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

Oregon Health Authority

Caregiver Registry Application Form

Type of Action	
New Registry* ☐	Ownership Change ☐
License Renewal* ☐	Effective Date of Change _____
License # _____	Other (Specify) ☐
Name/Address Change ☐	_____

* Fee Payment Required (See back of this form for amount)

Registry Information		
Parent Registry ◯	Branch/Subunit ◯	Registry E-Mail:
Registry Legal Name:		
Registry DBA Name (if applicable):		
Registry Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Registry Mailing Address (if different from above):		
Days of Operation:	Hours of Operation:	
Describe geographic service area for this parent registry/branch/subunit:		
Name of Administrator & Phone:		
Administrator Email:		
Emergency Contact Person & Phone:		
Emergency Contact Email:		
Office Hours: Days Times		

Owner Information (If partnership or corporation, list each person having 5% or more interest on an additional page)		
Corporation ◯	Partnership ◯	Individual ◯
Other (Specify): ◯		
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 the Health Care Regulation and Quality Improvement Section, in writing, of any changes in this information within 30-days of any such change.

Administrator's Signature	***Print Name***
Print Title	***Date (mm/dd/year)***

Person who filled out this application form	
Name:	Email:
Title:	Phone:

Fee Schedule	
New Registry/Subunit	$1500 for parent/$750 for each Subunit
Yearly Renewal/Subunit*	$750 for parent/$750 for each Subunit
Change of Ownership/Subunit	$350 for parent/$350 for each Subunit

***If renewal is desired, the licensee shall make application at least 30 days prior to the expiration date per 333-535-0025.**

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

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

HCRQI Office Use Only

Effective date of initial licensure: _____ Initials: _____ Date: _____

Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____

Initials: _____ Date: _____

CASH OFFICE: QC **621** initial/QC **622** renewal