DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
ACUTE & HOME CARE, LICENSURE AND CERTIFICATION SECTION
1205 UMSTEAD DR, RALEIGH, NC 27603– 2712 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-2712
TELEPHONE: (919) 855-4620 FAX: (919) 715-3073

LICENSE NUMBER: _____

2024
HOSPITAL LICENSE APPLICATION

Type: Initial ☐ Change of Ownership ☐ Name Change ☐ Change Site ☐
Change Beds ☐ Addition of Facility Under Hospital License ☐

Effective Date of Change: _____

Other (specify) _____

Legal Identity of Applicant:_____
(full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service for which this form is submitted)

Name(s) under which the hospital or services are advertised or presented to the public: (d/b/a's)

Primary: _____

Other: _____

Other: _____

Are the above names identical to the names on the current license? Yes ☐ No ☐
If no, please attach letter of explanation.

Facility Site Address:_____

City:_____ County:_____ Zip Code:_____

Facility Mailing Address:_____

City:_____ County:_____ Zip Code:_____

Name and Title of Administrator/Director: _____

AUTHENTICATING SIGNATURE: The undersigned submits application for the above-named hospital in accordance with 10A NCAC 27G., and rules and codes adopted thereunder, and certifies the accuracy of this information. [Designated agent (individual) responsible to the governing body (owner) for the management of the licensed facility]

Signature: _____ Title: _____

Printed Name: _____ Date: _____

Note: Please identify the contact person for questions regarding this form.

Name_____ Telephone_____

E-mail Address: _____

"The N.C. Department of Human Resources does not discriminate on the basis of race, color, national origin, religion, age or disability in employment or the provision of services."

OWNERSHIP DISCLOSURE

Check the term which describes the legal character of the operating ownership then proceed to the indicated block.

FOR PROFIT

- ☐ General Partnership (Proceed to Block I)
- ☐ Limited Partnership (Proceed to Block I)
- ☐ For Profit Corporation (Proceed to Block II)

NOT FOR PROFIT

- ☐ Not For Profit Corp (Proceed to Block II)
- ☐ Unit of Government (Proceed to Block III)

BLOCK I (PARTNERSHIP)

Partnership Name _____

Is it a general partnership? Yes ☐ No ☐ Is it a limited partnership? Yes ☐ No ☐

Is the limited partnership registered with the NC Secretary of State's Corporation Division? Yes ☐ No ☐

If "Yes," what is the exact wording of the partnership's registered name?

_____

Where is the partnership registered? State: _____ County: _____

Address and phone number of the partnership's home office?

Street: _____

City/State/Zip: _____Telephone: _____

Name and addresses of the principle partners:

_____ Percent Ownership _____

Name and Title

_____

Address

_____ Percent Ownership _____

Name and Title

_____

Address

_____ Percent Ownership _____

BLOCK II (CORPORATION)

Is the Corporation registered with the NC Secretary of State's Corporations Office? Yes ☐ No ☐

What is the exact wording of the corporation's name on the registration?

_____

State and county the corporation is registered in (if other than North Carolina) State _____County _____

Address and phone number of the corporation's home office:

Street:_____

City/State/Zip: _____ Telephone: _____

Name and address for the senior officer of the corporation:

Name _____ Title _____

Street: _____ City/State/Zip: _____

If the corporation is a wholly-owned subsidiary, what is the name of the parent corporation?

Name:_____

Block III (Unit of Government)

Name of Governmental Unit which has the ownership responsibility and liability for the services offered.

_____

What is the title of the official in charge of the above governmental unit: _____

Check which best describes the above type of governmental unit: City ☐ County ☐ State ☐ Authority ☐ District ☐

Type of Businesses Under The Hospital License

List names of facilities/businesses:

Name and Address	Business/purpose

BUILDING OWNERSHIP/LEASE DATA

Does the entity (partnership, corporation, etc) own or lease the premises from which services are offered:
Own ☐ Lease ☐

If leased, provide the following data on the lessor:

Name _____

Address _____ City _____

State _____ Zip _____ Telephone (___)_____

Is the business operated under a management contract? Yes ☐ No ☐
If "Yes," name and address of the management company:
Name_____

Street_____

City_____State_____Zip_____

Vice President of Nursing/Patient Services _____

BEDS BY SERVICE (INPATIENT)

C. Please indicate below the number of beds being changed.

General Acute Care (Please provide details below)	**Licensed Beds**	**Staffed Beds**	**Census Days of Care**
Intensive Care Units		Do not write	Do not write
a. Burn			
b. Cardiac			
c. Cardiovascular Surgery			
d. Medical/Surgical			
e. Neonatal Level IV (Not Normal Newborn)*			
f. Pediatric			
g. Respiratory/Pulmonary			
h. Other (List)			
Specialty Units			
i. Gynecology			**
j. Medical/Surgical			
k. Neonatal Level III (Not Normal Newborn)*			
l. Neonatal Level II (Not Normal Newborn)*			
m. Obstetric (including LDRP)			
n Oncology			
o. Orthopedics			
p Pediatric.			
Q . Other (List) _____			
1. **Total General Acute Care Beds (a through r)**			
2. Comprehensive In-Patient Rehabilitation			
3 Inpatient Hospice			
4. Detoxification			
5. Substance Abuse/Chemical Dependency Treatment			
6. Psychiatry			
7. Nursing Facility			
8.Adult Care Home			
9. Other .			
10. **Totals (1 thru 9)**			

* Per CON Rule definition

** Exclude swing-bed days

LICENSURE FEE

A non-refundable licensure fee is required and must accompany this application prior to the issuance of a hospital license. The payment should be in the form of check, certified check or money order and must be made payable to: "**The Division of Health Service Regulation**". Payment should include the facility's license number (if applicable) and be submitted with your license application.

Licensure Fee Calculation:

A. Multiply $17.50 by number of beds $17.50 x XXX	$0,000.00
B. Base Fee $450.00	$450.00
Total Fee Due	$0,000.00

This application must be completed and submitted to the Acute Care, Licensure and Certification Section, Division of Health Service Regulation, with the license fee, prior to the issuance of a hospital license. Upon receipt of the license fee, there will be a delay of five (5) business days before a new license may be issued. The license fee is non-refundable. Legislation (HB 397, Session Law 2003-284) prohibits a license from being issued if the fee has not been paid.