MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF HOSPITAL STANDARDS

APPLICATION FOR HOSPITAL LICENSE

In accordance with the requirements of the Missouri Hospital Licensing Law, application is hereby made for a license to conduct and maintain a hospital.

DO NOT WRITE IN THIS SPACE

LICENSE NO.
LICENSE DATE
CERTIFICATE NO.
ISSUE DATE

NAME OF HOSPITAL (NAME TO APPEAR ON LICENSE)	TELEPHONE NUMBER
LEGAL NAME OF HOSPITAL	

STREET ADDRESS	CITY AND ZIP CODE	COUNTY
CHIEF EXECUTIVE OFFICER (FULL NAME)	TITLE	EMAIL
NEXT IN CHARGE (FULL NAME)	TITLE	EMAIL

The hospital fiscal year starts on (MONTH/DAY) _____ and ends on (MONTH/DAY) _____

OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)

A. Governmental

☐ District ☐ County
☐ City-County ☐ City
☐ Other (specify) _____

B. Non-Governmental

Non-Profit
☐ Church Operated
☐ Church Affiliated
☐ Other Non-Profit
☐ Other (specify) _____

Proprietary
☐ Individual
☐ Partnership
☐ Corporation

LEGAL NAME OF OPERATING ENTITY

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

C. Attach an organizational chart which details all executive boards and/or supervisory boards for any entity that maintains management authority over the hospital or an ownership interest in this hospital of more than 50% to include the directors of each required service.

THE HOSPITAL HAS COMPLETED AND RETURNED THE MOST RECENT ANNUAL SURVEY OF MISSOURI HOSPITALS
☐ YES ☐ NO

ACCREDITATION

ACCREDITED	ACCREDITED BY	DEEMED
☐ YES ☐ NO		☐ YES ☐ NO

BED DESIGNATION BY SERVICES (indicate total beds in each category). If any of the beds have been converted to non-patient use please do not include those beds on the list.

MEDICAL-SURGICAL	PSYCHIATRIC	OBSTETRICAL	NEONATAL ICU	NURSERY BASSINETS (NOT INCLUDED IN BED COUNT)
REHABILITATION	ICU-CCU	PEDIATRIC	LONG TERM CARE	ALCOHOL/DRUG ABUSE
OTHER (SPECIFY SERVICE)			TOTAL BEDS	CHANGE FROM PREVIOUS TOTAL?
ER BAYS/BEDS (NOT INCLUDED IN BED COUNT)	OR SUITES (NOT INCLUDED IN BED COUNT)		SWING BEDS (NOT INCLUDED IN BED COUNT)	

NOTE: ATTACH AN EXPLANATION FOR ANY CHANGES IN TOTAL BED COMPLEMENT SINCE LAST APPLICATION

OTHER

Construction/Renovation

1. New hospitals - attach Certificate of Need approvals if applicable.
2. Renovations or construction projects during this licensure period should be submitted in accordance with 19 CSR 30-20.030.
3. Provide a copy of all DHSS current, approved variances.
   a. If new variance(s) is requested, please submit in accordance with 19 CSR 30-20.015.

Premises

For all locations that will be identified as premises, as defined by RSMo section 197.052, please provide a map or drawing of the premises to illustrate the location of each building. Attach a listing of all buildings with each listed by name, address and type of patient service offered.

Co-location status

Is there another provider or licensed entity, or a satellite location of another provider or licensed entity, that occupies space in a building used by the hospital, or in one or more entire buildings located on the hospital's licensed premises?

☐ YES ☐ NO

If answer is yes, then list the name and Medicare identification (i.e. 26xxxx) number of the co-located provider or licensed entity.

NAME OF CO-LOCATION PROVIDER, LICENSED ENTITY OR SATELLITE LOCATION	MEDICARE IDENTIFICATION NUMBER

CERTIFICATION

We the undersigned hereby certify that we have read the foregoing application and that the statements contained therein are true and correct to the best of our knowledge, and further assure the ability and intention of the _____ (NAME OF ENTITY) to comply with MIssouri statutes and regulations pertaining to hospital licensure.

CHAIR OF THE GOVERNING BODY SIGNATURE	PRINT NAME	DATE
CHIEF EXECUTIVE OFFICER SIGNATURE	PRINT NAME	DATE