Reset Form

APPLICATION FOR LICENSE TO OPERATE AN AMBULATORY OUTPATIENT SURGICAL CENTER

State Form 9340 (R6 / 9-18)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 15-2.3-1)

Division of Acute Care Use Only

Date Received_____ *(month, day, year)* **Date Approved**_____ *(month, day, year)* **Date Rejected** _____ *(month, day, year)*

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ **New Facility** ☐ **Renewal** ☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)*** *(month, day, year)*_____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Surgical Center Location

Name of Surgical Center

Street Address *(number and street)*		P.O. Box
City	County	ZIP Code +4

Telephone Number	Fax Number	Hours Procedures are Performed *(If no procedures performed, indicate "closed.")*
( )	( )	

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

B. Mailing Address *(if different from surgical center location)*

Street Address *(number and street)*		P.O. Box
City	County	ZIP Code +4

C. Licensee / Ownership Information

Licensee: The applicant entity as registered with the secretary of state

Street Address *(number and street)*		P.O. Box
City	State	Zip Code+4

Telephone Number	Fax Number	EIN Number	Fiscal Year End Date *(mm/dd)*
( )	( )		

D. Supplier Numbers

Medicare Supplier Number	Medicaid Supplier Number *(Related Supplier Number)*
15C	

E. Services provided under this license:
Coded as follows: 1. Provided directly by employee, 2. Provided by a contract service, 3. Both 1 and 2.

Ancillary Services: ☐ Laboratory ☐ Radiology ☐ EKG ☐ Pharmacy

Surgical Services: ☐ Cardiovascular ☐ Foot ☐ General ☐ Neurological ☐ Obstetrics/Gynecology
☐ Ophthalmology ☐ Oral ☐ Orthopedic ☐ Otolaryngology ☐ Plastic ☐ Thoracic
☐ Urology ☐ Gastroenterology ☐ Other

F. Number of Operating Rooms (as classified in the AIA, 2001 guidelines):

Class A	Class B	Class C	Endoscopy

G. Off-site centers:

Are there off-site facilities under this license? ☐ Yes ☐ No
If yes, please complete the following information:

Name	Address/City/State/ZIP	Telephone Number

H. Accreditation:

Does this center have accreditation that is "deemed" to meet CMS Conditions of Coverage? ☐ Yes ☐ No
If accredited, please complete the following:

Name	Effective Date of Accreditation *(month, day, year)*	Expiration Date of Accreditation *(month, day, year)*

I. Type of Entity:

For Profit
- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Other *(specify)* _____

Non-Profit
- ☐ Church Related
- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Other *(specify)* _____

Government
- ☐ State
- ☐ County
- ☐ City
- ☐ City / County
- ☐ Hospital District
- ☐ Federal
- ☐ Other *(specify)* _____

J. Officers *(if the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President / Chairperson / CEO		
Vice-President / Vice-Chairperson / COO		
Treasurer / CFO		
Secretary		

K. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address/City/State/ZIP	EIN Number

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Ambulatory Outpatient Surgical Center (Center) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Ambulatory Outpatient Surgical Center statues, IC 16-21, and the rules promulgated thereunder, 410 IAC 15-2.1 and will operate and maintain this center in accordance with those rules.

I certify that the operational policies of the center will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of centers in Indiana.

Signature of Chief Executive Officer / Owner:	
Printed Name and Title:	
Date of Signature *(month, day, year)*:	
Signature of the Facility Administrator:	
Printed Name and Title:	
Date of Signature *(month, day, year)*:	

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate license fee below and return the application, any attachments, and license fee to:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE
2 NORTH MERIDIAN STREET, SUITE 2-C
INDIANAPOLIS, INDIANA 46204

Total Annual Procedures are found on the <u>fourth</u> quarter report entitled "*Quarterly Utilization Review Report/Ambulatory Surgery Center (State form 49933)," item III, line "Since the beginning of the year", right hand box.*

Check One	Total Annual Procedures	Fee
☐	Zero to 799	$500.00
☐	800 to 3,499	$1,000.00
☐	3,500 to 6,999	$2,000.00
☐	7,000 and above	$3,000.00

Indiana Hospital Council; 414 IAC 1-2