Reset Form

APPLICATION FOR LICENSE TO OPERATE A BIRTHING CENTER

State Form 52235 (R2 / 9-18)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 27)

Division of Acute Care Use Only

Date Received_____ **Date Approved**_____ **Date Rejected** _____
(month, day, year) *(month, day, year)* *(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. Birthing Center Location

Name of Birthing Center		
Street Address *(number and street)*		P.O. Box
City	County	ZIP Code +4
Telephone Number ( )	Fax Number ( )	Birthing Center e-mail address:_____ Internet Web Address:_____

B. Mailing Address *(if different from birthing 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. Facility, staff, and services provided under this license:
The facility is a: ☐ Home ☐ Professional Office Building

List numbers of each: _____Reception Area _____ Business Office _____Exam Room _____Birth Rooms

_____Whirlpool/Tub Room _____Family Room _____ Classroom _____Kitchen

_____Bathroom _____Conference Room _____Storage Room _____Playroom/area

Other *(Specify)*: _____

Staffing (number of): Certified Nurse Midwives: _____ Registered Nurses (excluding CNMs): _____

Licensed Practical Nurses: _____ Obstetricians: _____ Family Practitioners: _____

Certified Birthing Educators: _____

Other *(Specify)*: _____

Services Provided: *(Check all that apply.)*

☐ Orientation to fees and services ☐ Written glossary and criteria for admission and continuation in the program ☐ Prenatal care ☐ Education regarding pregnancy, labor, breastfeeding, infant care, early discharge, parenting, self-care/self-help, and sibling preparation ☐ 24-hour telephone consultation ☐ Library resources ☐ Intrapartum care ☐ Immediate Postpartum care ☐ Nourishment during labor ☐ Home or office follow-up for mother and newborn ☐ Exercise programs ☐ Parent support groups ☐ Postpartum classes ☐ Family planning ☐ Well baby care ☐ Circumcision ☐ Nursing mother support program ☐ Well woman gynecologic care ☐ Public education ☐ Clinical investigation/research ☐ Domestic violence education ☐ Onsite laboratory, if yes CLIA Certificate number:_____

E. Charges:

	Practitioner	**Facility**
Birthing Center:	$_____.00	$_____.00
Hospital:	$_____.00	$_____.00

F. 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)* _____

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

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

H. 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 a Birthing 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 Birthing Center statue, IC 16-21-2-2.5, and the rules promulgated thereunder, 410 IAC 27 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 the Medical Director:	
Printed Name and Title:	
Date of Signature *(month, day, year)*:	
Signature of the Center 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

Based upon the number of births listed in item N of the Annual Birthing Center Report (State Form 52236), select the appropriate fee:

Check One	Total Births in the Center	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 1-1-4

Enclose the following:

1. A completed Application for License to Operate a Birthing Center (this form);

2. A completed Annual Birthing Center Report (State Form 52236);

3. Any supporting attachments; and

4. Payment made payable to "Indiana State Department of Health."

Mail to:

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