



APPLICATION FOR LICENSE TO OPERATE AN
OUTPATIENT CARE SERVICE OR ACTIVITY
BUREAU OF HEALTH FACILITIES LICENSING

In accordance with §44-41-10, §44-69-10, §44-71-40, §44-89-60, and/or §44-7-260 of the South Carolina Code (as amended) and Regulation 61-12, 61-75, 61-77, 61-78, 61-91, 61-93, 61-97, 61-102, or 61-108 licensees and prospective licensees must file an application under oath prior to operating an outpatient service or activity, and annually thereafter. Licenses are generally effective for a 12-month period following the date of issue unless otherwise determined by state statute or regulation.

1. REASON FOR APPLICATION:

- A. [] New Service or Activity (Initial License) Skip Lines 1.B and 1.C.
B. [] Renewal of License Number: _____ Expiring On: _____
C. [] Amended Licensing Information for License Number: _____

(1) [] Change of Owner (See instructions before completing). [] Ownership Change [] Name Change Only

Enter the current name on the first space and the new name on the second space.

From _____

To _____

(2) [] Change of Service/Activity Name on Line 2.A. (See instructions before completing).

From _____

To _____

(3) [] Increase/Decrease in Number of Licensed Units From _____ To _____ Description of units (Birth Rooms, Participants, OR's, Endoscopy Rooms, etc): _____

(4) [] *Change or [] Correction of Address Location of Service/Activity listed on Line 2:

From _____

To _____

*[NOTE: Relocation of Service/Activity requires prior approval from Department before occupying the new location]

(5) [] Addition/Change in Service or Modification (attach document describing the addition or change)

2. LOCATION OF SERVICE/ACTIVITY INFORMATION (Location where service/activity is administered to clients):

A. _____
(Name of the business where the service/activity is provided. See instructions regarding the naming of a service or activity)

B. _____
(Physical Location Address to include City, State and Zip Code)

C. _____
(Mailing Address, if different)

D. _____
(County in which the Service or Activity is physically located)

E. Phone Number at Location: _____ Emergency Contact Number: _____

F. *E-Mail Address: _____ *

[NOTE: E-mail is our primary means of communicating with the Service or Activity. Please ensure the e-mail address is accurate and monitored.]

3. **LICENSEE OR OWNER(S):** (1) is an organization or partnership as registered with the South Carolina Secretary of State; or (2) it is the individual names of partners in an agreement that has no organization title and is not required to be registered; or (3) it is an individual that is the sole-proprietor and is not a member/owner of an organization that has an interest in the facility.

A. _____
(Name of Organization as Registered with the SC Secretary of State or, Name of Individual(s) if this is a Sole-proprietorship or Partner Agreement)

B. _____
(Location Address to include City, State and Zip Code)

C. _____
(Mailing Address, if different)

D. _____
(Phone Number)

E. _____
(Name and title of presiding officer of the Registered Organization's Governing Body)

F. Entity named on Line 3.A is a (check one of following characteristics in each of the three categories that applies):

(1) For Profit Non-Profit (Registered with the Internal Revenue Service as a 501.c organization)

(2) Sole proprietorship Partnership Limited Partnership Corporation
 Limited Liability Company Other: _____

(3) State Government County Government District Government
 Religious Commercial None of these categories apply

4. **LOCATION CONTACT (Administrator/Director): Prefix:** Mr. Mrs. Ms. Dr. Other: _____

First Name: _____ **MI:** _____ **Last Name:** _____

Generation: Sr. Jr. III Other: _____ **Suffix:** MD Ph.D. RN Other: _____

5. **TYPE OF SERVICE/ACTIVITY FOR WHICH APPLICATION IS MADE: (Check only one category per application)**

A. **Abortion Clinic (Regulation 61-12)**

B. **Day Care Facility for Adults (Regulation 61-75)**

(1) Number of Participants _____

(2) Average census for last 12 months _____

C. **Birthing Center (Regulation 61-102)** Number of Birthing Rooms _____

Name of hospital(s) with which transfer agreement has been made:

D. **Ambulatory Surgical Facility (Regulation 61-91)**

(1) _____ Number of Operating Rooms

(2) _____ Number of Endoscopy Rooms

(3) _____ Number of Procedure Rooms

(4) _____ Total Number of 1, 2, & 3 above

E. **Renal Dialysis Facility (Regulation 61-97)**

(1) _____ Number of Chronic Hemodialysis Stations

(2) _____ Number of Home Hemodialysis Stations

(3) _____ Total of Number of 1 & 2 above (stations to be invoiced)

(4) _____ Total Number of Peritoneal Stations (do not include in the total stations to be invoiced on Line (3))

F. **Freestanding or Mobile Technology (Regulation 61-108)**

If you have equipment that is owned by the same entity but not located on the same adjoining or contiguous property, you must submit a separate license application. Otherwise, complete the information below for each piece of equipment to be license at this location:

(1) Equipment Description: _____

Serial # or Unique ID #: _____

(2) Equipment Description: _____

Serial # or Unique ID #: _____

Check this block if you have additional pieces of equipment that will be licensed at this location and attach a sheet with similar information as requested above for each additional piece of equipment.

G. **Outpatient Treatment Facility for Psychoactive Substance Abuse or Dependence (Regulation 61-93)**

Complete Line 7 if you have satellite or branch offices

Yes; No Do you have a Narcotic Treatment Program as described in the regulation?

If, you answered YES, list the narcotics used in your treatment program:

H. **Hospice Program (Regulation 61-78)** Number of Counties Served: _____

(Also complete Line 6 & 7 of this application)

I. **Home Health Agency (Regulation 61-77)** Number of Counties Served: _____

Services Offered:

Physical therapy Speech therapy Occupational therapy Medical social services

Home health aide services Medical Supplies/Appliances/Durable Medical Equipment (DME)

Other (specify): _____

(Also complete Line 6 & 7 of this application)

6. **NUMBER OF COUNTIES SERVED BY HOSPICE PROGRAM OR HOME HEALTH AGENCY**

(Applies only if Line H or I has been checked) Check each county to which you will be providing service:

- | | | | | | | |
|------------------------------------|---------------------------------------|-------------------------------------|-------------------------------------|------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Abbeville | <input type="checkbox"/> Berkeley | <input type="checkbox"/> Colleton | <input type="checkbox"/> Georgetown | <input type="checkbox"/> Lancaster | <input type="checkbox"/> Newberry | <input type="checkbox"/> Sumter |
| <input type="checkbox"/> Aiken | <input type="checkbox"/> Calhoun | <input type="checkbox"/> Darlington | <input type="checkbox"/> Greenville | <input type="checkbox"/> Laurens | <input type="checkbox"/> Oconee | <input type="checkbox"/> Union |
| <input type="checkbox"/> Allendale | <input type="checkbox"/> Charleston | <input type="checkbox"/> Dillon | <input type="checkbox"/> Greenwood | <input type="checkbox"/> Lee | <input type="checkbox"/> Orangeburg | <input type="checkbox"/> Williamsburg |
| <input type="checkbox"/> Anderson | <input type="checkbox"/> Cherokee | <input type="checkbox"/> Dorchester | <input type="checkbox"/> Hampton | <input type="checkbox"/> Lexington | <input type="checkbox"/> Pickens | <input type="checkbox"/> York |
| <input type="checkbox"/> Bamberg | <input type="checkbox"/> Chester | <input type="checkbox"/> Edgefield | <input type="checkbox"/> Horry | <input type="checkbox"/> Marion | <input type="checkbox"/> Richland | |
| <input type="checkbox"/> Barnwell | <input type="checkbox"/> Chesterfield | <input type="checkbox"/> Fairfield | <input type="checkbox"/> Jasper | <input type="checkbox"/> Marlboro | <input type="checkbox"/> Saluda | |
| <input type="checkbox"/> Beaufort | <input type="checkbox"/> Clarendon | <input type="checkbox"/> Florence | <input type="checkbox"/> Kershaw | <input type="checkbox"/> McCormick | <input type="checkbox"/> Spartanburg | |

7. **SATELLITE/BRANCH OFFICES (Only if you checked Line G, H, or I)**

Yes; No - Do you have satellite or branch offices? If yes, please complete the information below for each office in the spaces provide below (do not include the main office location as a satellite or branch office).

Location 1 Check this block if this is a new satellite office being added or if the existing satellite office has relocated.

Name: _____

Location Address: _____

Phone: _____

Hours of Operation: _____

Location 2 Check this block if this is a new satellite office being added or if the existing satellite office has relocated.

Name: _____

Location Address: _____

Location Phone: _____

Hours of Operation: _____

Location 3 Check this block if this is a new satellite office being added or if the existing satellite office has relocated.

Name: _____

Location Address: _____

Location Phone: _____

Hours of Operation: _____

Location 4 Check this block if this is a new satellite office being added or if the existing satellite office has relocated.

Name: _____

Location Address: _____

Location Phone: _____

Hours of Operation: _____

Check this block if you have additional satellite/branch offices other than the four identified above and attach a sheet with similar information as requested above for each additional satellite location.

8. REQUIRED ATTACHMENTS (Annual Renewal and Initial):

A. Nursing Supervisor – If you marked Line 5.C or 5.E and are required by regulation to have a Certified Nurse Midwife, Director of Nursing, or Nursing Services Supervisor, attach a copy of the registered nurse license issued by the South Carolina State Board of Nursing or other proof that the person is authorized to practice as a registered nurse in South Carolina. N/A Attached

B. Physician Supervisor – If you marked Line 5.E and are required by regulation to have a qualified physician as director of the ESRD services, attach a copy of the license issued by the South Carolina State Board of Medical Examiners or other proof that the physician is currently authorized to practice medicine in South Carolina. N/A Attached

C. Birthing Center – If you marked Line 5.C:

(1) Attach a description of arrangements for emergency transportation of patients from the facility. Attached

(2) Attach a description of arrangements for obstetric and pediatric consultation and referral. Attached

D. Licensee or Owner Documents Required:

(1) If the licensee is a corporation or partnership, attach a list identifying all officers. N/A Attached

(2) If the licensee or owner is a corporation or partnership, attach a list with the name, address and percentage of all owners that possess 5% or more ownership of the company or partnership. N/A Attached

(3) If any person or other legal entity can claim liabilities of the licensee or of the facility or service for which this license is requested, attach a list identifying the name, address, percent, and type of claim. N/A Attached

E. Real Property Ownership – If the land and/or building on/in which the facility or service is conducted are owned by an individual or organization other than the licensee identified on Line 3.A:

(1) Attach a copy of the current executed lease or rental agreement. N/A Attached

(2) Attach a list with the name, address and percentage of all owners that possess 5% or more ownership of the company or partnership that owns the land or building(s). N/A Attached

(3) Attach a list identifying all officers of the corporation or partnership that owns the land or building(s).
 N/A Attached

(4) If any person or other legal entity (other than the licensee or owner of the land/building(s)) can claim liabilities of the licensee or of the facility or service for which this license is requested, attach a list identifying the name, address, percent, and type of claim. N/A Attached

F. Management Agreement – If the licensee has engaged an entity other than an employee of the licensee to manage or operate the facility, attach a list providing information similar to that required in Line 3 and a copy of the current executed management agreement. N/A Attached

G. **Additional Ownership Information** - If applicable, attach a copy of any agreement, contract, option, understanding, intent or other arrangement that will effect a change in any of the information requested and/or provided in Line 8.D, 8.E, and 8.F.
 N/A Attached

9. **VERIFICATION**

State of: _____

County of: _____

I, _____ and _____
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 standards set forth in South Carolina Regulation 61-12, 61-75, 61-77, 61-78, 61-91, 61-93, 61-97, 61-102, or 61-108 (as applicable to the license applied for herein) and that non compliance with these standards may result in the Department pursuing enforcement actions as provided in the applicable regulation 61-12, 61-75, 61-77, 61-78, 61-91, 61-93, 61-97, 61-102, or 61-108.

(Signature)*

(Title)

(Signature)*

(Title)

An application must be signed by the owner if an individual; or in the case of a limited liability company, the head of the limited liability company; or two of the owners if a partnership; or, in the case of a corporation, by two of its officers; or, in the case of a governmental unit, by the head of the governmental department having jurisdiction over the facility.

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

NOTARY PUBLIC _____

My commission expires _____ NOTARY SEAL

10. _____
(Name and title of person preparing this application) (Telephone Number) (Date Prepared)

(E-mail address)

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 bed increases/decreases) from the Department that are in progress at the time the license is due for renewal. To avoid a lapse in your license we recommend you submit an application to renew the current license and a second application to effect the changes. Please read the attached instructions regarding pending changes for Line 3.

Instructions for Completing DHEC Form 0200

Application for License to Operate an Outpatient Care Facility

PURPOSE: In accordance with §44-41-10, §44-69-10, §44-71-40, §44-89-60, and/or §44-7-260 of the South Carolina Code (as amended) and Regulation 61-12, 61-75, 61-77, 61-78, 61-91, 61-93, 61-97, 61-102, or 61-108 licensees and prospective licensees must file an application under oath prior to operating an outpatient service or activity, and annually thereafter. Licenses are generally effective for a 12-month period following the date of issue unless otherwise determined by state statute or regulation.

INSTRUCTIONS:

Line 1.A. New Service or Activity (Initial License) – Check this block only if this is the first time you are applying for a license with the Department. Do not check this block if this is a change of ownership for an existing licensed service/activity. Skip Lines 1.B and 1.C.

Line 1.B. Renewal of License - Check this block only if you are renewing your license and then enter the license number and expiration date of the license in the spaces provided.

Line 1.C. Change of Licensing Information – Check this block if you are applying for a change that will alter the information on the face of your license. Then enter the license number in the space provided and apply for the following as appropriate:

(1) **Change of Owner** – If the information regarding the owner has changed check this block. If it is a change in the ownership, check the “Ownership Change” block. If it is a legal name change only for the owner, check the “Name Change Only” block. For an ownership change, the application is to be completed by the individual or entity that will become the new licensee, as licenses are not transferable. Regardless of the party that completes the application, the signatures on Line 9 must be that of the new licensee. The Department will continue to recognize the current licensee as the owner until the change is approved. Until approval is granted and a license is issued to the new owner, the current owner is responsible for renewing the license prior to the expiration date and must submit a separate application to renew the license. If the name of the owner will change, enter the current name on the first space provided and the new name on the second space provided. If you were issued a Certificate of Need (CON) regarding this change, attach a copy approving or exempting the change from CON review.

(2) **Change of Service/Activity Name** – Check this block if you are changing the name of the service or activity (See Line 2A. regarding the naming of a Service/Activity before completing this section). Enter the current name in the first space provided and then enter the new name in the second space provided)

(3) **Increase/Decrease in Number of Licensed Units** – Check this block if you are increasing or decreasing the number licensed units. Enter the current number of units you are licensed for in the first space and the new number of units you are applying for in the second space. If you were issued a Certificate of Need (CON), attach a copy of the letter approving or exempting the increase/decrease from CON review. In the third space, enter a description of the type of units you will be increasing/decreasing (i.e. participants; birthing rooms; operating rooms; endoscopy rooms; procedure rooms; chronic hemodialysis; home hemodialysis; and free standing/mobile equipment).

(4) **Change of Address** – The relocation of a service or activity requires prior approval from the Department before services can be provided at the new location. The main office of a Home Health Agency or Hospice Program may not be located in a county for where services have not been authorized. If the physical location of the Service or Activity listed on Line 2.A. will be changing, check this block. If this is a correction to the address previously provided, check this block. Address changes for satellite/branch offices should be submitted by letter.

(5) **Addition/Change in Service or Modification** – Attach a document describing the addition or change in services provided or any modifications to the building.

Line 2.A. Name of Service/Activity to be Licensed - If you are renewing your license, the name of the service/activity must appear exactly as it did for the prior year. If changing the name, enter the current name on Line 1.C (2) where it says “From” and then enter the new name on line 1.C (2) where it says “To” and again on line 2.A. We recommend names be limited to 65 characters (including spaces) as those having more than 65 characters will be truncated due to the limitations of our database. The abbreviated name will appear on all information made available to the public and may not accurately reflect the actual name if greater than 65 characters. Regardless of our database limitations, the name on Line 2.A. should be consistent with the name that appears on other documents submitted during the initial licensure process. Afterwards, if you desire to change the name, you may submit another application for the change. This will ensure the name reflects what you intended.

No service or activity can have the same name as another facility that is already licensed even if it is owned by the same owner. Under circumstances where the name of the service/activity is the same as the owner, we will add an additional identifier or delete part of the name to establish a distinction between the two. For example, if the owner is ABC Home Health, Inc., our office will drop the “Inc.” from the service/activity name. Our records will then reflect ABC Home Health, Inc. as the licensee and the service/activity name as ABC Home Health.

As another example, if ABC Home Health, Inc. will have more than one license, the service/activity name of each must be distinguishable from one another. For example ABC Home Health, Inc. has a license for an agency in Charleston and another license for an agency in Greenville. As such, a suggested name of each on their respective licenses might reflect one as ABC Home Health-Charleston and the other as ABC Home Health-Greenville. Each license will also reflect the name of ABC Home Health, Inc. as owning both.

Line 2.B. Service/Activity Location Address – Enter the street address where the service/activity is physically located. (Note: You cannot move the licensed service/activity to another location without prior approval from our office. Such a change may necessitate an application as a new or initial license.)

Line 2.C. Service/Activity Mailing Address – Enter the mailing address if it is different from the location address. If it is the same, enter “Same” on this line. The mailing address is where the Department will send all correspondence regarding the licensure, inspections, invoicing, and important notices. This will be the only mailing address we will list.

Line 2.D. County Location – Enter the county where the service or activity is physically located.

Line 2.E. Telephone Numbers – Enter telephone number of the service/activity in the space provided in the first space. In the second space, enter the number where the Department can call in the event of an emergency.

Line 2.F. E-Mail Address – We recommend creating a facility e-mail address that will be monitored by several staff. E-mail will be our primary means of communicating with the service/activity for licensure, inspections, invoicing, and important notices. If the e-mail address changes at any time, please notify the Department immediately. In the space provided, enter the e-mail that the Department can contact the service/activity.

Line 3.A. Licensee or Owner(s) – Enter the name according to one of the options below that best describes the owner:

(1) If the owner is an organization required to be registered with the South Carolina Secretary of State’s Office, enter the name of the organization in the space provided exactly as it appears with that office.

(2) If the owner is an organization having no title and is not required to be registered with the Secretary of State’s Office, enter the name of each individual partner with which you have entered into a written agreement.

(3) If the licensee is a sole-proprietor (an individual) and is not a member of an organization that has an ownership interest in the service/activity, then enter the name of the individual in the space provided.

Line 3.B. Licensee or Owner Location Address – Enter the address where the licensee is physically located. In the case of a partnership, enter the location address of only one partner identified on Line 3.A.

Line 3.C. Licensee or Owner Mailing Address - Enter the mailing address if different from the location address.

Line 3.D. Licensee or Owner Phone Number – Enter the phone number where we can contact the owner.

Line 3.E. Presiding Officer – Enter the name of the presiding officer of the organization identified on Line 1.A.

Line 3.F. Entity Type – Check one of the following characteristics in each of the three categories that best describes the licensee (owner). Only one block per category (1), (2), and (3) shall be checked. If the license is for a renewal, and you check any block different from the previous application, you must attach a full explanation and any other pertinent documentation to support the change. (Note: You cannot arbitrarily change from a sole proprietorship to any other category without an official notarized agreement if a partnership or; articles of incorporation if a limited partnership or corporation; or limited liability company. Such action may constitute an ownership change).

Line 4. Location Contact (Administrator/Director) – Enter the name of the person that is the primary contact and is the person that is in charge at the service or activity and has the authority to act on behalf of the licensee.

Line 5. Type of Service/Activity for which Application is Made - Only one category for Line 5. (A, B, C, D, E, F, G, H, or I) can be checked. If the licensee is the holder of multiple licenses with our Department, you must submit a separate application for each type of license that is held or being applied for.

Line 5.A. Abortion Clinic - Check this block if the license is for this type of service as defined in DHEC Regulation 61-12.

Line 5.B. Day Care Facility for Adults - Check this block if the license is for the type of activity as defined in DHEC Regulation 61-75.

(1) Enter the total number of participants that you are licensed to provide care for.

(2) The average 12 month census should be calculated by adding the average monthly censuses for the last 12 months together and dividing that number by 12. The average monthly census should be calculated by adding the daily census for each day the facility was open during that month by the number of days the facility was open during that month.

Line 5.C. Birthing Center - Check this block if the license is for this type of service as defined in DHEC Regulation 61-102. Enter the total number of birthing rooms in the space provided. Enter the name of the hospital(s) with which a transfer agreement has been made in the space provided.

Line 5.D. Ambulatory Surgical Facility - Check this block if the license is for this type of service as defined in DHEC Regulation 61-91. Line 5.D (1) enter the number of operating rooms, Line 5.D (2) enter the number of endoscopy rooms, Line 5.D (3) enter the number of procedure rooms, and Line 5.D (4) enter the total of Lines 5.D (1), (2) and (3).

Line 5.E. Renal Dialysis Facility - Check this block if the license is for this type of service as defined in DHEC Regulation 61-97. Line 5.E (1) enter the number of chronic hemodialysis stations, Line 5.E (2) enter the number of home hemodialysis stations, Line 5.E (3) enter the total of Lines Line 5.E (1) and (2). Line 5.E. (4) enter the total number of peritoneal stations [do not include in the total stations to be invoiced on Line 5.E. (3)].

Line 5.F. Free Standing or Mobile Technology – Check this block if you have equipment required to be licensed as defined in DHEC Regulation 61-108. If you have equipment that is owned by the same entity but not located on the same adjoining or contiguous property, you must submit a separate license application. Enter a description for each piece of the equipment and include the serial number (or a unique identification number). If you have more than two pieces of equipment to be registered, check the additional block and attach a sheet with similar information requested as the other two pieces of equipment.

Line 5.G. Outpatient Treatment Facility for Psychoactive Substance Abuse or Dependence – Check this block if the license is for this type of activity and service as defined in DHEC Regulation 61-93. Check either yes or no as to whether or not you have a narcotic treatment program as described in DHEC Regulation 61-93. If you check yes, list the narcotics used in your treatment program.

Line 5.H. Hospice Program – Check this block if the license is for this type of service as defined in DHEC Regulation 61-78. In the space provided, enter the total number of counties that you will be serving.

Line 5.I. Home Health Agency - Check this block if the license is for this type of service as defined in DHEC Regulation 61-77. In the space provided, enter the total number of counties that you will be serving and then check each additional block that applies to the type of services that you will provide.

Line 6. Number of Counties Served by a Hospice Program or Home Health Agency – Check the block(s) by each county to which you will be providing services (Note: total number of blocks checked must be equal to the total number of counties to be served as indicated on Line H or I).

Line 7. Satellite/Branch Offices - If you checked Line 5.G, 5.H, or 5.I, then on Line 7, check either yes or no as to whether or not you have satellite locations or branch offices. If you checked yes, then complete the location information for each office in the spaces provided. If you have more than four locations, check the additional block and attach a sheet with similar information as requested for the four you have listed on this line (Note: do not include your home office location as a satellite/branch office). For license renewal, if you are adding a new satellite office or if the existing office as noted on last year's application has relocated, check the appropriate block to the right of the location line that applies. [NOTE: a Hospice Program or Home Health Agency shall not have a satellite office or main office in county that has not been approved by the Department].

Line 8. Required Attachments – (Self explanatory)

Line 9. Verification – In the first two spaces, enter the State and County where signatures are to be notarized. In the second two spaces, print the name of the individual(s) authorized to sign the application. The remaining portion to be completed is self-explanatory. The verification signatures shall be those of the individuals who are officers of the licensee's governing body. Individuals belonging to a management company or other persons who are not officers of the governing body cannot sign on behalf of the licensee. In the case of a sole proprietorship, the signature shall be that of the person identified on Line 3.A. If the license application is being notarized outside of the State of South Carolina, the notary seal of that State shall be affixed to the application. The seal is not required if notarized in South Carolina by a notary registered in our State.