

**LICENSURE APPLICATION
for
HOSPITALS AND INSTITUTIONAL GENERAL
INFIRMARIES**

REGULATION 61-16

Return all documentation to:

Email address (preferred method):

HTL@dph.sc.gov

OR

Mailing address:

**Bureau of Health Facilities Licensing
2100 Bull Street
Columbia, SC 29201**

For additional questions, contact us at: 803-545-4370.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

NOTICE: Your license must be renewed prior to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or capacity increases/decreases) from the Department that are in progress at the time the license is due for renewal.

Application must be complete and legible. Any missing information may result in delays in processing this application. Any section that requires additional space or documentation shall be included as an attachment in the 8.5" x 11" format and be labeled to identify the appropriate section. Proof of payment is required for all applications submitted.

Reason for the Application

- Initial: Check this box only if this is the first time you are applying for a license with the Department. DO NOT check this box if this is a change of ownership for an existing licensed facility.
- Renewal: Check this box only if you are renewing your license. Enter the license number and expiration date. The name of the facility must appear exactly as it did the prior year.
- Amended License Request: Check this box if you are applying for a change that will alter the information on the face of your license; then, ensure that you complete Part D.

Part A: Facility Information

- Facility Information: Please complete the applicant information for the facility.
- Contact Person and Corresponding Mailing Address: All correspondence coming from the Bureau of Health Facilities Licensing will be sent to this person and address.
- CEO: Please complete each field.
- Food Service Areas: Please list all restaurants and/or food kiosks in the facility. If more than 10 (ten) attach an 8.5 x 11 sheet with additional names)

Part B: Operation/Ownership Disclosure

- Licensee Information: Name of the person(s) or entity to be licensed to operate the facility at the site indicated in Part A.
- Indicate the ownership type: Choose one type per category.
- Complete the requested information:
 - For partnerships, you must provide the name of each partner;
 - For limited liability company (LLC), you must provide the names of members, attach a list with the names and address of the members of the limited liability company;
 - For a corporation, you must provide the name and title of each corporate officer.
- If this is an LLC or Corporation list all persons/entities who have ownership interest in the entity applying for licensure.

Part C: Licensure Changes

- For Facility Name or Address changes, complete Section 1.
- For Ownership changes, complete Section 2.
- For changes in Capacity, complete Section 3.

Part D: Verification

- The application shall be signed by the following:
 - If an individual partnership, **the owner(s)**
 - If a corporation, **two** of its **officers** if a corporation
 - If governmental unit, the **head of the governmental department** having jurisdiction
- You must have this page notarized.



Hospitals and Institutional General Infirmaries Regulation 61-16

Reason for Application			
<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change Request <i>(Complete Part C and D)</i>	
	License Number:	Expiration Date:	
Part A. Facility Information			
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Emergency Number:			
Type of Hospital: (Can only check ONE)			
<input type="checkbox"/> General Hospital		<input type="checkbox"/> Institutional General Hospital	
<input type="checkbox"/> Institutional General Infirmary		<input type="checkbox"/> Privately-owned Educational Institutional Infirmary	
<input type="checkbox"/> Specialized Hospital (Specialty)		Specialty Type:	
Are you certified to perform abortions? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, a request to licensing must be on file.	
Number of beds to be licensed			
General Beds:	Psychiatric Beds:	Rehabilitation Beds:	Substance abuse beds:
Do you operate a swing bed unit? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, number of swing beds:	
Perinatal Services			
Does your hospital provide perinatal (obstetrics and newborn) services? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, indicate level: <input type="checkbox"/> I; <input type="checkbox"/> II; <input type="checkbox"/> III; <input type="checkbox"/> IV; <input type="checkbox"/> Regional Perinatal Center	
If licensed as level II, III, or IV how many NICU and Neonatal Special Care (Intermediate and Continuing Care) neonates are you capable of caring for? _____ NICU _____ Neonatal Special Care			
Buildings on Hospital Campus			
In how many buildings are patient/resident rooms located?			
Name of building:		Number of beds:	
Name of building:		Number of beds:	
Name of building:		Number of beds:	
Name of building:		Number of beds:	
Name of building:		Number of beds:	
Are any facility services or functions located in buildings other than those listed above? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please provide the following: (Attach a separate sheet of 8.5 x 11 paper if needed)			
Name of building:		Function of building:	
Location: (if at address other than that of hospital)			
City:	State:	Zip:	
Name of building:		Function of building:	
Location: (if at address other than that of hospital)			
City:	State:	Zip:	

Food Service Areas

Number of Kitchens:	
Number of Restaurants and/or food kiosks inside hospital (if applicable):	
List name of restaurants and/or food kiosks inside hospital (if applicable)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
Certified Food Protection Manager: (must attach a copy of the certification FOR INITIAL APPS ONLY)	
Name:	
Certificate Date:	Expiration Date:
Course Taken:	Institution:

Contact Person and Correspondence Mailing Address:

(Name of person who can make licensure/operation decisions about facility and address where you want to receive ALL correspondence, including the license, from the Bureau of Health Facilities Licensing.)

Name:	Title:	
Address:		
City:	State:	Zip:
Telephone:		
Primary Email:		
Chief Executive Officer		
Name:		
Address:		
Telephone Number:	Fax:	
Email Address:		

Part B. Operation and Ownership Disclosure

Licensee Information: *(name of the person(s) or legal entity licensed to operate the business at that site as indicated in Part A)*

****This can be found on your current license OR your documentation from the Secretary of State.***

Licensee Name:		
Mailing Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Name of Presiding Officer of the Registered Organization's Governing Body:		
Ownership Type		
<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other:
<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited Liability (LLC)*	
<input type="checkbox"/> Limited Partnership	<input type="checkbox"/> Government	

Part C: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES

<input type="checkbox"/> Change of Facility Name and/or Location (Complete Section 1)	<input type="checkbox"/> Change of Licensee/Ownership (Complete Section 2)	<input type="checkbox"/> Change of Licensed Beds (Complete Section 3)
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Section 1 (FACILITY INFORMATION)

PRIOR TO CHANGE

Current License Number:

Current Facility Name:

Current Facility Address:

City: _____ Zip: _____ County: _____

Facility Telephone Number: _____ Fax Number: _____

AFTER CHANGE

New Facility Name:

New Facility Address:

City: _____ Zip: _____ County: _____

New Facility Telephone Number: _____ Fax Number: _____

Section 2 (LEGAL IDENTITY OF OWNERSHIP)

Application must be completed by new owner, as licenses are not transferable.

PRIOR TO CHANGE

Name of Current Owner: _____ License Number: _____

License Number of Current Owner: _____

Address of Current Owner:

City: _____ Zip: _____ County: _____

Telephone Number of Current Owner: _____

Signature of current owner: _____ Date: _____

AFTER CHANGE

Name of New Owner: _____

Address of New Owner:

City: _____ Zip: _____ County: _____

Telephone Number of New Owner: _____

Signature of new owner: _____ Date: _____

Section 3 (CHANGE IN LICENSED UNITS)

License Number: _____

Facility Name: _____

Facility Address:

City: _____ Zip: _____ State: _____ County: _____

Facility Telephone Number: _____ Fax Number: _____

Increase **Decrease**

Number of General Beds From: _____ To: _____

Number of Rehabilitation Beds From: _____ To: _____

Number of Psychiatric Beds From: _____ To: _____

Number of Substance Abuse Beds From: _____ To: _____

For Perinatal Services Only

Increase from Level _____ to Level _____ Decrease Level from Level _____ to Level _____

Number of beds increasing _____ Number of beds decreasing _____

Part D: Verification

The application shall be signed by the following:

- If an individual, the **owner(s)**
- If a limited liability company, the **head of the limited liability company**
- If a corporation, **two** of its **officers**
- If governmental unit, the **head of the governmental department** having jurisdiction

I, the undersigned, being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with the standards set forth in South Carolina Regulation 61-16. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 61-16.

Signature:
Print Name:
Date:

Signature:
Print Name:
Date:

Subscribed and sworn to before me this _____ day of _____, _____.
(Month) (Year)

NOTARY PUBLIC _____

My commission expires _____

NOTARY SEAL