

**CRITICAL ACCESS HOSPITAL
Checklist for State Licensure**

FACILITY NAME: _____

CITY: _____

CONTACT PERSON: _____

PHONE: _____ EMAIL: _____

Please mail or E-mail the following items to Healthcare Licensing and Surveys:

CHECK OFF	ITEM
	1. A completed license application form and required fee.
	2. Copy of the letter/notice received from the Wyoming Dept of Health approving the designation to become a critical access hospital.
	3. Copy of the formal designation, at a level determined by the critical access hospital, through the Wyoming Department of Health's trauma system enhancement program.
	4. Copy of organizational chart that reflects the administrative control and lines of authority for the delegation of responsibility from management down to the patient care level.
	5. Verification of the Department of Family Services central registry check on all employees hired.
	6. Copy of policy and procedure on the quality improvement program.
	7. Copy of policy and procedure indicating there shall be one person designated responsible for maintaining the confidentiality of personnel records.
	8. Copy of policy and procedure on employee health, including communicable and reportable diseases.
	9. A list of professional specialists who will be providing patient care services and their qualifications. Copy of policy regarding mid-level (MAs, NPs) responsibilities and oversight.

	10. Copy of policy and procedure on emergency services and disaster preparedness.
	11. Copies of any agreements or contracted services.
	12. Copy of policy and procedure for the quality improvement program.
	13. Copy of policy and procedure on infection control.
	14. Copy of menus for a two week period.
	15. Copy of policy and procedures on advance directives.
	16. Detailed location of swing-beds (include floor plan) with ALL appropriate policies and procedures. (If applicable)
	17. Copy of policies and procedures on transfers and discharge planning.
	18. Copy of policy on background screening for new hires.

FOR HEALTHCARE LICENSING AND SURVEYS USE ONLY**Date:****Surveyor Assigned to Review:****Surveyor Recommendation Review Summary/Comments:****Date****Surveyor Signature:****State Survey Agency Director/Administrator (or designee) Comments:****Additional Information Needed:** ☐ **Approved:** ☐ **Denied:** ☐**Date:****Signature:**

(08/14/2025)