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| DEPARTMENT OF HEALTH SERVICESDivision of Quality AssuranceF-62092 (03/2024) | **STATE OF WISCONSIN**Chapter 50.35, 50.498, and 946.32, Wis. Stats.Page 1  |
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**HOSPITAL CERTIFICATE OF APPROVAL APPLICATION**

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| * Hospitals are required to complete this form per Chapter 50.35, Wis. Stats. Failure to complete this form may result in non-issuance of a hospital certificate of approval.
* The personally identifiable information collected on this form will be used to determine licensure eligibility and for statistical information and for no other purpose.
* Collection of the applicant’s social security number (SSN) or federal employer identification number (FEIN) is required by Chapter 50.498, Wis. Stats**.** Failure to supply the number may result in denial of the application. The number will be disclosed only to the Department of Revenue for use in collection of tax delinquencies.
* Each Wisconsin location that meets the definition of a hospital under Wis. Admin. Code § DHS 124.02(6) needs a separate Wisconsin hospital certificate of approval. This applies even if that location plans to operate under the same Medicare number as an existing hospital.
* Hospitals applying for a certificate of approval will also need to work with the Office of Plan Review and Inspection (OPRI) to obtain engineering approval for their new construction. Contacting OPRI should be one of the first steps for a new hospital. They can be reached at DHSDQAPlanReview@dhs.wisconsin.gov or 414-227-4085.
* **Return electronic copies of completed application and supporting materials via email to** **DHSDQALCCS@dhs.wisconsin.gov****.** If the files are too large, paper copies or a USB drive can also be mailed to:

DHS / DQA / Hospital Licensing PO Box 2969Madison, WI 53701-2969Regardless of the submission method for the rest of the document, a check for the licensing fee of $18 per bed will have to be mailed to the address above.* Questions about this application or its supporting materials may be directed to the Licensing and Certification Section at (608)266-7297 or DHSDQALCCS@dhs.wisconsin.gov
 |
| I. GENERAL INFORMATION |
| OWNERSHIP |
| Applicant (OWNER)*Identify person(s) or business entity having the authority to direct the management or policies of the facility.*  |
| Name – Applicant (Owner)      | FEIN      |
| Street (Physical) Address      | Fiscal Year End Date       |
| Corporate Phone Number       | Corporate E-mail Address       |
| Holding (i.e., what the owner owns): [ ]  Operations [ ]  Building [ ]  Land |
| Type of Organization *Check type of ownership.* |
| Governmental | [ ]  City **[ ]** County **[ ]** State | [ ]  Federal**[ ]** City / County**[ ]** Tribal |
| Proprietary  | [ ]  Sole Proprietary[ ]  Partnership [ ]  Corporation | [ ]  Limited Liability Company[ ]  Limited Liability Partnership [ ]  Trust |
|  Voluntary Non-Profit | [ ]  Corporation [ ]  Church[ ]  Association[ ]  Church / Corporation | [ ]  Private Non-Profit [ ]  Limited Liability Company[ ]  Limited Liability Partnership[ ]  Trust |
| B. HOSPITAL LOCATION |
| Hospital DBA Name      |
| Street (physical) Address      |
| City      | County      | State   | Zip Code      |
| Mailing Address (if different)      |
| City      | State   | Zip Code      |
| Phone Number      | Fax Number      | E-mail Address      |
| **C. CHANGE OF OWNERSHIP [ ]  Yes [ ]  No *(If no, skip to Section D)***  |
| *List the previous owner’s name, Certificate of Approval (COA) number, and Medicare and Medicaid numbers.* |
| Name – Previous Owner      | Previous DBA Name (if applicable)      |
| COA Number      | Medicare Number       | Medicaid Number       |
| **D. TYPE OF HOSPITAL** |
| [ ]  General / Acute Care[ ]  Children’s[ ]  Rehabilitation[ ]  Psychiatric  | [ ]  Critical Access Hospital[ ]  Long-Term Care[ ]  Other       |
| **E. MEDICARE/MEDICAID CERTIFICATION**  |
| Applying for:[ ]  Medicare (Title XVIII) [ ]  Medicaid (Title XIX) [ ]  Neither  |
| Medicare Survey Agency: [ ]  State of Wisconsin [ ]  Outside Accrediting Agency       |
| F. BED CAPACITY  |
| *Indicate the total number of beds requested for those categories that apply.* |
| General Acute Beds     | Breakdown |
| TOTAL Psychiatric Beds     | Non-PPS-E Psychiatric Beds     | \*PPS-E Psychiatric Beds     |
| TOTAL Rehabilitation Beds     | Non-PPS-E Rehabilitation Beds     | \*PPS-E Rehabilitation Beds     |
| Chemical Dependency / Alcohol Beds      | \* Hospitals intending to have Prospective Payment System Excluded (PPS-E) beds need to submit a letter on hospital letterhead using language from CMS-Exhibit 127, along with the appropriate version of the CMS-437 form. |
| TOTAL BEDS     |

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|  G. SERVICES PROVIDED BY THE HOSPITAL |
| *Check one, both, or neither box for each service to indicate whether each is provided directly by hospital staff or via a contracted entity. Include signed contracts for all services marked ‘via contract’ along with your hospital application.* |
| **Services** | **Via Staff** | **Via Contract** |  | **Services** | **Via Staff** | **Via Contract** |
| Alcohol and/or Drug Services | [ ]  | [ ]  |  | Organ Transplant Services (Not Medicare-Certified) | [ ]  | [ ]  |
| Anesthesia Service | [ ]  | [ ]  |  | Orthopedic Surgery | [ ]  | [ ]  |
| Audiology | [ ]  | [ ]  |  | Pediatric Services | [ ]  | [ ]  |
| Burn Care Unit | [ ]  | [ ]  |  | Pharmacy | [ ]  | [ ]  |
| Cardiac Catheterization Laboratory | [ ]  | [ ]  |  | Physical Therapy Services | [ ]  | [ ]  |
| Cardiac-Thoracic Surgery | [ ]  | [ ]  |  | Positron Emission Tomography Scan | [ ]  | [ ]  |
| Chemotherapy Services | [ ]  | [ ]  |  | Post-Operative Recovery Rooms | [ ]  | [ ]  |
| Chiropractic Service | [ ]  | [ ]  |  | Psychiatric Services – Emergency | [ ]  | [ ]  |
| CT Scanner | [ ]  | [ ]  |  | Psychiatric – Child/Adolescent | [ ]  | [ ]  |
| Dental Services | [ ]  | [ ]  |  | Psychiatric – Forensic | [ ]  | [ ]  |
| Dietetic Services | [ ]  | [ ]  |  | Psychiatric – Adult Inpatient | [ ]  | [ ]  |
| Emergency Department (Dedicated) | [ ]  | [ ]  |  | Psychiatric – Outpatient | [ ]  | [ ]  |
| Extracorporeal Shock Wave Lithotripter | [ ]  | [ ]  |  | Radiology Services – Diagnostic | [ ]  | [ ]  |
| Gerontological Specialty Services | [ ]  | [ ]  |  | Radiology Services – Therapeutic | [ ]  | [ ]  |
| ICU – Medical/Surgical | [ ]  | [ ]  |  | Reconstructive Surgery | [ ]  | [ ]  |
| ICU – Neonatal ICU – Pediatric | [ ]  | [ ]  |  | Respiratory Care Services | [ ]  | [ ]  |
| ICU – Surgical | [ ]  | [ ]  |  | Rehab Services – Inpatient | [ ]  | [ ]  |
| Laboratory-Clinical | [ ]  | [ ]  |  | Rehab – Outpatient | [ ]  | [ ]  |
| Magnetic Resonance Imaging (MRI) | [ ]  | [ ]  |  | Renal Dialysis (Acute Inpatient) | [ ]  | [ ]  |
| Neonatal Nursery | [ ]  | [ ]  |  | Social Services | [ ]  | [ ]  |
| Neurosurgical Services | [ ]  | [ ]  |  | Speech Pathology Services | [ ]  | [ ]  |
| Nuclear Medicine Services | [ ]  | [ ]  |  | Surgical Services – Inpatient | [ ]  | [ ]  |
| Obstetric Service | [ ]  | [ ]  |  | Surgical Services – Outpatient | [ ]  | [ ]  |
| Occupational Therapy Services | [ ]  | [ ]  |  | Trauma Center (Designated) | [ ]  | [ ]  |
| Operating Rooms | [ ]  | [ ]  |  | Transplant Center (Medicare Certified) | [ ]  | [ ]  |
| Ophthalmic Surgery | [ ]  | [ ]  |  | Urgent Care Center Services | [ ]  | [ ]  |
|  |  |  |  |  |  |  |
| H. STAFFING  |
| *Indicate number of full-time (FT) and part-time (PT) employees.*  |
|  | FT | PT |  | FT | PT |
| 1. Chief Executive Officer
 |      |      | 8. Pharmacy |      |      |
| 1. Nurse Administrator, RN
 |      |      | 1. Dietary
 |      |      |
| 1. Nurse Supervisor
 |      |      | 1. Laboratory
 |      |      |
| 1. Registered Staff Nurses
 |      |      | 1. Housekeeping
 |      |      |
| 1. LPN Staff Nurses
 |      |      | 1. Maintenance Personnel
 |      |      |
| 1. Nurse Aides
 |      |      | 13. Laundry Personnel |      |      |
| 1. Medical Records
 |      |      | 14. Other (Specify.)       |      |      |

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| II. ADMINISTRATION |
| **A. HOSPITAL ADMINISTRATOR/CHIEF EXECUTIVE OFFICER (CEO)** |
| Name - Administrator / CEO      |
| Title      |
| **B. PERSON IN CHARGE IN ABSENCE OF ADMINISTRATOR/CEO (SUBSTITUTE ADMINISTRATOR)** |
| Name      |
| Title      |
| **C. MEDICAL DIRECTOR** |
| Name – Medical Director      |
| Title      |
| **D. CHIEF NURSING OFFICER**  |
| Name      | Nursing License Number      |
| E. NAME OF PERSON IN CHARGE OF EACH DEPARTMENT |
| *Provide the name of the Medical Record Administrator, Staff/Consulting Pharmacist, and Registered Dietitian. Additionally provide the name and department for each qualified director, based on hospital services provided (Please use more copies of this page if needed).* |
| Name – Medical Record Administrator       |
| Name – Staff or Consulting Pharmacist       |
| Name – Registered Dietitian       |
| Name – Director      | Department       |
| Name – Director      | Department       |
| Name – Director      | Department       |
| Name – Director      | Department       |
| Name – Director      | Department       |
| Name – Director      | Department       |
| Name – Director      | Department       |
| Name – Director      | Department       |
| **III. CORPORATE STRUCTURE** |
| **A. INTERESTED PARTIES** |
| *List all names, principal business addresses and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, and members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors, and board members. Attach additional pages if necessary.* |
| Name      | Title      |
| Address      | Begin Date      |
| City      | State   | Zip Code      | Ownership Percentage     |
| Name      | Title      |
| Address      | Begin Date      |
| City      | State   | Zip Code      | Ownership Percentage     |
| Name      | Title      |
| Address      | Begin Date      |
| City      | State   | Zip Code      | Ownership Percentage     |
| Name      | Title      |
| Address      | Begin Date      |
| City      | State   | Zip Code      | Ownership Percentage     |
| Name      | Title      |
| Address      | Begin Date     |
| City      | State   | Zip Code      | Ownership Percentage     |
| **B. OTHER PROVIDERS**  |
| *Identify other providers that are licensed and / or Medicare certified, located in Wisconsin, and are owned or operated by the applicant / owner under the exact same owner name.**If more than two, check here* *[ ]  and attach additional pages.* |
| Name – Provider      |
| City      | State   | Zip Code      |
| Relationship Type (nursing home, home health agency, community based residential facility, hospital)      |
| Name – Provider      |
| City      | State   | Zip Code      |
| Relationship Type (nursing home, home health agency, community based residential facility, hospital)      |
| **C. SUBSIDIARY/PARENT INFORMATION** |
| 1. Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

 [ ]  Yes [ ]  No If “Yes,” provide the following information: |
| Legal Business Name – Parent Company      |
| DBA (Doing Business As)      |
| Type of Ownership      |
| Mailing Address      |
| City      | State   | Zip Code      |
| Contact Person      | Phone Number      |
|  |  |
| 2. Is the applicant affiliated with any subsidiaries in the health care field in this state or any other state? [ ]  Yes [ ]  No  If Yes, provide one of the following: |
| * Names and addresses of all subsidiaries owned by the parent company, in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
* Organizational chart exhibiting the legal business names and, if applicable, the DBA name of all the subsidiaries currently owned by the parent company in the health care field in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
* Complete annual report to shareholders.
 |
| D. CHAIN ORGANIZATION |
| Is the applicant under the control of a chain organization? [ ]  Yes [ ]  NoChain organization is defined as multiple providers, and/or suppliers owned, leased, or through any other devises, **controlled** by a **single business entity** (defined as chain home office). Each entity in the chain may have a different owner but the “home office” maintains **uniform procedures** in each facility for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, provider/suppliers cost reports, etc.In addition, a chain facility would not necessarily be a subsidiary of the parent corporation but the chain facility or facilities could be owned by different subsidiaries of the same corporate parent. |
| Name – Chain Organization      |
| E. OWNER OF BUILDING/LAND |
| *If the building, land, or building and land are owned by an entity (i.e., corporation, partnership, individual etc.) other than the owner of the hospital, complete this section. If the building and land are both owned by separate companies, then use a 2nd copy of this page to note both the owner of the building and owner of the land.* |
| [ ]  Building [ ]  Land |
| Name      | Phone Number      |
| Mailing Address      | Fax Number      |
| City      | County      | State   | Zip Code      |
| **Type Of Organization**  |
| *Check type of ownership.* |
| **Governmental** | **Proprietary** | **Voluntary Non-Profit** |
| [ ]  City[ ]  County[ ]  State[ ]  Federal[ ]  City / County[ ]  Tribal | [ ]  Sole Proprietary[ ]  Partnership[ ]  Corporation[ ]  Limited Liability Company[ ]  Limited Liability Partnership[ ]  Trust | [ ]  Corporation[ ]  Church[ ]  Association[ ]  Church / Corporation[ ]  Private Non-Profit[ ]  Limited Liability Company[ ]  Limited Liability Partnership[ ]  Trust |
| IV. LEASE AGREEMENT |
| Is there a lease agreement? [ ]  Yes [ ]  No  *If “yes,” list the name and address of the lease holder.* |
| Name      |
| Mailing Address      |
| City      | State   | Zip Code      | Lease Agreement End Date      |
| V. MANAGEMENT COMPANY |
| **A. MANAGEMENT CONTRACT**   |
| Is the operation of the facility under a management contract? [ ]  Yes [ ]  No*If “yes,” provide the following information regarding any management company retained to operate this facility or program.* |
| Type of Management Company [ ]  Corporation [ ]  Partnership [ ]  Individual [ ]  Government |
| Name – Management Company      |
| Name – Contact Person      | Phone Number      |
| Address      |
| City      | State   | Zip Code      |
| **B. OTHER MANAGEMENT COMPANY FACILITIES**  |
| *Identify other facilities the management company has owned, operated, or managed in the last five years. Attach additional pages, if necessary.* |
| Name      |
| Address      |
| City      | State   | Zip Code      |
| Dates of Involvement      |
| Name      |
| Address      |
| City      | State   | Zip Code      |
| Dates of Involvement      |
| Name      |
| Address      |
| City      | State   | Zip Code      |
| Dates of Involvement      |
| **C. ADVERSE ACTIONS** |
| The following questions refer to **any of the facilities identified in item B.** |
| 1. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or  revocation (R) of a license? [ ]  Yes [ ]  No *If “yes,” please complete the following table. Use abbreviations to describe the type of adverse action and refer to IV.G.1. for abbreviations for type of health care provider.* |
| **Facility Name and Address** | **City and State** | **Type of Health Care Provider** | **Type of** **Adverse Action** | **Effective Dates of** **Adverse Action** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|  |
| 2. Has any adverse action been initiated by a state or federal agency based on noncompliance resulted in civil money  penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of  temporary management of the facility (TMF)? [ ]  Yes [ ]  No  *If “yes,” please complete the following table. Use abbreviations to describe the type of adverse action and refer to*  *IV.G.1. for abbreviations for type of health care provider.*  |
| **Facility Name and Address** | **City and State** | **Type of Health****Care Provider** | **Type of** **Adverse Action** | **Effective Dates of Adverse Action** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
| **D. COPY OF MANAGEMENT CONTRACT**  |
| ***Attach a copy of the signed contract******with the management company.*** |
| **VI. SUPPLEMENTARY HOSPITAL APPLICATION MATERIAL CHECKLIST** |
| [ ]  | Letter of Intent / Detailed statement of proposed hospital facility on business letterhead. |
| [ ]  | Hospital licensed bed fee ($18/bed). |
| [ ]  | Copies of contracts for services provided via contracted organizations, including organ/tissue procurement organizations and eye banks. |
| [ ]  | Registered nurse staff pattern for 24-hour coverage seven days per week. |
| [ ]  | Facility Floor Plan (Attach copies of plans for RN surveyor review of floor layout). |
| [ ]  | Patient Rights and Responsibilities policies established by governing board. |
| [ ]  | Governing Body By-laws. |
| [ ]  | Medical Staff By-laws including the various committees. |
| [ ]  | Quality Assessment and Performance Improvement Program. |
| [ ]  | A policy or brief description of how the hospital plans to implement the provision of services for the following (as applicable): |
|  | * Nursing Services
 | * Surgical and Anesthesia Services
 | * Medical Records Services
 |
| * Organ, Tissue, and Eye Procurement
 | * Food and Dietetic Services
 | * Respiratory Services
 |
| * Pharmaceutical Services
 | * Outpatient Services
 | * Laboratory Services
 |
| * Emergency Services
 | * Infection Prevention and Control
 | * Psychiatric Services
 |
| * Radiology Services
 | * Rehabilitation Services
 | * Discharge Planning
 |
| [ ]  | Type of Organization—provide documentation (Corporation—provide Copy of Articles of Incorporation, LLC—provide copy of articles of organization and operation agreement, LLP—provide copies of partnership agreement). |
| [ ]  | Organizational chart (identify any other entities or the parent company related to the applicant). |
| [ ]  | If the applicant has health care facilities in other states a statement is required from each state’s licensing agency verifying each facility’s current licensure and certification status. |
| [ ]  | Lease Agreements and Management Contracts if applicable. |
| [ ]  | Internal Revenue Service (IRS) Tax Identification (EIN) document. |
| **VII. CONTACT PERSON** |
| *Identify the person responsible for completing this application and who can be contacted to address questions*. |
| Name – Contact Person       | Title      |
| Phone Number      | Fax Number      | Date Application Completed      |
| VIII. DESIGNEE |
| *Identify the person authorized to accept personal service and receive registered and certified mail.* |
| Is the administrator also the Designee? [ ]  Yes [ ]  No *If “no,” provide the following information.* |
| Name – Designee      | Title      |
| **IX. ATTESTATION** |
| **The Management Company CANNOT attest to or sign on behalf of the applicant (Owner).** |
| I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000or imprisonment not to exceed six years, or both, per Chapter 946.32, Wis. Stats. |
| **SIGNATURE** - Applicant’s (Owner’s) Legal Representative | Date Signed      |
| Name (Print or type.) – Legal Representative       | Title – Legal Representative      |