient Services                                | <input type="checkbox"/> Renal Dialysis (Acute Inpatient)       |
| <input type="checkbox"/> Dietetic Services                      | <input type="checkbox"/> Pediatric Surgery                                  | <input type="checkbox"/> Social Services                        |
| <input type="checkbox"/> Emergency Department (Dedicated)       | <input type="checkbox"/> Pharmacy   | <input type="checkbox"/> Speech Pathology Services              |
| <input type="checkbox"/> Extracorporeal Shock Wave Lithotripter | <input type="checkbox"/> Physical Therapy Services                          | <input type="checkbox"/> Surgical Services-Inpatient            |
| <input type="checkbox"/> Gerontological Specialty Services      | <input type="checkbox"/> Positron Emission Tomography Scan                  | <input type="checkbox"/> Surgical Services-Outpatient           |
| <input type="checkbox"/> ICU-Cardiac (non-surgical)             | <input type="checkbox"/> Post-Operative Recovery Rooms                      | <input type="checkbox"/> Swing Bed Services                     |
| <input type="checkbox"/> ICU-Medical/Surgical                   | <input type="checkbox"/> Psychiatric Services-Emergency                     | <input type="checkbox"/> Trauma Center (Designated)             |
| <input type="checkbox"/> ICU-Neonatal                           | <input type="checkbox"/> Psychiatric-Child/Adolescent                       | <input type="checkbox"/> Transplant Center (Medicare Certified) |
| <input type="checkbox"/> ICU-Pediatric                          | <input type="checkbox"/> Psychiatric-Forensic                               | <input type="checkbox"/> Urgent Care Center Services            |
| <input type="checkbox"/> ICU-Surgical                           |   |   |

**RENAL DIALYSIS CENTER**

- a. # of licensed stations:
- b. Fidelity Bond requirement: (\$2500 minimum)
  - i. Carrier:
  - ii. Bond amount:
  - iii. Copy of bond attached:  Yes  No

(You must submit a copy of the bond. In order to meet the bond requirement of the rules, ONLY a fidelity bond or an employee dishonesty bond will be accepted. A surety bond or an insurance policy with employee dishonesty coverage, employee theft coverage, etc. is not acceptable for this rule requirement.)

(Continued on next page)

c. Services Provided: (check as appropriate)

- |   |  |
|---|--|
| <input type="checkbox"/> In-Center Hemodialysis           | <input type="checkbox"/> Home Hemodialysis Training and Support        |
| <input type="checkbox"/> In-Center Peritoneal Dialysis    | <input type="checkbox"/> Home Peritoneal Dialysis Training and Support |
| <input type="checkbox"/> In-Center Nocturnal Hemodialysis | <input type="checkbox"/> Home Training & Support Only                  |
| <input type="checkbox"/> Reuse                            |  |

d. Hours of operation:

SUN	MON	TUE	WED	THU	FRI	SAT

**FREE-STANDING DIAGNOSTIC TESTING CENTER**

a. Hours of operation:

SUN	MON	TUE	WED	THU	FRI	SAT

- b. Is your center: (Check one:)  mobile  re-locatable  transportable

c. Please list the outpatient diagnostic testing services and minimally invasive procedures you perform:

**HOME HEALTH AGENCY**

- a.  Free-Standing  Provider Based
- b. Do you currently have a “deemed” status with one of the nationally recognized accrediting organizations below?  Yes  No  
 (You can belong to an accrediting organization but not be deemed. Deemed status means you have requested and received approval from Centers for Medicare and Medicaid Services (CMS) to accept the accrediting organization’s survey process instead of using the State Survey Agency for certification.)
- c. If yes, what approved accrediting organization do you belong to:  
 (Check one:)  TJC  CHAP  ACHC
- d. If no, are you in the process or plan to become deemed within the next 12 months?  Yes  No
- e. Date of Last Accrediting Survey: (You must submit copy of the survey results with this application.)

(Continued on next page)

- f. Fidelity Bond requirement: (\$2500 minimum)
- i. Carrier:
  - ii. Bond amount:
  - iii. Copy of bond attached:  Yes  No  
 (You must submit a copy of the bond. In order to meet the bond requirement of the rules, ONLY a fidelity bond or an employee dishonesty bond will be accepted. A surety bond or an insurance policy with employee dishonesty coverage, employee theft coverage, etc. is not acceptable for this rule requirement.)
- g. Services Provided: (check as appropriate)
- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Skilled nursing | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> CNA             | <input type="checkbox"/> Homemaker   |
| <input type="checkbox"/> PT              | <input type="checkbox"/> Companion   |
| <input type="checkbox"/> OT              | <input type="checkbox"/> Nutritional |
| <input type="checkbox"/> Speech          | <input type="checkbox"/> Pharmacy    |
| <input type="checkbox"/> Other:          |                                      |
- h. Geographic area you service: (list by city location)  
 (You must include a map clearly identifying the geographic area.)
- i. Do you have an approved branch location?  Yes  No
- j. If yes, provide branch location physical address:
- k. Branch phone:
- l. How many miles is there between parent and branch location?
- m. Do you offer the exact same services at your branch as you do the parent location?  Yes  No
- n. If no, explain:
- o. Do you have an approved subunit location?  Yes  No
- p. If yes, subunits must be licensed/certified separately. What is the subunit's CCN?
- q. What city is the subunit located in?
- r. How many miles is there between parent and subunit location?

**HOSPITAL**

- a. Number of licensed beds:
- b. Number of observation beds:
- c. Number of operating rooms:
- d. Number of endoscopy procedure rooms:
- e. Number of cardiac catheterization procedure rooms:

(Continued on next page)

- f. Do you currently have a “deemed” status with one of the nationally recognized accrediting organizations below?  Yes  No  
 (You can belong to an accrediting organization but not be deemed. Deemed status means you have requested and received approval from Centers for Medicare and Medicaid Services (CMS) to accept the accrediting organization’s survey process instead of using the State Survey Agency for certification.)
- g. If yes, what approved accrediting organization do you belong to:  
 (Check one:)  TJC  AOA  DNV
- h. If no, are you in the process or plan to become deemed within the next 12 months?  Yes  No
- i. Date of Last Accrediting Survey: (you must submit copy of the survey results with this application)
- j. Admission & Occupancy Data: (Use period from April 1 previous calendar year through March 31 current calendar year. Example of calculations in Attachment A.) (Only required for renewal applications.)
- i. Annual Admissions:
  - ii. Actual Total Patient Days of Care: (total daily census for the year)
  - iii. Available Total Patient Days of Care: (# of licensed beds X # of days in year)
  - iv. Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)
- k. If you provide swing bed services, you must complete occupancy data on swing beds. (Only required for renewal applications.)
- i. Annual Swing Bed Admissions:
  - ii. Actual Total Swing Bed Patient Days of Care: (total daily census for the year)
  - iii. Available Total Swing Bed Patient Days of Care: (# of licensed beds X # of days in year)
  - iv. Swing Bed Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)
- l. Specialized Units: (check as appropriate)
- |  |   |
|--|---|
| <input type="checkbox"/> Alzheimer Unit          | <input type="checkbox"/> Substance Abuse Unit |
| <input type="checkbox"/> PPS Psychiatric Unit    | <input type="checkbox"/> Special Care Unit    |
| <input type="checkbox"/> PPS Rehabilitation Unit |   |
| <input type="checkbox"/> Other:                  |   |
- m. Number of provider-based off-site locations under this CCN. (See section D.)

(Continued on next page)

n. Services Provided: (Check as appropriate. See list of service description in Attachment B.)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Alcohol and/or Drug Services           | <input type="checkbox"/> Laboratory-Clinical                                | <input type="checkbox"/> Psychiatric-Geriatric                  |
| <input type="checkbox"/> Anesthesia Services                    | <input type="checkbox"/> Magnetic Resonance Imaging (MRI)                   | <input type="checkbox"/> Psychiatric-Adult Inpatient            |
| <input type="checkbox"/> Audiology                              | <input type="checkbox"/> Obstetric Services                                 | <input type="checkbox"/> Psychiatric-Outpatient                 |
| <input type="checkbox"/> Burns Care Unit                        | <input type="checkbox"/> Occupational Therapy Services                      | <input type="checkbox"/> Radiology Services-Diagnostic          |
| <input type="checkbox"/> Cardiac Catheterization Laboratory     | <input type="checkbox"/> Operating Rooms                                    | <input type="checkbox"/> Radiology Services-Therapeutic         |
| <input type="checkbox"/> Cardiac-Thoracic Surgery               | <input type="checkbox"/> Ophthalmic Surgery                                 | <input type="checkbox"/> Reconstructive Surgery                 |
| <input type="checkbox"/> Chemotherapy Services                  | <input type="checkbox"/> Optometric Services                                | <input type="checkbox"/> Respiratory Care Services              |
| <input type="checkbox"/> Chiropractic Services                  | <input type="checkbox"/> Organ Transplant Services (Non Medicare-certified) | <input type="checkbox"/> Rehab Services – Inpatient             |
| <input type="checkbox"/> CT Scanner                             | <input type="checkbox"/> Orthopedic Surgery                                 | <input type="checkbox"/> Rehab Service – Outpatient             |
| <input type="checkbox"/> Dental Services                        | <input type="checkbox"/> Outpatient Services                                | <input type="checkbox"/> Renal Dialysis (Acute Inpatient)       |
| <input type="checkbox"/> Dietetic Services                      | <input type="checkbox"/> Pediatric Surgery                                  | <input type="checkbox"/> Social Services                        |
| <input type="checkbox"/> Emergency Department (Dedicated)       | <input type="checkbox"/> Pharmacy   | <input type="checkbox"/> Speech Pathology Services              |
| <input type="checkbox"/> Extracorporeal Shock Wave Lithotripter | <input type="checkbox"/> Physical Therapy Services                          | <input type="checkbox"/> Surgical Services-Inpatient            |
| <input type="checkbox"/> Gerontological Specialty Services      | <input type="checkbox"/> Positron Emission Tomography Scan                  | <input type="checkbox"/> Surgical Services-Outpatient           |
| <input type="checkbox"/> ICU-Cardiac (non-surgical)             | <input type="checkbox"/> Post-Operative Recovery Rooms                      | <input type="checkbox"/> Swing Bed Services                     |
| <input type="checkbox"/> ICU-Medical/Surgical                   | <input type="checkbox"/> Psychiatric Services-Emergency                     | <input type="checkbox"/> Trauma Center (Designated)             |
| <input type="checkbox"/> ICU-Neonatal                           | <input type="checkbox"/> Psychiatric-Child/Adolescent                       | <input type="checkbox"/> Transplant Center (Medicare Certified) |
| <input type="checkbox"/> ICU-Pediatric                          | <input type="checkbox"/> Psychiatric-Forensic                               | <input type="checkbox"/> Urgent Care Center Services            |
| <input type="checkbox"/> ICU-Surgical                           |   |   |

**HOSPICE FACILITY**

- a. Provide services for:  Outpatient only  Inpatient only  Both in/outpatient
- b. Number of licensed beds: (inpatient)
- c.  Free-Standing  Provider Based
- d. Do you currently have a “deemed” status with one of the nationally recognized accrediting organizations below?  
 Yes  No  
 (You can belong to an accrediting organization but not be deemed. Deemed status means you have requested and received approval from Centers for Medicare and Medicaid Services (CMS) to accept the accrediting organization’s survey process instead of using the State Survey Agency for certification.)
- e. If yes, what approved accrediting organization do you belong to:  
 (Check one:)  TJC  CHAP
- f. If no, are you in the process or plan to become deemed within the next 12 months?  Yes  No

(Continued on next page)

- g. Date of Last Accrediting Survey: (You must submit copy of the survey results with this application.)
- h. Fidelity Bond requirement: (\$2500 minimum)
- i. Carrier:
  - ii. Bond amount:
  - iii. Copy of bond attached:  Yes  No
- (You must submit a copy of the bond. In order to meet the bond requirement of the rules, ONLY a fidelity bond or an employee dishonesty bond will be accepted. A surety bond or an insurance policy with employee dishonesty coverage, employee theft coverage, etc. is not acceptable for this rule requirement.)
- i. Services offered: (directly or under arrangement) (Check as appropriate)
- |  |  |
|--|--|
| <input type="checkbox"/> Nursing Services        | <input type="checkbox"/> OT  |
| <input type="checkbox"/> Physician Services      | <input type="checkbox"/> Speech  |
| <input type="checkbox"/> Medical Social Services | <input type="checkbox"/> Counseling Services (including but not limited to: bereavement, spiritual, dietary) |
| <input type="checkbox"/> Homemaker Services      | <input type="checkbox"/> Volunteer Services  |
| <input type="checkbox"/> Hospice Aide            |  |
| <input type="checkbox"/> PT                      |  |
| <input type="checkbox"/> Other:                  |  |
- j. Do you have an approved multiple location?  Yes  No
- k. If yes, provide multiple location physical address:
- l. Multiple location phone:
- m. How many miles apart is the parent location and the multiple location?
- n. Do you offer the exact same services at your multiple location as you do the parent location?  Yes  No
- o. If no, explain:

**INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED**

- a. Number of beds to be licensed:
- b. Fidelity Bond requirement: (\$2500 minimum)
- i. Carrier:
  - ii. Bond amount:
  - iii. Copy of bond attached:  Yes  No
- (You must submit a copy of the bond. In order to meet the bond requirement of the rules, ONLY a fidelity bond or an employee dishonesty bond will be accepted. A surety bond or an insurance policy with employee dishonesty coverage, employee theft coverage, etc. is not acceptable for this rule requirement.)

## **MEDICAL ASSISTANCE FACILITY**

a. Fidelity Bond requirement (\$2500 minimum):

i. Carrier:

ii. Bond amount:

iii. Copy of bond attached:  Yes  No

(You must submit a copy of the bond. In order to meet the bond requirement of the rules, ONLY a fidelity bond or an employee dishonesty bond will be accepted. A surety bond or an insurance policy with employee dishonesty coverage, employee theft coverage, etc. is not acceptable for this rule requirement.)

## **NURSING CARE HOME**

a. Provider type:  SNF  NF  SNF/NF

b. Number of licensed beds:

c. Admission & Occupancy Data: (Use period from April 1 previous calendar year through March 31 current calendar year. Example of calculations in Attachment A.) (Only required for renewal applications.)

i. Annual Admissions:

ii. Actual Total Patient Days of Care: (total daily census for the year)

iii. Available Total Patient Days of Care: (# of licensed beds X # of days in year)

iv. Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)

d. Do you have a secure unit?  Yes  No

e. Do you offer outpatient rehab services?  Yes  No

## **PSYCHIATRIC HOSPITAL**

a. Number of licensed beds:

b. Number of observation bed:

c. Number of operating rooms:

d. Number of endoscopy procedure rooms:

e. Number of cardiac catheterization procedure rooms:

f. Do you currently have a “deemed” status with one of the nationally recognized accrediting organizations below?

Yes  No

(You can belong to an accrediting organization but not be deemed. Deemed status means you have requested and received approval from Centers for Medicare and Medicaid Services (CMS) to accept the accrediting organization’s survey process instead of using the State Survey Agency for certification.)

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- g. If yes, what approved accrediting organization do you belong to:  
 (Check one:)  TJC             AOA             DNV
- h. If no, are you in the process or plan to become deemed within the next 12 months?  Yes             No
- i. Date of Last Accrediting Survey: (you must submit copy of the survey results with this application)
- j. Admission & Occupancy Data: (Use period from April 1 previous calendar year through March 31 current calendar year. Example of calculations in Attachment A.) (Only required for renewal applications.)
- i. Annual Admissions:
  - ii. Actual Total Patient Days of Care: (total daily census for the year)
  - iii. Available Total Patient Days of Care: (# of licensed beds X # of days in year)
  - iv. Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)
- k. If you provide swing bed services, you must complete occupancy data on swing beds. (Only required for renewal applications.)
- i. Annual Swing Bed Admissions:
  - ii. Actual Total Swing Bed Patient Days of Care: (total daily census for the year)
  - iii. Available Total Swing Bed Patient Days of Care: (# of licensed beds X # of days in year)
  - iv. Swing Bed Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)
- l. Specialized Units:
- |  |   |
|--|---|
| <input type="checkbox"/> Alzheimer Unit          | <input type="checkbox"/> Substance Abuse Unit |
| <input type="checkbox"/> PPS Psychiatric Unit    | <input type="checkbox"/> Special Care Unit    |
| <input type="checkbox"/> PPS Rehabilitation Unit |   |
| <input type="checkbox"/> Other:                  |   |
- m. Number of provider-based off-site locations under this CCN. (See section D.)

(Continued on next page)

n. Services Provided: (Check as appropriate. See list of service description in Attachment B.)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Alcohol and/or Drug Services           | <input type="checkbox"/> Laboratory-Clinical                                | <input type="checkbox"/> Psychiatric-Geriatric                  |
| <input type="checkbox"/> Anesthesia Services                    | <input type="checkbox"/> Magnetic Resonance Imaging (MRI)                   | <input type="checkbox"/> Psychiatric-Adult Inpatient            |
| <input type="checkbox"/> Audiology                              | <input type="checkbox"/> Obstetric Services                                 | <input type="checkbox"/> Psychiatric-Outpatient                 |
| <input type="checkbox"/> Burns Care Unit                        | <input type="checkbox"/> Occupational Therapy Services                      | <input type="checkbox"/> Radiology Services-Diagnostic          |
| <input type="checkbox"/> Cardiac Catheterization Laboratory     | <input type="checkbox"/> Operating Rooms                                    | <input type="checkbox"/> Radiology Services-Therapeutic         |
| <input type="checkbox"/> Cardiac-Thoracic Surgery               | <input type="checkbox"/> Ophthalmic Surgery                                 | <input type="checkbox"/> Reconstructive Surgery                 |
| <input type="checkbox"/> Chemotherapy Services                  | <input type="checkbox"/> Optometric Services                                | <input type="checkbox"/> Respiratory Care Services              |
| <input type="checkbox"/> Chiropractic Services                  | <input type="checkbox"/> Organ Transplant Services (Non Medicare-certified) | <input type="checkbox"/> Rehab Services – Inpatient             |
| <input type="checkbox"/> CT Scanner                             | <input type="checkbox"/> Orthopedic Surgery                                 | <input type="checkbox"/> Rehab Service – Outpatient             |
| <input type="checkbox"/> Dental Services                        | <input type="checkbox"/> Outpatient Services                                | <input type="checkbox"/> Renal Dialysis (Acute Inpatient)       |
| <input type="checkbox"/> Dietetic Services                      | <input type="checkbox"/> Pediatric Surgery                                  | <input type="checkbox"/> Social Services                        |
| <input type="checkbox"/> Emergency Department (Dedicated)       | <input type="checkbox"/> Pharmacy   | <input type="checkbox"/> Speech Pathology Services              |
| <input type="checkbox"/> Extracorporeal Shock Wave Lithotripter | <input type="checkbox"/> Physical Therapy Services                          | <input type="checkbox"/> Surgical Services-Inpatient            |
| <input type="checkbox"/> Gerontological Specialty Services      | <input type="checkbox"/> Positron Emission Tomography Scan                  | <input type="checkbox"/> Surgical Services-Outpatient           |
| <input type="checkbox"/> ICU-Cardiac (non-surgical)             | <input type="checkbox"/> Post-Operative Recovery Rooms                      | <input type="checkbox"/> Swing Bed Services                     |
| <input type="checkbox"/> ICU-Medical/Surgical                   | <input type="checkbox"/> Psychiatric Services-Emergency                     | <input type="checkbox"/> Trauma Center (Designated)             |
| <input type="checkbox"/> ICU-Neonatal                           | <input type="checkbox"/> Psychiatric-Child/Adolescent                       | <input type="checkbox"/> Transplant Center (Medicare Certified) |
| <input type="checkbox"/> ICU-Pediatric                          | <input type="checkbox"/> Psychiatric-Forensic                               | <input type="checkbox"/> Urgent Care Center Services            |
| <input type="checkbox"/> ICU-Surgical                           |   |   |

## **REHABILITATION FACILITY**

a. Fidelity Bond requirement: (\$2500 minimum)

i. Carrier:

ii. Bond amount:

iii. Copy of bond attached:  Yes  No

(You must submit a copy of the bond. In order to meet the bond requirement of the rules, ONLY a fidelity bond or an employee dishonesty bond will be accepted. A surety bond or an insurance policy with employee dishonesty coverage, employee theft coverage, etc. is not acceptable for this rule requirement.)

## **REHABILITATION HOSPITAL**

- a. Number of licensed beds:
- b. Number of observation bed:
- c. Number of operating rooms:
- d. Number of endoscopy procedure rooms:
- e. Number of cardiac catheterization procedure rooms:
- f. Do you currently have a “deemed” status with one of the nationally recognized accrediting organizations below?  Yes  No  
(You can belong to an accrediting organization but not be deemed. Deemed status means you have requested and received approval from Centers for Medicare and Medicaid Services (CMS) to accept the accrediting organization’s survey process instead of using the State Survey Agency for certification.)
- g. If yes, what approved accrediting organization do you belong to:  
(Check one:)  TJC  AOA  DNV
- h. If no, are you in the process or plan to become deemed within the next 12 months?  Yes  No
- i. Date of Last Accrediting Survey: (You must submit copy of the survey results with this application.)
- j. Admission & Occupancy Data: (Use period from April 1 previous calendar year through March 31 current calendar year. Example of calculations in Attachment A.) (Only required for renewal applications.)
  - i. Annual Admissions:
  - ii. Actual Total Patient Days of Care: (total daily census for the year)
  - iii. Available Total Patient Days of Care: (# of licensed beds X # of days in year)
  - iv. Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)
- k. If you provide swing bed services, you must complete occupancy data on swing beds. (Only required for renewal applications.)
  - i. Annual Swing Bed Admissions:
  - ii. Actual Total Swing Bed Patient Days of Care: (total daily census for the year)
  - iii. Available Total Swing Bed Patient Days of Care: (# of licensed beds X # of days in year)
  - iv. Swing Bed Occupancy Rate Percentage: (actual total patient days of care ÷ available total patient days of care)
- l. Specialized Units:
  - Alzheimer Unit  Substance Abuse Unit
  - PPS Psychiatric Unit  Special Care Unit
  - PPS Rehabilitation Unit
  - Other:

(Continued on next page)

k. Number of provider-based off-site locations under this CCN. (See section D.)

l. Services Provided: (Check as appropriate. See list of service description in Attachment B.)

<input type="checkbox"/> Alcohol and/or Drug Services	<input type="checkbox"/> Magnetic Resonance Imaging (MRI)	<input type="checkbox"/> Psychiatric-Outpatient
<input type="checkbox"/> Anesthesia Services	<input type="checkbox"/> Obstetric Services	<input type="checkbox"/> Radiology Services-Diagnostic
<input type="checkbox"/> Audiology	<input type="checkbox"/> Occupational Therapy Services	<input type="checkbox"/> Radiology Services-Therapeutic
<input type="checkbox"/> Burns Care Unit	<input type="checkbox"/> Operating Rooms	<input type="checkbox"/> Reconstructive Surgery
<input type="checkbox"/> Cardiac Catheterization Laboratory	<input type="checkbox"/> Ophthalmic Surgery	<input type="checkbox"/> Respiratory Care Services
<input type="checkbox"/> Cardiac-Thoracic Surgery	<input type="checkbox"/> Optometric Services	<input type="checkbox"/> Rehab Services – Inpatient
<input type="checkbox"/> Chemotherapy Services	<input type="checkbox"/> Organ Transplant Services (Non Medicare-certified)	<input type="checkbox"/> Rehab Service – Outpatient
<input type="checkbox"/> Chiropractic Services	<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Renal Dialysis (Acute Inpatient)
<input type="checkbox"/> CT Scanner	<input type="checkbox"/> Outpatient Services	<input type="checkbox"/> Social Services
<input type="checkbox"/> Dental Services	<input type="checkbox"/> Pediatric Surgery	<input type="checkbox"/> Speech Pathology Services
<input type="checkbox"/> Dietetic Services	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Surgical Services-Inpatient
<input type="checkbox"/> Emergency Department (Dedicated)	<input type="checkbox"/> Physical Therapy Services	<input type="checkbox"/> Surgical Services-Outpatient
<input type="checkbox"/> Extracorporeal Shock Wave Lithotripter	<input type="checkbox"/> Positron Emission Tomography Scan	<input type="checkbox"/> Swing Bed Services
<input type="checkbox"/> Gerontological Specialty Services	<input type="checkbox"/> Post-Operative Recovery Rooms	<input type="checkbox"/> Trauma Center (Designated)
<input type="checkbox"/> ICU-Cardiac (non-surgical)	<input type="checkbox"/> Psychiatric Services-Emergency	<input type="checkbox"/> Transplant Center (Medicare Certified)
<input type="checkbox"/> ICU-Medical/Surgical	<input type="checkbox"/> Psychiatric-Child/Adolescent	<input type="checkbox"/> Urgent Care Center Services
<input type="checkbox"/> ICU-Neonatal	<input type="checkbox"/> Psychiatric-Forensic	
<input type="checkbox"/> ICU-Pediatric	<input type="checkbox"/> Psychiatric-Geriatric	
<input type="checkbox"/> ICU-Surgical	<input type="checkbox"/> Psychiatric-Adult Inpatient	
<input type="checkbox"/> Laboratory-Clinical		

## C. PERSONNEL

16. Name/Title of person in charge of facility, agency, or clinic:

17. Name of Administrator/Director:

b. Professional License Type:

c. Professional License Number:

18. a. Name of Director of Nursing/Nursing Supervisor:

b. Professional License Type:

c. Professional License Number:

(Continued on next page)

- 19. a. Name of Medical Director (if applicable):
- b. Professional License Type:
- c. Professional License Number:
  
- 20. a. Name of Maintenance Director (if applicable)
- b. Contact phone number:

**D. LOCATIONS/BUILDINGS** (Note: Not required for home health agency or outpatient only hospice facility.)

21. Main Building Location (You must attach a current floor plan with beds and services areas clearly identified.)

- a. Property Ownership:    Own                       Rent                       Lease
- b. Physical Address: (Include city.)
- c. Services at this location (Those services billed under this provider type’s Medicare/Medicaid number):
  
- d. Date services began at this location:
- e. Is there a current construction or remodel project going on at this location?    Yes            No
- f. If yes, list HLS project numbers:

**If you have any ancillary or provider-based locations, continue on to #22. If not, skip to #26.**

22. Ancillary Location #1 (You must attach a current floor plan with beds and services areas clearly identified.)

- a. Property Ownership:    Own                       Rent                       Lease
- b. Physical Address: (Include city.)
- c. How many miles between main location (#22) and this location?
- d. Has this location been approved as a provider based location by the Medicaid Contractor (MAC)?  
 Yes  No
- e. Services at this location (Those billed under this provider type’s Medicare/Medicaid number):
  
- f. Date services began at this location:
- g. Is there a current construction or remodel project going on at this location?    Yes            No
- h. If yes, list HLS project numbers:

23. Ancillary Location #2 (You must attach a current floor plan with beds and services areas clearly identified.)

- a. Property Ownership:    Own                       Rent                       Lease
- b. Physical Address: (Include city.)
- c. How many miles between main location (#22) and this location?

(Continued on next page)

- d. Has this location been approved as a provider based location by the Medicaid Contractor (MAC)?  
 Yes  No
- e. Services at this location (Those billed under this provider type's Medicare/Medicaid number):
- f. Date services began at this location:
- g. Is there a current construction or remodel project going on at this location?  Yes  No
- h. If yes, list HLS project numbers:

24. Ancillary Location #3 (You must attach a current floor plan with beds and services areas clearly identified.)

- a. Property Ownership:  Own  Rent  Lease
- b. Physical Address: (Include city.)
- c. How many miles between main location (#22) and this location?
- d. Has this location been approved as a provider based location by the Medicaid Contractor (MAC)?  
 Yes  No
- e. Services at this location (Those billed under this provider type's Medicare/Medicaid number):
- f. Date services began at this location:
- g. Is there a current construction or remodel project going on at this location?  Yes  No
- h. If yes, list HLS project numbers:

25. Ancillary Location #4 (You must attach a current floor plan with beds and services areas clearly identified.)

- a. Property Ownership:  Own  Rent  Lease
- b. Physical Address: (Include city.)
- c. How many miles between main location (#22) and this location?
- d. Has this location been approved as a provider based location by the Medicaid Contractor (MAC)?  
 Yes  No
- e. Services at this location (Those billed under this provider type's Medicare/Medicaid number):
- f. Date services began at this location:
- g. Is there a current construction or remodel project going on at this location?  Yes  No
- h. If yes, list HLS project numbers:

If needed, attach additional pages for any additional ancillary locations including the same information with the current floor plan with beds and services areas clearly identified.

## E. OWNER/OPERATOR

26. Ownership type (check one) (This is the owner of the healthcare facility provider – not the owner of property/physical structure.)

- a.  Sole Proprietor/Individual
- b.  Partnership
- c.  Profit Corporation
- d.  Nonprofit Corporation
- e.  Limited Liability Company
- f.  Governmental:                       City                       County                       Hospital District                       State
- g. Other:

27. Ownership Name:

28. Mailing Address:

29. Phone:

30. Contact person:

31. Contact person's email:

32. List all officers and titles below:    or     List attached.

- a.
- b.
- c.
- d.

33. Has the owner ever had a license to operate a healthcare facility or agency providing healthcare services in this or any other state denied, suspended, revoked or otherwise terminated for cause?     Yes                       No

34. If yes, explain:

35. Is the healthcare facility operated or managed by a business entity other than the owner listed in #27 above?

Yes                       No

- a. If yes, Operating Entity Name:
- b. Mailing Address:
- c. Phone:
- d. Contact Person's Name:
- e. Contact Person's Email:

36. Has the operator ever had a license to operate a healthcare facility or agency providing healthcare services in this or any other state denied, suspended, revoked or otherwise terminated for cause?     Yes     No

a. If yes, explain:

37. Did you read and understand the healthcare facility licensure requirements (W.S. 35-2-901 and 902 et seq) outlined at the end of this application?     Yes     No

## F. SIGNATURE

Wyoming Statutes requires signature by two (2) officers of the organization, or a signature of all managing agents. If signed by managing agents, copies must be attached of company documents indicating the individuals signing are managing agents for the company.

I have read the contents of this application. My signature legally binds the facility's agreement to abide by the rules promulgated by the Stat of Wyoming for this category of healthcare facility and do hereby state the information provided on this application is true to the best of my knowledge and belief.

The facility further understands the facility is responsible for admitting and retaining only those person who qualify for this category of healthcare facility as defined in the applicable rule and facility policies and procedures. The facility agrees to allow authorized representative of the Wyoming Department of Health, upon presentation of proper identification, to request and/or enter the facility at any time without a warrant, any facility records and documentation as necessary to ascertain compliance with State licensing laws and rules promulgated by the Wyoming Department of Health.

Application must have original signatures of two officers as listed in the ownership section above. In most cases, a CEO, CFO, Administrator, or Director signature will not be accepted.

Signature #1: \_\_\_\_\_

Printed Name:

Title:

Date:

Signature #2: \_\_\_\_\_

Printed Name:

Title:

Date:

**ATTACHMENT A**  
**OCCUPANCY RATE % EXAMPLE**  
 (April 1 – March 31)

x = Determine Actual Total Resident Days of Care	Add up the total daily census for the year. Apr 1 = 10; Apr 2 = 15; Apr 3 = 15, etc. TOTAL = x
y = Determine Available Total Residents Days of Care	Take the number of licensed beds X number of days in calendar year 105 lic beds x 365 days = y
z = Determine Occupancy Rate Percentage	(Actual Total Resident Days of Care ÷ Available Total Residents Days of Care) x ÷ y = z
EXAMPLE:	x = 34,659 days (10+15+15+etc.)
	y = 38,325 days (105 x 365)
	z = 90% (34,659 ÷ 38,325)

**LICENSE STATUTE**

TITLE 35 / PUBLIC HEALTH AND SAFETY  
 CHAPTER 2 / HOSPITALS, HEALTH CARE FACILITIES AND HEALTH SERVICES  
 ARTICLE 9 / LICENSING AND OPERATIONS

**35-2-901. Definitions; applicability of provisions.**

- (a) As used in this act:
- (i) "Acute care" means short term care provided in a hospital;
  - (ii) "Ambulatory surgical center" means a facility which provides surgical treatment to patients not requiring hospitalization and is not part of a hospital or offices of private physicians, dentists or podiatrists;
  - (iii) "Birthing center" means a facility which operates for the primary purpose of performing deliveries and is not part of a hospital;
  - (iv) "Boarding home" means a dwelling or rooming house operated by any person, firm or corporation engaged in the business of operating a home for the purpose of letting rooms for rent and providing meals and personal daily living care, but not habitative or nursing care, for persons not related to the owner. Boarding home does not include a lodging facility or an apartment in which only room and board is provided;
  - (v) "Construction area" means thirty (30) highway miles, from any existing nursing care facility or hospital with swing beds to the site of the proposed nursing care facility, as determined by utilizing the state map prepared by the Wyoming department of transportation;
  - (vi) "Department" means the department of health;
  - (vii) "Division" means the designated division within the department of health;
  - (viii) "Freestanding diagnostic testing center" means a mobile or permanent facility which provides diagnostic testing but not treatment and is not part of the private offices of health care professionals operating within the scope of their licenses;
  - (ix) Repealed By Laws 1999, ch. 119, § 2.
  - (x) "Health care facility" means any ambulatory surgical center, assisted living facility, adult day care facility, adult foster care home, alternative eldercare home, birthing center, boarding home, freestanding diagnostic testing center, home health agency, hospice, hospital, intermediate care facility for people with intellectual disability, medical assistance facility, nursing care facility, rehabilitation facility and renal dialysis center;
  - (xi) "Home health agency" means an agency primarily engaged in arranging and directly providing nursing or other health care services to persons at their residence;
  - (xii) "Hospice" means a program of care for the terminally ill and their families given in a home or health facility which provides medical, palliative, psychological, spiritual and supportive care and treatment;
  - (xiii) "Hospital" means an institution or a unit in an institution providing one (1) or more of the following to patients by or under the supervision of an organized medical staff:
    - (A) Diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons;
    - (B) Rehabilitation services for the rehabilitation of injured, disabled or sick persons;
    - (C) Acute care;
    - (D) Psychiatric care;
    - (E) Swing beds.
  - (xiv) "Intermediate care facility for people with intellectual disability" means a facility which provides on a regular basis health related care and training to persons with intellectual disabilities or persons with related conditions, who do not require the degree of care and treatment of a hospital or nursing facility and services above the need of a boarding home. The term also means "intermediate care facility for the mentally retarded" or "ICFMR" or "ICFs/MR" as those terms are used in federal law and in other laws, rules and regulations;
  - (xv) "Medical assistance facility" means a facility which provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient care to persons needing that care for a period of no longer than sixty (60) hours and is located more than thirty (30) miles from the nearest Wyoming hospital;
  - (xvi) "Nursing care facility" means a facility providing assisted living care, nursing care, rehabilitative and other related services;
  - (xvii) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine or surgery under state law;
  - (xviii) "Psychiatric care" means the in-patient care and treatment of persons with a mental diagnosis;
  - (xix) "Rehabilitation facility" means an outpatient or residential facility which is operated for the primary purpose of assisting the rehabilitation of disabled persons including persons with acquired brain injury by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluations and training or any combination of these services and in which the major portion of the services is furnished within the facility;
  - (xx) "Renal dialysis center" means a freestanding facility for treatment of kidney diseases;
  - (xxi) "Swing bed" means a special designation for a hospital which has a program to provide specialized in-patient long term care. Any medical-surgical bed in a hospital can be designated as a swing bed;
  - (xxii) "Assisted living facility" means a dwelling operated by any person, firm or corporation engaged in providing limited nursing care, personal care and boarding home care, but not habitative care, for persons not related to the owner of the facility. This definition may include facilities with secured units and facilities dedicated to the special care and services for people with Alzheimer's disease or other dementia conditions;
  - (xxiii) "Adult day care facility" means any facility not otherwise certified by the department of health, engaged in the business of providing activities of daily living support and supervision services programming based on a social model, to four (4) or more persons eighteen (18) years of age or older with physical or mental disabilities;
  - (xxiv) "Adult foster care home" means a home where care is provided for up to five (5) adults who are not related to the provider by blood, marriage or adoption, except in special circumstances, in need of long term care in a home like atmosphere. Clients in the home shall have private rooms which may be shared with spouses and shall have individual handicapped accessible bathrooms. "Adult foster home" does not include any residential facility otherwise licensed or funded by the state of Wyoming. The homes shall be regulated in accordance with this act and with the Wyoming Long Term Care Choices Act, which shall govern in case of conflict with this act;
  - (xxv) "Alternative eldercare home" means a facility as defined in W.S. 42-6-102(a)(iii). The homes shall be regulated in accordance with this act and with the Wyoming Long Term Care Choices Act which shall govern in case of conflict with this act;
  - (xxvi) "This act" means W.S. 35-2-901 through 35-2-912.

(b) This act does not apply to hospitals or any other facility or agency operated by the federal government which would otherwise be required to be licensed under this act or to any person providing health care services within the scope of his license in a private office.

**35-2-902. License required.**

No person shall establish any health care facility in this state without a valid license issued pursuant to this act.

## ATTACHMENT B

### Service Category Descriptions

**Alcohol and/or Drug Services.** Organized hospital services that provide medical care and/or rehabilitative treatment services to patients for whom the primary diagnosis is alcoholism or chemical dependency.

**Anesthesia Service.** Organized hospital service for the provision of anesthesia services to patients undergoing surgery or other invasive procedures.

**Audiology.** Organized service specializing in identifying, diagnosing, treating and monitoring disorders of hearing.

**Burn Care Unit.** An organized service that provides care to severely burned patients. Severely burned patients are those with second-degree burns of more than 25% of their total body surface area for adults or 20% total body surface area for children; third degree burns of more than 10% of their total body surface area; any severe burns of the hands, face, eyes, ears, or feet or; all inhalation injuries, electrical burns, complicated burn injuries involving trauma and all other poor risk factors.

**Cardiac Catheterization Laboratory.** An organized unit offering catheter-based diagnostic and interventional procedures for cardiac patients.

**Cardio-Thoracic surgery.** Surgical services to treat diseases of the heart and great vessels as well as other organs in the chest or thorax.

**Chemotherapy Service.** An organized service which provides treatment of cancer via antineoplastic drugs. These drugs may be combined into a standardized treatment regimen.

**Chiropractic Service.** An organized clinical service offering spinal manipulation or adjustment and related diagnostic and therapeutic services.

**Computed tomography (CT) Scanner.** A medical device used in medical imaging that employs digital geometry processing to generate a three-dimensional image of the interior of patients from a large series of two-dimensional X-ray images taken around a single axis of rotation.

**Dental Service.** An organized service that provides dental or oral services to inpatients or outpatients.

**Dietetic Service.** An organized dietary service that provides for therapeutic diets for patients in accordance with the orders of practitioners or meets the nutritional needs of patients in accordance with recognized dietary practices and the orders of practitioners.

**Emergency Department (Dedicated).** In accordance with the EMTALA regulations at 42 CFR 489.24, any department or facility of the hospital or CAH, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

**Extracorporeal Shock Wave Lithotripter.** A medical device used for treating stones in the kidney or ureter. The device disintegrates kidney stones noninvasively through the transmission of acoustic shock waves directed at the stones.

**Gerontological Specialty Services.** An organized service that specializes in the treatment of disease in elderly patients including the physical, mental, and social aspects.

**Intensive Care Unit (ICU)** Unit of the hospital that provides treatment and is concerned with the provision of life support or organ support systems in patients who are critically ill requiring intensive monitoring. Intensive care units may be specific to the area of the body or the age of patient being treated such as the Cardiac ICU, Medical/Surgical ICU, Neonatal ICU, Pediatric ICU, and the Surgical ICU.

**Laboratory – Clinical.** An organized service that is certified by Medicare for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. (42 CFR 493.2)

**Magnetic resonance Imaging (MRI).** The use of a uniform magnetic field and radio frequencies to study tissue and structure of the body. This procedure enables the visualization of biochemical activity of the cell in vivo without the use of ionizing radiation, radioisotopic substances, or high-frequency sound.

**Neurosurgical Services.** Services provided by the hospital dealing with the operative and nonoperative management of disorders of the central, peripheral, and autonomic nervous system.

**Nuclear Medicine Service.** An organized hospital service that uses the nuclear properties of matter in medical imaging for the diagnosis and therapy of patients.

**Obstetric Service.** An organized hospital service that provides services for maternity and newborn cases.

**Occupational Therapy Services.** Hospital service that provides therapy to patients through the provision of the skills related to conduct of activities of daily living.

**Operating Room.** A room within the hospital where surgical operations and other invasive procedures are carried out.

**Ophthalmic Surgery.** Surgical services provided by the hospital that focus on treating diseases of the visual pathway, including the eye, brain, and areas surrounding the eye, such as the lacrimal system and eyelids. Ophthalmic surgery is completed by ophthalmologists, medical doctors with a specialty in ophthalmology.

**Optometric Services.** A service of the hospital that focuses on examining the eye for defects and faults of refraction, with prescribing correctional lenses or eye exercises, with diagnosing diseases of the eye, and with treating such diseases or referring them for treatment.

**Organ Transplant Services, Not Medicare-certified.** A service of the hospital that offers organ-specific transplants and other medical and surgical specialty services required for the care of transplant patients but is not Medicare-certified as a transplant program. *Do not confuse with Transplant Center-Medicare certified, which is to be used for all Medicare-certified organ transplantation services.*

**Orthopedic Surgery.** Surgical services provided by the hospital that treats patients with acute, chronic, traumatic, and overuse injuries and other disorders of the muscles, bones, and joints of the body.

**Outpatient hospital service.** Diagnostic, therapeutic (both surgical & nonsurgical), and rehabilitation services provided to sick or injured persons who do not require hospitalization.

**Pediatric Services.** A service of the hospital that focuses on the medical treatment of infants, children, and adolescents up to the age of 18.

**Pharmacy.** A service of the hospital that is responsible for the safe and effective storage, control and distribution of drugs and biologicals utilized in the diagnosis or treatment of patients.

**Physical Therapy Service.** A service of the hospital that is provided by a physical therapist or a physical therapy assistant to treat patients with movement disorders arising from conditions and diseases.

**Positron Emission Tomography Scan.** A type of nuclear medicine imaging that produces a three-dimensional image of functional processes in the body that can be used in the diagnosis and treatment of patients.

**Psychiatric emergency services.** Services or facilities available on a 24-hour basis to provide immediate unscheduled outpatient care, diagnosis, evaluation, crisis intervention, and assistance to person suffering acute emotional or mental distress.

**Psychiatric child/adolescent services.** A service for provision of inpatient mental health services to children and adolescents, including those admitted for diagnosis and those admitted for treatment. The service may or may not take place in an IPPS-excluded unit.

**Psychiatric forensic services.** An organized unit of the hospital that provides inpatient services to individuals under the control and jurisdiction of a police authority.

**Psychiatric geriatric services.** A service for provision of inpatient mental health services to elderly patients, including those admitted for diagnosis and those admitted for treatment. The service may or may not take place in an IPPS-excluded unit.

**Psychiatric inpatient services.** A service for provision of mental health services to adult individuals who have been admitted to the hospital as inpatients for diagnosis and treatment of mental illness. The service may or may not take place in an IPPS-excluded unit.

**Psychiatric outpatient services.** A service for provision of mental health services, including diagnosis and treatment, to individuals who do not require hospitalization.

**Radiology services - diagnostic.** An organized service of the hospital that uses medical imaging technologies to diagnose disease.

**Radiology services - therapeutic.** An organized service of the hospital that uses medical imaging technologies to treat disease.

**Reconstructive surgery.** Surgical services that focus on reshaping or rebuilding (reconstruct) a part of the body changed by previous surgery.

**Respiratory care services.** An organized service for the provision of respiratory therapy to hospital patients.

**Rehab Inpatient.** An organized service for the provision of rehabilitation therapies to inpatients. The service may or may not take place in an IPPS-excluded unit.

**Rehab-Outpatient.** Services providing rehabilitation therapies to outpatients.

**Renal dialysis (Acute Inpatient).** A treatment for inpatients that replaces the function of the kidney to remove waste products and excess fluids and restore the proper chemical balance of the blood. Do not include separately licensed outpatient dialysis treatment services.

**Social Services.** A hospital service that provides supportive services to address non-medical needs of patients.

**Speech Pathology Services.** Services designed to evaluate and treat oral communication disorders and swallowing problems.

**Surgical Services –Inpatient.** An organized service for the provision of surgery to inpatients.

**Surgical Services –Outpatient.** An organized service for the provision of surgery to patients not requiring inpatient admission.

**Trauma Center (Designated).** An organized service designated by a State or, in the absence of a State trauma designation system, the American College of Surgeons, to provide emergency and specialized intensive care to critically injured patients.

**Transplant Center, Medicare certified.** A separately Medicare-certified, organ-specific transplant service within a hospital that offers organ-specific transplants and other medical and surgical specialty services required for the care of transplant patients and meets the requirements of 42 CFR 482 Subpart E.

**Urgent Care Center Services.** Outpatient services provided to patients, usually on an unscheduled, walk-in basis, in a part of the hospital or CAH that does not meet the definition of a dedicated emergency department under EMTALA regulations at 42 CFR 489.24.

**ATTACHMENT C**

**LICENSE FEE SCALE**

**Make Payment to:** *Treasurer, State of Wyoming*

**INITIALS, ANNUAL RENEWAL OR CHANGE IN OWNERSHIP**

Adult Day Care Adult Foster Care Home Ambulatory Surgical Center Birthing Center End Stage Renal Dialysis Free-Standing Diagnostic Testing Center Home Health Agency Hospice Facility Intermediate Care Facility for the Mentally Retarded Medical Assistance Facility Rehabilitation Facility	<b>\$100</b>
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Assisted Living Facility Boarding Home Nursing Care Home	<b>0 – 50 BEDS</b>	<b>\$100</b>
	<b>51 – 100 BEDS</b>	<b>\$200</b>
	<b>101 – 150 BEDS</b>	<b>\$300</b>
	<b>151 – 200 BEDS</b>	<b>\$400</b>
	<b>201 OR MORE BEDS</b>	<b>\$500</b>

Critical Access Hospital Hospital Psychiatric Hospital Rehabilitation Hospital	<b>ACCREDITED:</b>	
	Accredited <b>WITHOUT</b> swing beds	<b>\$100</b>
	Accredited <b>WITH</b> swing beds	<b>\$200</b>
	<b>NON-ACCREDITED</b>	
	Non-Accredited <b>0-50</b> beds	<b>\$100</b>
	Non-Accredited <b>51-100</b> beds	<b>\$200</b>
	Non-Accredited <b>101-150</b> beds	<b>\$300</b>
	Non-Accredited <b>151-200</b> beds	<b>\$400</b>
	Non-Accredited <b>201 or more</b> beds	<b>\$500</b>

**CHANGE IN FACILITY NAME, BEDS/STATIONS, LOCATION**

<b>ALL PROVIDERS</b>	<b>\$50</b>
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