Reset Form

APPLICATION FOR LICENSE TO OPERATE A HOSPITAL

State Form 44885 (R6 / 9-18)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 15-1.3-1)

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**
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Hospital Location *(facility location)*

Name of Hospital		
Street Address *(number and street)*		P.O. Box
City	County	ZIP Code +4
Telephone Number ( )	Fax Number ( )	

B. Mailing Address *(if different from hospital location)*

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

C. Ownership Information

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. Provider Numbers

Medicare Provider Number	Medicaid Provider Number

E. Additional Services and/or Off-site Practice Locations Operated Under Hospital License

If not applicable, leave blank. Do not list on-site skilled or distinct part units unless located off-site. (Use additional sheet if necessary.)

Type of Service	Name	Address	Provider Number if different from Hospital
Blood Center			
Hospice			
Home Health			
Other Off-Site Locations *List below.*			

F. Long Term Care Unit:
Does the hospital have a long term care unit? ☐ Yes ☐ No If yes, number of beds: _____
Are the beds Medicare certified? ☐ Yes ☐ No

If yes, Medicare certification number: _____

Is the long term care unit also licensed by the Indiana State Department of Health Division of Long Term Care? ☐ Yes ☐ No

G. Beds:
Total Number of setup and staffed beds for inpatients in the hospital *(exclude pediatric visitors, newborn nursery cribs, maternity labor and delivery beds)* as of the date of this application: _____

Does this facility have swing beds? ☐ Yes ☐ No

H. Hospital within a Hospital Status:

Is this a host hospital? ☐ Yes ☐ No

Is this a tenant hospital? ☐ Yes ☐ No

I. Type of Control: *(Check all that apply.)*

For Profit	**Non-Profit**	**Government**
☐ Sole Proprietorship	☐ Church Related	☐ State
☐ Partnership	☐ Sole Proprietorship	☐ County
☐ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☐ Corporation	☐ City / County
☐ Other: *(specify below)*:	☐ Limited Liability Company	☐ Federal
	☐ Other *(specify below)*:	☐ Other *(specify below)*:
_____	_____	_____
_____	_____	_____

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

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

K. Change in Ownership
If this application is for a change in ownership (required if the change in ownership is fifty percent (50%) or greater), complete the following. Otherwise, leave blank. *(The mere sale of shares of an owning corporation [or for corporations controlled by a 'member' or 'members' which can be individuals, partnerships, or other corporations] does not constitute a change of ownership.)*

☐ Asset Purchase Agreement	☐ Assignment of Interest	☐ Lease
☐ Merger	☐ New Partnership	☐ Sale
☐ Termination of Lease	☐ Transfer of Asset Agreement	☐ Other: _____

K. Change of Ownership *(Continued)*

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) or more 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 make application for a license to operate a hospital in the State of Indiana pursuant to hospital statute, IC 16-21, and the rules promulgated there under at 410 IAC 15.

I certify that the operational policies of the hospital 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 true and accurate and in compliance with regulations, laws, and rules governing the licensing of hospitals in Indiana.

Signature of Chief Executive Officer or designee:	
Printed Name and Title:	
Date of Signature *(month, day, year)*:	
Signature of Governing Board Chairperson/President or designee:	
Printed Name and Title:	
Date of Signature *(month, day, year)*:	
Signature of Chief of Medical Staff or designee:	
Printed Name and Title:	
Date of Signature *(month, day, year)*:	

License Fee

Select the appropriate license fee below and return the application, any attachments, and license fee made payable to:
INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE
2 NORTH MERIDIAN STREET, SUITE 2-C
INDIANAPOLIS, INDIANA 46204

Total Operating Expenses are found on the most recently filed Hospital Fiscal Report, State Form 49520 as required by IC 16-21-6-3.

Check One	Total Operating Expenses	Fee
☐	Zero to $49,999,999.00	$1,000.00
☐	$50,000,000.00 to $99,999,999.00	$2,000.00
☐	$100,000,000.00 to $199,999,999.00	$3,000.00
☐	$200,000,000.00 to $299,999,999.00	$4,000.00
☐	$300,000,000.00 and above	$5,000.00

Indiana Hospital Council; 414 IAC 1-1