



**STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES**

**Medical Facilities Unit – Acute Care
Critical Access Hospital**

SECTION 1: Facility Information			
Facility Name:			
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: ()		Fax No.: ()	
Email Address:			

SECTION 2: Fees	
APPLICATION FOR CRITICAL ACCESS HOSPITAL	
License Type: <input type="checkbox"/> Initial License (fee \$40 x Number of Acute/Swing Beds: _____) <input type="checkbox"/> Renewal License (fee \$40 x Number of Acute/Swing Beds: _____) License Renewal Period (dates): _____ to _____ Total Fee Enclosed for Licensed Capacity	\$ _____ \$ _____ \$ _____
Make checks or money orders payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time.	Total Checks/Money Orders enclosed = \$ _____

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
 Licensing and Regulatory Services
 Medical Facilities – Acute Care Program
 41 Anthony Ave; 11 State House Station
 Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
 Email: DLRS.MedFacilities@maine.gov

<i>Office Use Only:</i> Check# _____ MO # _____ Amount \$ _____ Initials: _____ License# _____

SECTION 3: Facility Information (Use additional sheets, if necessary)

Owner of Hospital:

Operator of Hospital:

Non-Profit:

Proprietary:

Chief Executive Officer:

Title:

Locations. List any other hospital facilities at locations other than the above address, which are under the same ownership and governing authority.

Name of Facility
Telephone Number

Address

1. _____

2. _____

3. _____

Changes since last licensure.

Has the Hospital Charter, Constitution, or Bylaws been amended since last license application?

No Yes, date on which current Hospital Charter, Constitution, or Bylaws adopted by Governing Authority: _____

Have the Medical Staff Bylaws been amended since the last license application?

No Yes, date on which current Medical Staff Bylaws were approved by Governing Authority: _____

Accreditation: Please select all Accreditation Organizations that this Critical Care Access Hospital is accredited by.

- | | | |
|--|----------------------------|----------------------------|
| <input type="checkbox"/> Joint Commission | Date of Last Survey: _____ | Accredited for _____ years |
| <input type="checkbox"/> AOA | Date of Last Survey: _____ | Accredited for _____ years |
| <input type="checkbox"/> Laboratory Accredited by C.A.P. | Date of Last Survey: _____ | Accredited for _____ years |
| <input type="checkbox"/> Laboratory Accredited by Joint Commission | Date of Last Survey: _____ | Accredited for _____ years |
| <input type="checkbox"/> Other: _____ | Date of Last Survey: _____ | Accredited for _____ years |

Agreements and/or Contracts: Use the space below to elaborate on the agreements and/or contracts with other hospitals for services.

SECTION 4: Facility Services

Total Number of Beds:

<u>Number of Beds by Level of Care</u>	<u>Location (if other than main campus)</u>
Acute Hospital Beds _____	_____
Designated Swing Beds _____	_____
Bassinets _____	_____

Health Care Services Provided. Official license will be limited to health care services, beds, and bassinets applied for and approved.

- Section A, Daily Hospital Inpatient Services, complete the number of beds by category. This must match the number of beds in the previous section.
- Section B, Ancillary Services, are services that can be provided to either inpatients and/or outpatients. Select all that apply.

A. Daily Hospital Inpatient Services

<u>Acute Care</u>	<u>11X Private No. Beds</u>	<u>12X Semi-Private No. Beds</u>	<u>15X Ward No. Beds</u>	<u>16X Other No. Beds</u>
1. Surgical	_____	_____	_____	_____
2. OB/GYN	_____	_____	_____	_____
3. Pediatric	_____	_____	_____	_____
4. Medical	_____	_____	_____	_____
5. Isolation	_____	_____	_____	_____
6. Other Acute Hosp. Beds	_____	_____	_____	_____
7. Swing Beds	_____	_____	_____	_____
8. ICU/CCU/SCU	_____	_____	_____	_____
Acute Bed Totals	_____	_____	_____	_____

B. Ancillary Services (Select all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Pharmacy (25X) | <input type="checkbox"/> Emergency Room (45X) | <input type="checkbox"/> EKG (73X) |
| <input type="checkbox"/> Central Services (27X) | <input type="checkbox"/> Level I | <input type="checkbox"/> EEG (74X) |
| <input type="checkbox"/> Laboratory (30X) | <input type="checkbox"/> Level II | <input type="checkbox"/> Nursery (76X) Number |
| <input type="checkbox"/> Clinical | <input type="checkbox"/> Level III | <input type="checkbox"/> Newborn (level I) _____ |
| <input type="checkbox"/> Anatomical Pathology | <input type="checkbox"/> Level IV | <input type="checkbox"/> Isolation _____ |
| <input type="checkbox"/> Hematology | <input type="checkbox"/> Audiology (47X) | Total Bassinets: _____ |
| <input type="checkbox"/> Chemistry | <input type="checkbox"/> Outpatient Clinical Services (51X) | <input type="checkbox"/> Ambulatory Surgery (77X) |
| <input type="checkbox"/> Immunology | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Other Services (90X) |
| <input type="checkbox"/> Bacteriology | <input type="checkbox"/> Surgery | <input type="checkbox"/> Dental Services |
| <input type="checkbox"/> Urine | <input type="checkbox"/> Diabetic | <input type="checkbox"/> Electromyography |
| <input type="checkbox"/> Cytology | <input type="checkbox"/> ENT | <input type="checkbox"/> Recreational Therapy |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Eye | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Radiology-Diagnostic (32X) | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Other Therapy: _____ |
| <input type="checkbox"/> Nuclear Medicine (34X) | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Patient Education/Training |
| <input type="checkbox"/> Diagnostic | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Podiatric Services |
| <input type="checkbox"/> Therapeutic | <input type="checkbox"/> Cardiology | <input type="checkbox"/> Psychiatric/Psychological Svcs (91X) |
| <input type="checkbox"/> Anesthesia (37X) | <input type="checkbox"/> Physical Medicine | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Anesthesia M.D. | <input type="checkbox"/> Urology | <input type="checkbox"/> Day Care |
| <input type="checkbox"/> Anesthesia C.R.N.A | <input type="checkbox"/> Oncology | <input type="checkbox"/> Individual Therapy |
| <input type="checkbox"/> Acupuncture | | <input type="checkbox"/> Group Therapy |

- | | | |
|---|--|---|
| <input type="checkbox"/> Blood Bank (38X) | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Family Therapy |
| <input type="checkbox"/> Oncology Service (39X) | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Bio Feedback |
| <input type="checkbox"/> Respiratory Services (41X) | <input type="checkbox"/> Ambulance Service (54X) | <input type="checkbox"/> Testing |
| <input type="checkbox"/> Inhalation Services | <input type="checkbox"/> Medical Social Services (56X) | <input type="checkbox"/> Electric Shock Treatment |
| <input type="checkbox"/> Hyperbaric Oxygen Therapy | <input type="checkbox"/> Home Health Service (59X) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pulmonary function | <input type="checkbox"/> Recovery Room (71X) | |
| <input type="checkbox"/> Physical Therapy (42X) | <input type="checkbox"/> Labor and Delivery (72X) | |
| <input type="checkbox"/> Occupational Therapy (43X) | <input type="checkbox"/> Labor Room | |
| <input type="checkbox"/> Speech Pathology (44X) | <input type="checkbox"/> Delivery Room | |
| | <input type="checkbox"/> LDR | |
| | <input type="checkbox"/> LDP | |

Do we want to add a section on DPU's?

SECTION 5: Submission

Submit your completed application with the following:

- A check or money order made payable to "Treasurer, State of Maine"
- A listing of outpatient departments/services and locations
- A listing of affiliates with addresses
- Results of any Accreditation Survey, if applicable

SECTION 6: Declaration

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, _____, being duly authorized to assume responsibility for the conduct of the institution herein described, do hereby file this application for a license and do agree to assume responsibility that the institution will comply with all current regulations of the Department of Health and Human Services, as authorized by Title 22, MRSA §1964, Title 22; MRSA §1811-1822, and amendments and additions thereto; and in compliance with CFR §485.610.

Print name of Chief Executive Officer

Signature of Chief Executive Officer

Date

Address of CEO, if different from above

Mailing Address:

City:

State:

Zip:

County: