LICENSURE APPLICATION
for
HOSPITALS AND INSTITUTIONAL GENERAL INFIRMARIES

REGULATION 61-16

Return all documentation to:

Email address (preferred method):
HTL@dhec.sc.gov

OR

Mailing address:
Bureau of Health Facilities Licensing
2600 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 =m 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 thefacility 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			
☐ Initial	☐ Renewal		☐ Change Request *(Complete Part C and D)*
	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)	
☐ General Hospital	☐ Institutional General Hospital
☐ Institutional General Infirmary	☐ Privately-owned Educational Institutional Infirmary
☐ Specialized Hospital (Specialty)	Specialty Type:
Are you certified to perform abortions? ☐ YES ☐ 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? ☐ YES ☐ NO		If yes, number of swing beds:	

Perinatal Services	
Does your hospital provide perinatal (obstetrics and newborn) services? ☐ YES ☐ NO	If yes, indicate level: ☐ I; ☐ II; ☐ III; ☐ IV; ☐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? ☐ YES ☐ 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		
☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership	☐ Corporation ☐ Limited Liability (LLC)* ☐ Government	☐ Other:

Part C: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES		
☐Change of Facility Name and/or Location (Complete Section1)	☐Change of Licensee/Ownership (Complete Section2)	☐Change of Licensed Beds(Complete Section 3)

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 TelephoneNumber:		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**