Australian Government
Department of Health

PRIVATE HOSPITAL INFORMATION FORM

Instructions

This application form is designed to be completed electronically and then emailed as an attachment. Complete the form by entering the information in the fields provided. Save the form as a Word document.

The completed form should be forwarded to **hospital.declarations.info@health.gov.au** together with the hospital licence from the state or territory health department and accreditation certification (if available).

This form is part of the Hospital Declaration process. The Declaration is a legal instrument and as such it is important that declared hospital information is both accurate and complete. A hospital declaration is made by the Minister of Health (or the Minister's delegate) pursuant to s.121-5 of the Private Health Insurance Act 2007. Completing this form will provide the Minister (or Delegate) with the necessary details for determining whether to declare the facility as a 'hospital'.

FACILITY DECLARATION DETAILS	
Facility Name: Enter Facility name	
Previous Name/s *(if applicable)*: Enter previous name/s	
Ownership *(as per State/Territory Licence/Approval)*: Enter owner name	
Date of commencement / change: Select date of commencement/change	
Provider Number *(if applicable)*: Enter provider number	
Facility Address	
Street: Enter Street Address	
Suburb / Town: Enter suburb/town	
State/Territory: Select State/Territory	Postcode: Enter Postcode
Facility Contact Details	
Phone: Enter Facility Phone Number	
Email: Enter Facility email address (please provide a generic email address for your facility)	

CEO Information
Name: Enter CEO full name
Phone: Enter CEO phone
Email: Enter CEO email address

POSTAL ADDRESS DETAILS	
As above ☐ (Tick if postal address details are the same as facility address details)	
Postal Address	
Street: Enter Street Address	
Suburb / Town: Enter suburb/town	
State/Territory: Select State/Territory	Postcode: Enter Postcode

FACILITY INFORMATION
Facility Open Date: Select date facility is to open
Bed Numbers: Enter number of beds in facility
Facility Type
Tick one box: ☐ Private Overnight ☐ Private Same Day
Financial Classification
Tick one box: ☐ For Profit ☐ Not For Profit
Tick one box if applicable: ☐ Religious ☐ Charitable ☐ Community ☐ Bush Nursing

PATIENT SERVICES Tick the box(es) that relate to the patient services offered by this facility		
☐ Alcohol & Drug	☐ Hepatobiliary	☐ Paediatric
☐ Burns	☐ Hospice care	☐ Pain management
☐ Cardiology	☐ Hospital in the home	☐ Palliative care
☐ Cardiology - coronary care	☐ Hyberbaric medicine	☐ Plastics/Reconstructive
☐ Cardiothoracic	☐ Immunology	☐ Podiatry
☐ Chronic disease management	☐ Infectious disease	☐ Rehabilitation
☐ Clinical genetics	☐ Infectious disease – HIV/AIDS	☐ Renal dialysis
☐ Dental	☐ Intensive care	☐ Renal dialysis - acute
☐ Dermatology	☐ Intensive care – Neonatal intensive care	☐ Renal dialysis - maintenance
☐ Domiciliary care	☐ Mental health/Psychiatry	☐ Reproductive
☐ Endocrinology	☐ Mental health/Psychiatry – substance related disorders	☐ Reproductive - IVF
☐ Endocrinology – diabetes	☐ Neonatal	☐ Reproductive - vasectomy
☐ Endoscopy	☐ Nephrology	☐ Respiratory
☐ ENT	☐ Neurology	☐ Respite
☐ Gastroenterology	☐ Neurology - epilepsy	☐ Rheumatology
☐ General medicine	☐ Neurology - neurosurgery	☐ Sleep centre
☐ General surgery	☐ Obstetrics/Maternity	☐ Transplant
☐ Genetics	☐ Obstetrics/Maternity – Postnatal care	☐ Transplant – bone marrow
☐ Geriatric	☐ Oncology	☐ Transplant - heart
☐ Geriatric - assessment	☐ Oncology - Chemotherapy	☐ Transplant - liver
☐ Geriatric – Nursing Home	☐ Oncology - Radiotherapy	☐ Transplant - pancreas
☐ Gynaecology	☐ Ophthalmology	☐ Transplant - renal

CO-LOCATION

Is this facility co-located with a public hospital?

☐ NO

☐ YES - Enter Public Hospital Name

* If YES – You and the public hospital you are co-located with will need to fill out the co-location forms **(last four pages of this document)** and submit with the rest of this Hospital Information Form.

EMERGENCY FACILITIES

Does this facility provide reasonable access to an appropriate range of services for the treatment of a person in an emergency situation?

☐ YES –

Please provide details:

Enter details of services available in emergency situations

☐ NO – Please complete 'Emergency Transfer Arrangements' section below

Emergency transfer Arrangements

Does this facility have formal arrangements for the transfer of a person, within a reasonable time, to a hospital where such services are available?

☐ YES –

Please provide details:

Enter details of arrangements in place for transfer of a person

☐ NO –

Please explain your facility's response to emergencies:

Enter details of your facility's response to emergencies

COMPLIANCE REQUIREMENTS UNDER THE PRIVATE HEALTH INSURANCE ACT 2007

ACCREDITATION
Currently Accredited
☐ This hospital has accreditation from an appropriate accrediting body and a copy of our hospital's accreditation certificate is attached. This hospital has been accredited by: Name of Accrediting Body
In the process of obtaining accreditation
☐ Attached is correspondence/evidence from an appropriate accrediting body indicating accreditation is scheduled or being negotiated. ☐ I confirm that a copy of the hospital's accreditation certificate will be provided to the Department of Health upon accreditation inspection completion. This hospital is in the process of obtaining accredited from: Name of Accrediting Body

NOTE: Hospitals are advised that accreditation by an appropriate accrediting body is one condition specified in 121-5 of the Private Health Insurance Act 2007 that the Minister must have regard to when deciding whether to declare a facility as a 'hospital', or to revoke such a declaration. For administrative best practice and to assist the Minister (or Delegate) in making an informed decision, hospitals are to maintain their accreditation approval and provide a copy of the current accreditation certificate to the Department as evidence on a regular basis.

DATA PROVISION - Tick the appropriate box(es) and attach the required information
☐ This facility confirms that Hospital Casemix Protocol (HCP) fund data will be provided to health insurers. ☐ This facility confirms that Private Hospital Data Bureau (PHDB) data will be provided to the Commonwealth Department of Health. For further information regarding data provisions – please email hcp@health.gov.au

NOTE: Hospitals are advised of their obligation to submit monthly data to the Commonwealth Department of Health under the Private Health Insurance Act 2007 and associated rules. Private health insurance legislation allows for remedial action to be initiated where reporting requirements of HCP and PHDB data are not met. Data submission is one of the requirements the Minister (or Delegate) must have regard to when considering whether declare or revoke a facility as a 'hospital'.

ACKNOWLEDGEMENT
I acknowledge on behalf of this facility that: ☐ As a Commonwealth declared facility I will adhere to the requirements as specified in the *Private Health Insurance Act 2007* (The Act) and its associated rules. ☐ For administrative best practice and to assist the Minister (or Delegate) in making an informed decision I will immediately advise the Commonwealth if the circumstances of this facility change. ☐ The facility is required (under the Act) to maintain the accreditation approval by an appropriate accrediting body and will provide a copy of the current accreditation certificate to the Department of Health as evidence each time accreditation is amended/renewed. ☐ The facility will meet the appropriate HCP and PHDB data reporting requirements. ☐ The facility's provider number will be published on the Department's website, published in a PHI Circular, and may be issued to stakeholders upon request.

SIGNATORY
I declare that the information provided in this form is both true and accurate.
Name/Signature: Enter your full name ***Note:*** *If you are emailing this form please type your name in the box above.*
Date: Select date document being signed
Position: Enter your position
Company: Enter the name of your Company

Please return this document to the Department of Health along with a copy of your Accreditation certificate and Hospital licence, via:

email: hospital.declarations.info@health.gov.au

or

post: MDP 406
GPO Box 9848
Canberra
ACT 2601

Australian Government
Department of Health

CO-LOCATED FORMS

(Private Hospital, first two pages, Public Hospital, second two pages.
If not applicable delete these four pages)

Private Hospital Details
Facility Name: *Click here to enter name*
Co-located with: *Click here to enter name/s*

The *Private Health Insurance (Health Insurance Business) Rules 2010,* sets out the matters to which the Minister is to have regard in declaring that a facility is a hospital. These are set out below. **Please answer the following questions by ticking the appropriate box**

Impacts	
In the case of a private facility, whether or not declaration of the premises would materially affect reasonable access by public patients to a reasonable range of services; and	◉ Yes ○ No ○ Not Applicable
whether or not declaration of the premises would result in a transfer of costs from the State or Territory to any other party; and	◉ Yes ○ No ○ Not Applicable
in the case of a private facility which was previously part of a public hospital, operated as a public hospital or was co-located with a public hospital operated by a State or Territory, the adequacy of arrangements in that public hospital to ensure that patients presenting for treatment are able to exercise freely their right to elect to be treated as a public patient in that facility; and	◉ Yes ○ No ○ Not Applicable

in the case of a private facility which was previously part of a public hospital, operated as a public hospital or co-located with a public hospital operated by a State or Territory, whether or not the State or Territory and the licensee of the hospital have entered into or are you prepared to enter into enforceable agreements with the Commonwealth to supply data or information to the Commonwealth to allow the Commonwealth to monitor access by public patients to a reasonable range of services, the adequacy of arrangements for patient election as to treatment as a public or private patient, the costs to the State/Territory and any other party, and the extent to which costs incurred by other parties are increasing or decreasing.	◉ Yes ○ No ○ Not Applicable

I declare that the information provided above is accurate to the best of my knowledge

Signature	
Name / Signature	Position: Enter your position
Note: If you are emailing this form please type your name in the box above.	

Public Hospital Details
Facility Name: *Click here to enter name*
Co-located with: *Click here to enter name/s*

The *Private Health Insurance (Health Insurance Business) Rules 2010,* sets out the matters to which the Minister is to have regard in declaring that a facility is a hospital. These are set out below. **Please answer the following questions by ticking the appropriate box**

Impacts	
In the case of a private facility, whether or not declaration of the premises would materially affect reasonable access by public patients to a reasonable range of services; and	○ Yes ○ No ○ Not Applicable
whether or not declaration of the premises would result in a transfer of costs from the State or Territory to any other party; and	◉ Yes ○ No ○ Not Applicable
in the case of a private facility which was previously part of a public hospital, operated as a public hospital or was co-located with a public hospital operated by a State or Territory, the adequacy of arrangements in that public hospital to ensure that patients presenting for treatment are able to exercise freely their right to elect to be treated as a public patient in that facility; and	◉ Yes ○ No ○ Not Applicable
in the case of a private facility which was previously part of a public hospital, operated as a public hospital or co-located with a public hospital operated by a State or Territory, whether or not the State or Territory and the licensee of the hospital have entered into or are you prepared to enter into enforceable agreements with the Commonwealth to supply data or information to the Commonwealth to allow the Commonwealth to monitor access by public patients to a reasonable range of services, the adequacy of arrangements for patient election as to treatment as a public or private patient, the costs to the State/Territory and any other party, and the extent to which costs incurred by other parties are increasing or decreasing.	◉ Yes ○ No ○ Not Applicable

I declare that the information provided above is accurate to the best of my knowledge

Signature	
Name / Signature	Position: Enter your position
Note: If you are emailing this form please type your name in the box above.	