PUBLIC HEALTH DIVISION
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
healthoregon.org/hflc

Oregon Health Authority

Extended Stay Center Application Form

Type of Action	
New Facility* License Renewal* Name/Address Change Ownership Change Other: (Specify) _____________ Room Increase/Decrease Effective Date of Change: _________	License # ______________________________ Name of affiliated Ambulatory Surgery Center: _______________________________________ License # of ASC: ____________________ Name of ASC's Accrediting Organization: _____________________________________ How many ORs does the ASC have? _____

*Fee Payment Required (See back of this form for amount). There is no fee required for room decreases, name or address changes.

Facility Information		
Facility E-Mail:		
Facility Legal Name:		
Facility DBA Name (if applicable):		
Facility Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Facility Mailing Address (if different from above):		
Name of Administrator & Phone:		
Administrator Email:		
Name of Facility Manager:		
Emergency Contact Person & Phone:		
Days and Hours of Operation:	Number of Recovery Beds:	

Yes	No	
		Is the ASC affiliated with any other ESC?
		Is the ASC physically contiguous with the ESC?
		Is the ASC certified by CMS as participating in the ASC Quality Reporting Program, administered by CMS?
		Does the ESC have an agreement with a local hospital for the transfer of patients?
		Has the ASC had any condition-level deficiencies cited in a survey or complaint investigation in the previous 24 consecutive months?
		Is the ESC affiliated with only one ASC?
		FPS Final Project Approval enclosed

Revised 07/2022

Owner Information (If partnership or corporation, list each person having 5% or more interest on an additional page)			
Ownership Category (Choose One):			
Individual	State	Health District	Partnership
City	County	Church	Corporation
Ownership Type: For Profit	Non- Profit		Tax ID#:
Name of Owner(s):			
Address, City, State & ZIP of Owner(s):			
Phone:	Fax:	County:	

I declare, under penalties of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct, and complete. I will notify Health Care Regulation and Quality Improvement, in writing, of any changes in this information within 30 days of any such change. In accordance with Oregon Administrative Rule Chapter 333, Division 076, the ASC affiliated with this ESC application is accredited and all accrediting survey and inspection reports, and written evidence of all corrective action and progress reports related to accrediting surveys shall be provided to the Health Care Regulation and Quality Improvement Section.

______________________________ ______________________________
Administrator's Signature ***Print Name***

______________________________ ______________________________
Print Title ***Date (mm/dd/year)***

Fee Schedule	
$20,000.00	New application fee
$4,100.00	Renewal application fee

Make check payable to: **Oregon Health Authority**
Mail payment and application to: **HFLC**
PO Box 14260
Portland, OR 97293

Questions about this application? Phone: 971-673-0540 **Email:** **mailbox.hclc@odhsoha.oregon.gov**

HCRQI Office Use Only

Effective date of initial licensure: _____________ Initials: ___________ Date: __________

Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____

Initials: ___________ Date: __________

CASH OFFICE: QC **797** initial/QC **798** renewal