Office of Health Facilities Application for Hospital Facility Reference Guide for New Applicants

Let's begin!



Log In to the platform

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Enter your username and password.

TIP: If you don't have an account click the

Click the **Log In** button.

Create New Account link.

	DEC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA GOVERNMENT OF THE DISTRICT OF COLUMBIA
	Welcome to the Office of Health Facilities Portal The Health Regulations and Licensing Administration (HRLA) promotes public safety by ensuring medical facilities maintain compliance with district mandates and health codes. Login or Create an Account to:
Forgot username?	About DC Health DC health promotes health, wellness, and equity, across the Disctrict, and protects the safety of residents, visitors and those doing business in our nation's Capital. Our Responsibilities include identifying health risks; educating the public; preventing and controlling diseases, injuries and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources.





Navigate to the New Application screen



Once you Log in to the Office of Facilities Portal, click the **New Application** tab.

	DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA	DOMORIEL DOM
DC HEALTH Home New Application Application History Support	٩	Search
Welcome to the Office of Facilities Portal DC Health protects our citizens by ensuring proper licensure for various intermediate and healthcare facilities in the Dist What's the status of my application?	trict of Columbia.	





Select the Facilities New Application



Select the **Hospital** option from the list.



Click the **Next** button.

		DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA	GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR	
EA	TH Home <u>New Application</u> Application History Support		Q. Search	Dani Biar
ſ		Facilities New Application		
	Please Select Application Type: Ambulatory Surgery Center Assisted Living Residency Child Placement Agency Community Residential Facility for the Elderly Community Residential Facility for the Intellectually Disabled Home Care Agency Home Care Agency Home Support Agency Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFIID) Maternity Center Nurse Staffing Agency Nursing Home		2	Next





Select the Application Type

Select the **Initial** option from the drop-down list.

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Click the **Next** button.

DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA	GOVERNMENT OF THE DISTRICT OF COLUMBIA CMURIEL BOWSER, MAYOR	
	Q Search	Dani Bianciotti
	PI 2	* Next
		GOVERNMENT OF THE DISTRICT OF COLUMBIA





Fill out the Main - Facility Information

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Fill out all the required fields.

Main- Facilities New Application		
Hospital Location		
* Facility Name	* Street Address	
Robert Zieme	49930 Tod Mountains	
*City	*County	
East Cruzmouth	Ethiopia	
^ State	*ZipCode	
NH	20001	
* Telephone Number	*Fax Number	
398	622	
* Email Address	* Initial Begin Date (at present location)	
your.email+fakedata23275@gmail.com	Oct 10, 2022	iii iii
Type of Hospital Type of Hospital Chemical Dependency/Alcohol Children's critical Access Hospital (CAH) Generic Hospital Located Within Another Hospital Long-Term Acute Care Maternity Orthopedic Psychiatric		
Rehabilitation		

DC HEALTH



Fill out the Main - Facility Information



Finish filling out the required fields. If needed, upload relevant files using the **Upload Files** button.



Click the Save & Next button.

	th Care Facilities Division, please attach a separate listing. The listing should include all required information for each number and that will operate under the hospitula's certificate of approval number. Also, describe the services that will be wall letter for each offste location.
"Services provided by the hospital: Please list the type of services that will be provided. Attach additional pay be provided by contracting with another provider of service. If services will be provided both directly and by	ges if necessary. Place a "1" beside the listing if service will be provided directly by hospital staff and a "2" if the service will contract, list a "3."
Asperiores qui adipisci minus dignissimos quibusdam consequuntur dolorum. Id voluptas excepturi est rer Nam tenetur illo et odit facere quibusdam voluptate. Nihil corporis in fugit consectetur cum repellendus e	um consectetur quaerat quos mollitia. Error est corrupti consequatur laboriosam aut voluptate vitae quaerat. t. Ut asperiores placeat eum ex dolores vitae aut reiciendis.
Please list number of Full-Time and Part-Time employees for the following roles:	
1. Chief Executive Officer	2. Nurse Administrator, RN
Dignissimos error sit commodi voluptas inventore nulla et.	Explicabo id explicabo sed provident rem sit.
3. Nurse Supervisor	4. Registered Staff Nurses
Doloremque aliquam non aliquid repellat possimus cupiditate corporis porro perspiciatis.	Alaska
5. LPN Staff Nurses	6. Nurse Aides
New Mexico	88721 Nikolaus Locks
7. Medical Records	8. Pharmacy
excepturi qui laudantium	Labore a sed.
9. Dietary	10. Laboratory
Sit esse earum.	Nulla neque quos aut.
11. Housekeeping	12. Maintenance Personnel
Vel repellat quia molestiae illo numquam.	Aliquid est dicta libero voluptatibus iste eum velit quasi quisquam.
13. Laundry Personnel	14. Other (specify)
583-615-9639	Haley Welch
"Under 2, 3, 4 and 5, report only those registered or licensed nurses with a current registration or license nur	mber. Report all other nurses under number 6.



Fill out the Facility Information

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Fill out all the required fields.

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TIP: This step is not required for facilities that already have departmentally approved plans.

Not required for facilities that already have departmentally approved plans.	
Description of Facility	
*Attach plans or drawings for each floor of the building occupied by the existing hospital and identify:	
Life Safety Code Plans:	
Exiting	
Smoke Barriers	
Exit passageways Linen and trash chutes	
Linen and stash chutes Fire Barriers	
rie daniens Horizontal exits	
Vertical shifts	
Additional relevant information	
Upload Files Or drop files	
Building Information:	
-	
Construction type	
Age of existing building segments	
Local zoning compliance statement	
Additional relevant information	
1 Upload Files Or drop files	
1 <u></u> 1	
Existing Space Description:	
Current room/space use	
ldentification of hazardous areas protected by rated fire resistive partitions Other relevant information	
Outer relevant intornation	
typicad Files Or drop files	
1i	
Proposed Use of Rooms/Space within the Hospital	
A Hard Tax Decime Fire	
1. Upload Files Or drop files	1





Fill out the Facility Information

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Finish filling out all the required fields.

Click the **Next** button.

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TIP: This step is not required for facilities that already have departmentally approved plans.

Will the building have a mixed occupancy?		If yes, identify all classifications and locations on the drawings or plans requested above.	
None	\$		
		1 Upload Files Or drop files	
Has the JCAHO (Joint Commission on the Accreditation of Healthcare Organizations), or the State appn Safety Code variances or waivers?	roved any Life	If yes, attach a copy of the award letter and walvers that have been approved.	
None	\$	typiad Files Or drop files	
Are all patients/clients/residents capable of leaving the building on their own?		If no, are there instances when four (4) or more staff dependent patient/clients/residents are present in the building at	
None	\$	the same time?	
		None	
Is the building equipped with a fire alarm system?			
None	<u></u>		
	•		
Is there an interconnected smoke detection system?		If yes, where is the smoke detection system located?	
None	\$	None	
Is there an approved and supervised automatic sprinkler system?		If yes, where is the sprinkler system?	
None	\$	None	
Indicate number of building stories above ground, including the exit level.		Indicate number of building stories below ground level of the exit.	
Proposed Use of Idle Space			
Proposed ose of fale space			
		enters or types of uses, etc. The direction and scope of renovations must be in compliance with Life Safety to declare idle. Renovation cost may be a factor to consider before applying for hospital licensure status.	
Explain how you will utilize the idle space, e.g., rental to outside groups, expansion of outpatier	nt services, integrati	on of existing or new health care services (attach narrative).	
If applicable, provide a description of construction considerations and time frame for the renov of Quality Assurance prior to initiating all physical plant and environment renovations.	vations described in	table above (attach only one narrative covering all proposed building changes). NOTE: You must contact the Office	
Plan Approval applications can be obtained by calling DCRA @ (202) 442-4400			
		3 Next	J





Fill out the Hospital Staff Information

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Fill out all the required fields.

Click the **Next** button.

Oct 10, 2018 Oct 10, 2018 Image: City of the second o	* Years Attende : Beginning Year		*Years Attended - Ending Year
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Work Experience *Position * Employer *Position Fugiat nihil impedit voluptatibus culpa et ullam aliquam reprehenderit natus. Ratione sapiente sit. * Street Address *Cky 1195 Tamara Points New Billichester * State *2ip Code H1 2ip Code Oct 30, 2019 @ Nurse Administrator (Director of Nursing) *End date of Employment Vivian Collier *Begin Date Vivian Collier *Begin Date Oct 37, 2020 @	* Diploma/Degree		*Year Graduated
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Name of Person in Charge of Each Department *Dietary Service *Medical Records]	
* Dietary Service * Medical Records]	
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	Nora Witting		pariatur exercitationem quae



Fill out the Applicant Information

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Fill out all the required fields.

Click the **Next** button.

Type of Organization			
None		÷	
Interested Parties			
		nd directors if the entity is a corporation, and (4) if the entity is either s all the required information, attach a copy of that listing to this application. If a	
1 Upload Files Or drop files			
Owner of Land			
Complete this section if the owner of the land is not the same as the ow	vner of the operation or the owner of the building.		
First Name	MI	*Last Name	
		Jast	
Street Address	City		
State	*Zip Code		
None	00167-1770		
* Telephone Number	Fax Number	_	
905-347-7355			
*Organization Type (GM = Governmental, PP = Proprietary, VNP = Voluntary No	on-Profit)		
-None		÷	
Interested Parties			
	entity is a corporation, and (4) if the entity is either governmental or non-pro	is are (1) persons or business entities having ownership interest of 5% or more, fit, interested parties are the officers and directors. If there is a separate listing	
Upload Files Or drop files			
		2 Next	



Lease Agreement

	1	
	÷.	
-		/

Select **Yes** or **No** from the dropdown menu. This depends if there is an existing lease agreement.



Click the **Next** button.

	<u>New Application</u> Application Histo	.,,		~	lusto neque laborum ab recusandae na	atus et. Di
Lease Agreement						
* Is there a lease ag	reement?		÷			
If yes, list the nam	e and address of the lease holder.					
						P 2 Ne



Management Contract

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Select **Yes** or **No** from the dropdown menu. This depends if the facility is under management contract.



Click the **Next** button.

Is the operation of the facility under a management	nt contract?		
No			;
			P 2 Next





Fill out the Designee Information

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Fill out all the required fields.

Click the **Next** button.

	administrator also the designee?			
Yes				
Contac	:t Person			
Identify	y the person responsible for completing this application and who can	n be contacted if we have questions.		
* First N		MI	*Last Name	
Edmo	ond		Nikolaus	
Title		*Telephone Number	 ·	
		018-205-0173		
Fax Nun	mber	* Email Address		
		your.email+fakedata18824@gmail.com		
			Pri 2	Nei



Total Fee

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Check if **Total Fee** is correct.

Click the **Next** button.

ALTH Home New Application <u>Application History</u> Sup	port	Q, Search	Dani
In order your application to be processed, you must submit payment. Total Beds - 100		ertify & Submit. 2 - \$700.00	
			Pri 2 Next



Payment Wizard



Fill out the **Billing Address** and **Payment Info** fields.



Click the **Pay** button.

e complete the payment for your application using the form below. Click "Pay" when you a ication History" tab of the portal header later.	Payment Wizard are done inputting your payment details. If you are unable to	pay at this time, you may exit this saved draft and r	return to it in the
your payment has processed, click "Next" below to certify and submit the ap	plication. Your application will not be reviewed unti	I these steps have been completed.	
Billing Address		Payment Info	
2879 Ortiz Crest	Solon Miller		
788 Gottlieb Pass	3782 822463 10005		OM REPORT
Fort Joan	09/25		?
Oregon			
16913-4451			
		2	Pay \$700.00
		-	
Click the Next button at th	ne bottom of this page to Certify & Submit	the application.	
			Previous



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Payment Wizard

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Once the Transaction is approved, click **Next** button.

		Payment Wizard		
	complete the payment for your application using the cation History" tab of the portal header later.	form below. Click "Pay" when you are done inputting your payment details. If you are	unable to pay at this time, you may exit this saved draft and return to it in the	
After	your payment has processed, click "Next" belo	ow to certify and submit the application. Your application will not be review	ved until these steps have been completed.	
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	2879 Ortiz Crest			J
	788 Gottlieb Pass		Restauro Status]
	Fort Joan		?]
	Oregon			
	16913-4451			
		Transaction approved		
			Pay \$700.00	
	C	lick the Next button at the bottom of this page to Certify & S	Submit the application.	
				Next



Certify and Submit

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Fill out the Name field.

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Click the **Next** button.

TIP: The date should correspond to today's date.

	Certify and Submit			
	By clicking the submit button below, you are acknowledging that you are providing information for an offic knowingly and willfully making a false statement on an official record may result in action against your licer Health.			
	*(a) A person commits the offense of making false statements if that person willfully makes a false stateme under circumstances in which the statement could reasonably be expected to be relied upon as true; provio makes an affirmation by signing an entity filing or other document under Title 29 of the District of Columb affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not tru forth in § 22-3571.01 or imprisoned for not more than 180 days, or both. A violation of this section shall be p	led, that the writing indicates that the ma a Official Code, knowing that the facts sta e in any material respect; (b) Any person o	aking of a false statement is punishable by criminal penalties or if tha ated in the filing are not true in any material respect or if that person convicted of making false statements shall be fined not more than th	t person makes an
1	Py electronically entering my name on this form, I attest that all statements are true and accurate. Name			
	Celine Gleason			
	Date Oct 5, 2022	ä		
			2	Next



Close the Application

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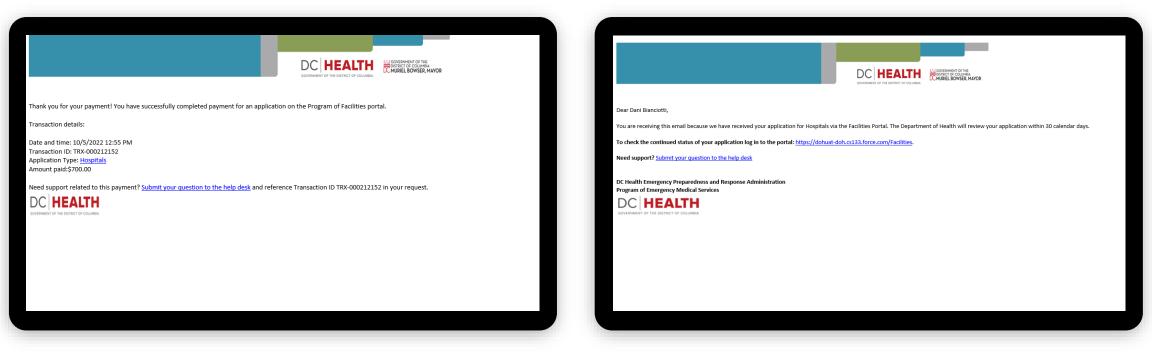
You have finished submitting your application. Click the **Close** button.

EALTH Home New Application Application History	Connect .	Q Adipisci delectus quam corrupti consequuntur.	Dani B
EALTH Home New Application <u>Application History</u>	Support	Adipisci delectus quam corrupti consequuntur.	Dani B
Hospital Application			
You have successfully submitted your Hospital application. One	e review is complete, you will be notified by our team. You may now	hit the ""Close"" button or close your browser.	
		1	Close



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E-mail Confirmation





Check if you have received confirmation of payment.



Check if you have received confirmation for your application.





Thank you!

