

FOR OFFICE USE ONLY

Checked by: _____

Approved by: _____

CRITICAL ACCESS HOSPITAL LICENSURE RENEWAL APPLICATION

**State of Maine
Department of Health and Human Services**

TO: Division of Licensing and Regulatory Services
Medical Facilities Unit
41 Anthony Avenue, #11 SHS
Augusta, ME 04333-0011

SUBJECT: Application for Licensure Renewal as a Critical Care Access Hospital

FROM: _____
(Name of Hospital)

(Street Address)

(City) (Zip) (Telephone Number)

E-Mail Address: _____

Under the provisions of MRSA 1964, Title 22, §1811-1821, an act relating to licensing hospitals and related institutions in the State of Maine, application is hereby made to the Department of Health and Human Services for a license or renewal of license to maintain and operate a Critical Care Access Hospital, as herein specified.

1. Applicant Hospital is owned by: _____
 Operated by: _____
 Non-Profit: _____

2. Chief Executive Officer: _____

(Name)
(Title)

<u>Number of Beds by Level of Care:</u>	<u>Location (if other than above)</u>
Acute Hospital Beds _____	_____
Designated Swing Beds _____	_____
Bassinets _____	_____
Skilled Nursing Beds _____	_____
Banked Beds _____	_____

4. Check those healthcare services you propose to render. License will be limited to healthcare services, beds, and bassinets applied for and approved. The first group of services relates to Daily Hospital Inpatient Services. Give number of beds by category. This total number of beds should agree with the totals on the first page. The second group of services relates to Ancillary Services, which can be provided to either inpatients and/or outpatients.

DAILY HOSPITAL INPATIENT SERVICES

Acute Care	11X Private Beds	12X Semi-Priv. Beds	15X Ward Beds	16X Other Beds
1. Surgical				
2. OB/GYN				
3. Pediatric				
4. Medical				
5. Isolation				
6. Other Acute Hospital Beds				
7. Swing Beds				
Acute Total Beds				

HOSPITAL ANCILLARY SERVICES

- 25X Pharmacy
- 27X Central Services
- 30X Laboratory
 - 1. Clinical
 - 2. Anatomical Pathology
 - 3. Hematology
 - 4. Chemistry
 - 5. Immunology
 - 6. Bacteriology
 - 7. Urine
 - 8. Cytology
 - 9. Other (specify)
- 32X Radiology-Diagnostic

34X Nuclear Medicine

- 1. Diagnostic
- 2. Therapeutic

37X Anesthesia

- 1. Anesthesia MD
- 2. Anesthesia CRNA
- 3. Acupuncture

38X Blood Bank

39X Oncology Service

41X Respiratory Services

- 1. Inhalation Services
- 2. Hyperbaric Oxygen Therapy
- 3. Pulmonary Function

42X Physical Therapy

43X Occupational Therapy

44X Speech Pathology

54X Ambulance Service

56X Medical Social Services

59X Home Health Services

72X Labor and Delivery

- 1. Labor Room
- 2. Delivery Room
- 3. LDR
- 4. LDP

76X Nursery # of Bassinets

- 1. Newborn (Level 1) _____
- 2. Isolation _____

Total Bassinets _____
 (Should agree with total on Page 1)

45X Emergency Room

- Level I
- Level II
- Level III
- Level IV

47X Audiology

50X Outpatient Clinical Services

- 1. Psychiatric
- 2. Surgery
- 3. Diabetic
- 4. ENT
- 5. Eye
- 6. OB/GYN
- 7. Orthopedic
- 8. Pediatric
- 9. Cardiology
- 10. Physical Medicine
- 11. Urology
- 12. Oncology
- 13. Ophthalmology
- 14. Other (specify)

71X Recovery Room

73X EKG

74X EEG

77X Ambulatory Surgery

90X Other Services

- 1. Dental Services
- 2. Electromyography
- 3. Recreational Therapy
- 4. Ultrasound
- 5. Other Therapy (specify)
- 6. Patient Education/Training
- 7. Podiatric Services

91X Psychiatric/Psychological Services

- 1. Rehabilitation
- 2. Day Care
- 3. Individual Therapy
- 4. Group Therapy
- 5. Family Therapy
- 6. Bio Feedback
- 7. Testing
- 8. Electric Shock Treatment
- 9. Other (specify)

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

5. Accreditation and Certifications

Joint Commission: Date of last Joint Commission Survey: _____

Accredited for: _____ years

AOA: Date of Last AOA Survey: _____

Accredited for: _____ years

Laboratory Accredited by CAP Date: _____

Number of years: _____

Laboratory Accredited by Joint Commission Date: _____

Number of years: _____

6. Has Hospital Charter, Constitution, or Bylaws been amended since last license application? (If yes, file an amended copy with this application.)

Date on which current Hospital Charter, Constitution, or Bylaws adopted by the Governing Authority _____.

7. Have Medical Staff Bylaws been amended since last license application? _____

(If yes, file an amended copy with this application.) Date on which current Medical Staff Bylaws were approved by hospital Governing Authority _____

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

I, _____ being duly authorized to assume responsibility for the conduct of the institution herein described, hereby file this application for a license and agree to assume responsibility for the institution, complying with all the current regulations of the Department of Health and Human Services, as authorized by MRSA, 1964, Title 22, §1811-1821 and amendments and additions thereto, and in compliance with CFR §485.610.

(Date)

(Signature, Chief Executive Officer)

(Address)

(Address of CEO , if different from above)

FEES: The Legislature has recently revised licensing fees to \$40.00 for each Acute Bed, including Banked Beds, and \$26.00 for each Skilled Nursing bed within a hospital. Your check or money order, made payable to *Treasurer, State of Maine*, should be mailed with this application to:

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