State of Wyoming–Department of Health
Aging Division
Healthcare Licensing and Surveys
Hathaway Bldg, Suite 510
2300 Capitol Avenue
Cheyenne WY 82002

Ph: 307-777-7123
Fax: 307-777-7127
Web: https://www.health.wyo.gov/aging/hls
Email: wdh-ohls@wyo.gov

CRITICAL ACCESS HOSPITAL
LICENSE APPLICATION FOR CHANGE OF INFORMATION

Fees:	Change of Information $250 (This application is not to be used for a change in ownership; a different application form is required.)		
Make Payment To:	***Wyoming Department of Health***		
FOR HLS USE ONLY			
Fee Paid		License #	Appl Approved
Check #			

If we have questions/concerns, regarding the information provided on this application, whom should we contact?
Contact Person's Name: _____ Email: _____

This is a fillable form. Tab through the document to advance.
(The license will NOT be sent in hard copy, the license will be sent electronically to the Email address below.)

GENERAL APPLICATION INFORMATION

1. Type of Application: (check one)

a. ☐ Change in Address of Main Physical Location Effective Date of Change: _____
Previous Address: _____
New Address: _____

b. ☐ Add New Ancillary Location ☐ Modify Ancillary Location ☐ Delete Ancillary Location

If more than one ancillary addition, modification or deletion, attach an additional sheet with the required information below and check this box. ☐

New Ancillary Address: _____
List of services to be provided at this new location:_____
Complete the Ancillary Attestation Form attached. *(Only for an addition)*

Modify Ancillary Address: _____
Previous Address: _____

Deleted Ancillary Address: _____
Where are the services from this location being relocated to: _____

c. ☐ Change in Facility Name Effective Date of Change: _____
Previous Name: _____
New Name: _____

d. ☐ Change in # of Inpatient Licensed Beds Effective Date of Change: _____
Previous # of Total Inpatient Licensed Beds: _____
New # of Total Inpatient Licensed Beds: _____

NOTE: If this application is for a change in address/location, you are required to work with our Life Safety and Construction Branch for the required approval. Please contact our office at 307-777-7123.

FACILITY NAME: ___

2. Facility Name: (This is how it will appear on your license.)
   _____
3. Physical Facility Full Address: (Include city, st., and zip.)
   _____
4. Mailing Address: (If different from #3. Include city, st., and zip.)
   _____
5. Phone: _____
6. Email: _____
7. Name of Administrator: _____
8. Name of Director of Nursing: _____
8. Total # of Beds to be Inpatient Licensed: _____

SIGNATURE

Application must be signed. This can be an Administrator/Director, CEO, CFO, Executive Director, or an Owner.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Submit application via Email to:
Wdh-ohls@wyo.gov

ANCILLARY ATTESTATION FORM

Ancillary/Locations Not Located Within the Main Building

(Complete one form for each additional location)

HOSPITAL NAME: _____

Ancillary Location Name: _____

Ancillary Location Address (include city): _____
(**BE SPECIFIC**: Located in a specific suite(s) # within building, specific floor, etc.)

Please attach a copy of the organization chart and clearly indicate where the responsibility of this ancillary location fits into the hospital organization.

# of Highway Miles from Main Hospital: _____ # of Radius Miles from Main Hospital: _____

List all hospital services (indicate appropriate suites, if applicable) being provided at this ancillary location: _____

For the time employees are working at this ancillary location are their hours charged to the hospital's cost report?

YES ☐ NO ☐

While working at this ancillary location are the employees under the supervision of a hospital employee?

YES ☐ NO ☐ If no, explain: _____

Are the services at this ancillary location under the supervision of the hospital's organized medical staff?

YES ☐ NO ☐ If no, explain: _____

How are referrals made to this location? _____

Are the services being billed as a hospital service under the hospital's Medicare/Medicaid agreement (hospital's provider number)?

YES ☐ NO ☐

If No, explain how these services are billed (be specific)? _____

Name of Person Completing this form: _____

Title: _____ Date: _____