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

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CRITICAL ACCESS HOSPITAL
LICENSE APPLICATION

Fees:	Initial (New) Provider or Change in Ownership		$500
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. You must tab through the document to advance. Please read the License Application Instructions prior to completing this application.
(Licenses will NOT be sent in hard copy but sent electronically to the Email address below.)

GENERAL APPLICATION INFORMATION

1. Type of Application: (check one)

   ☐ Initial Application

   ☐ Change in Ownership Effective Date of Change: _____
   Accepting assignment of the existing provider agreement ☐ Yes ☐ No

2. Facility Name: (This is how it will appear on your license. See specific details on the license application instructions.)
   _____

3. Physical Facility Full Address: (Main location. Include city, st., zip)
   _____

4. Mailing Address: (If different than #3. Include city, st., zip)
   _____

5. Fiscal Year End Date: _____
   (See specific details on the license application instructions.)

6. Phone: _____

7. Fax: _____

8. Email: _____
   (See specific details on the license application instructions.)

FACILITY NAME: ___

PROVIDER DETAILS

9. Are you a Wyoming Medicare/Medicaid Certified Provider? ☐ Yes ☐ No

   a. If yes, what is your CMS Certification Number (CCN): _____
   (See specific details on the license application instructions.)

   b. If no, are you planning on applying for Medicare/Medicaid Certification within the next 12 months?
   ☐ Yes ☐ No

      i. If yes, when do you anticipate applying for certification? _____

10. National Provider Identifier (NPI) number: _____
    (See specific details on the license application instructions.)

11. Federal Employer Tax ID (EIN) number: _____
    (See specific details on the license application instructions.)

12. Does the facility have in place a documented quality management function to evaluate and improve patient care and services? ☐ Yes ☐ No

13. Number of inpatient licensed beds: _____

14. Number of observation beds: _____

15. Number of operating rooms: _____

16. Number of endoscopy procedure rooms: _____

17. Number of cardiac catheterization procedure rooms: _____

18. Specialized Units: (check as appropriate)
    - ☐ Alzheimer Unit
    - ☐ PPS Psychiatric Unit
    - ☐ PPS Rehabilitation Unit
    - ☐ Substance Abuse Unit
    - ☐ Special Care Unit
    - ☐ Other _____

FACILITY NAME: ___

19. Services Provided: (Check as appropriate.)

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

20. Do you currently have "deemed" status with one of the nationally recognized accrediting organizations below? (See specific details on the license application instructions.) ☐ Yes ☐ No

a. If yes, what approved accrediting organization do you belong to:
(Check one) ☐ TJC ☐ HFAP ☐ DNV GL

i. Date of Last Accrediting Survey (Attach a copy.): _____

b. If no, do plan on obtaining "deemed" status within the next 12 months? ☐ Yes ☐ No

i. If yes, approximately when do you plan on applying for "deemed" status? _____

FACILITY NAME: ___

21. In accordance with W.S. 35-2-910(c), does the Hospital provide for the review of professional practices in the hospital for the purpose of reducing morbidity and mortality and for the improvement of the care of patients in the hospital? This review shall include but not be limited to:

(a) The quality and necessity of the care provided to patients as rendered in the hospital;
(b) The prevention of complications and deaths occurring in the hospital;
(c) The review of medical treatments and diagnostic and surgical procedures in order to ensure safe and adequate treatment of patients in the hospital; and
(d) The evaluation of medical and health care services and the qualifications and professional competence of persons performing or seeking to perform those services.

The review shall be performed according to the decision of a hospital's governing board by:

(a) A peer review committee appointed by the organized medical staff of the hospital;
(b) A state, local or specialty medical society; or
(c) Any other organization of physicians established pursuant to state or federal law and engaged by the hospital for the purposes of W.S. 35-2-910(c).

☐ Yes ☐ No

PERSONNEL

22. Name/Title of person in charge of facility, agency, or clinic: _____
(See specific details on the license application instructions.)

23. Name of Administrator: _____

24. Name of Director of Nursing: _____

a. Professional License Type: _____

b. Professional License Number: _____

25. Name of Registered Dietitian: _____

a. Wyoming License Number: _____

b. On Staff ☐ Under Contract ☐

26. Name of Certified Dietary Manager: _____

a. Date Completed Course: _____ or

b. If currently enrolled in course, anticipated completion date: _____

27. Name of Medical Director (if applicable): _____

a. Professional License Type: _____

b. Professional License Number: _____

FACILITY NAME: ___

28. Name of Maintenance Director (if applicable): _____

a. Contact phone number: _____

LOCATIONS/BUILDINGS (You must attach a readable and clear floor. See specific details on the license application instructions.)

29. Main Building Location

a. Property Ownership: ☐ Own ☐ Rent ☐ Lease

b. Physical Address: (Include city.) _____

c. Services at this location: _____

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: _____

30. Number of ancillary locations under the CCN in 10a. _____

a. For each of these locations an Attestation Form must be attached to this application. The Attestation Form can be found with the license application instructions.

31. Please attach a copy of your Critical Access Hospital PTAN report. This report will identify all locations enrolled under your hospitals CCN as filed with your CMS 855 application. This report can be obtained from the PECOS system. See specific details on the license application instructions.)

OWNER

32. Ownership type: (check one)
(See specific details on the license application instructions.)

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: _____

FACILITY NAME: ___

33. Ownership Name: _____

34. Mailing Address: _____

35. Phone: _____

36. Contact Person: _____

37. Contact Person's Email: _____

38. List all officers in the ownership and titles below: or ☐ List attached.
(This is the Pres, VP, etc. or Board Members; not the CEO, CFO, etc. See specific details on the license application instructions.)

a. _____

b. _____

c. _____

d. _____

e. _____

39. 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

a. If yes, explain: _____

OPERATOR

40. Is the facility operated or managed by a business entity other than the owner section above?
☐ Yes ☐ No

a. If yes, Operating Entity Name: _____

b. Mailing Address: _____

c. Phone: _____

d. Contact Person's Name: _____

e. Contact Person's Email: _____

41. 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: _____

42. Did you read and understand the healthcare facility licensure requirements (W.S. 35-2-901 and 902 et seq) outlined in the license application instructions? ☐ Yes ☐ No

FACILITY NAME: ___

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 persons 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: _____