NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
LICENSURE /CERTIFICATION /ACUTE/HOME CARE SECTION
SITE: 1205 UMSTEAD DRIVE
RALEIGH, NORTH CAROLINA 27603
MAILING: 2712 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-2712
PHONE (919) 855-4620 FAX(919)715-3073

FOR OFFICIAL USE ONLY
LICENSE NO.____________
PC________DATE________

INITIAL [ ]   ADDITIONAL SITE [ ]   CHOW [ ]   NAME CHANGE [ ]   OTHER _____

2008
LICENSE APPLICATION FOR HOME CARE, NURSING POOL, AND HOSPICE

A separate application is to be completed for each site from which home care (including home health), nursing pool, or hospice services are offered. Separate legal entities operated out of the same office must submit separate applications.

LEGAL IDENTITY OF APPLICANT: OWNER/CORPORATE IDENTITY

(Full legal name of corporation or partnership, individual, or other legal entity owning the enterprise or services.)

____

AGENCY NAME/DOING BUSINESS AS

(D/B/A) - Name(s) under which the facility or services are advertised or presented to the public:

Primary: ____

AGENCY MAILING ADDRESS: If materials are to be mailed to another address list here:
P. O. Box______________________________________

City _________________________State_________________Zip_________________

AGENCY SITE ADDRESS:

Street____
City _________________State______________Zip_________County_____________
E-mail Address ______________________ Web Site _____________________
(If applicable) (If applicable)
Telephone (___)______________Fax(___)____________
Administrator/Director:____

Title: ____

LICENSURE CATEGORIES APPLIED FOR: *(CHECK ALL THAT APPLY)*

1. ____Home Care Agency (G.S. 131E-138)
2. ____Nursing Pool (G.S. 131E-154.3)
3. ____Hospice Services (G.S. 131E-200)

(The information provided in this application will be used by the Department for the Certificate of Need and for planning process.)

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

SCOPE OF SERVICES:

In the columns below, check each service offered through this site.

YES	HOME CARE
____	Nursing Services
____	Infusion Nursing Services
____	In-Home Aide
____	Medical Social Services
____	Physical Therapy
____	Occupational Therapy
____	Speech Therapy
____	Clinical Respiratory Services (including Pulmonary or Ventilation)
____	Home Medical Equipment (DME) Do you also have a medical equipment permit issued by the Board of Pharmacy? Yes ___ No ___ **<u>Note</u>:** Not required for Home Care Licensure or Nursing Pool

YES	NURSING POOL
____	Licensed Nursing Personnel, Nurse Aides or Allied Health Personnel

YES	HOSPICE
____	Hospice Home Services (Licensed hospice care services only)
____	Hospice In-patient Beds (List only if you operate licensed beds in your own facility) Number of Beds_____
____	Hospice Residential Beds (List only if you operate licensed beds in your own facility) Number of Beds____
____	Do you have an agreement to operate Hospice licensed inpatient beds or hospice residential beds in another facility. If so, list facility________________________________
____	If you have contract for patients needing in-patient or residential accommodations, give the name of the contractor :________________________________ ________________________________

ACCREDITATION INFORMATION

If home care licensure is being requested on the basis of deemed status as an accredited agency, **attach a <u>complete</u> copy of accrediting organization's inspection report (or findings) together with its decision, if surveyed within the last 12 months**. Licensure based upon deemed status cannot be completed without full disclosure.

	ACCREDITING ORGANIZATION	EXP DATE
____	JCAHO (Joint Commission on Accreditation for Healthcare Organizations)	__________
____	CHAP (Nat'l League for Nursing)	__________
____	NCHC (Nat'l Home Caring Council)	__________
____	ACHC (Accreditation Commission for Home Care, Inc.)	__________
____	Other________________________________	__________

HOME CARE AGENCY APPLICANTS

1. If Medicare Certified Home Health, what is your provider number?______

2. This agency is a Home Health Agency. Please check one.
   Parent_____ Branch _____ Sub-unit

HOSPICE APPLICANTS

1. If Medicare certified, what is your hospice provider number?_______________________

2. Has this site been issued a Certificate Of Need to provide hospice services?
   Yes _____ No _____

NURSING POOL APPLICANTS ONLY

1. Nursing Pool applicants must attach a copy of the written administrative and personnel policies governing the provided services. **(Initial applications only)**

   All nursing pool applicants must attach a copy of the agency's current general and professional liability insurance policy (binder acceptable). The document must show that the applicant is insured against loss, damage, and expense related to a death or injury claim resulting from negligence or malpractice in the provision of health care by the nursing pool and its employees.

OWNERSHIP DISCLOSURE (Please fill in any blanks and make changes where necessary).

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

_______For-Profit

1. Proprietor (Proceed to Block I)
2. General Partnership (Proceed to Block II)
3. Limited Partnership (Proceed to Block II)
4. For Profit Corporation (Proceed to Block III)

______ Not-For-Profit

5. Not for Profit Corporation (Proceed to Block III)
6. Unit of Government (Proceed to Block IV)

BLOCK I. PROPRIETOR (unincorporated individual)

Proprietor's Name____

Proprietor's Home Address and Telephone

Street ____

City/State/Zip ____

Telephone (_____)____

BLOCK II. PARTNERSHIP

Partnership Name:____
Is it a general partnership? ____ Yes ____ No
Is it a limited partnership? ____ Yes ____ No
Is the partnership registered with the NC Secretary of State, 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 Telephone Number of the Partnership:
Street/Box:____
City/State/Zip____
Telephone (____)____
Give the name and address of the principal partners

Name	Title	Percent Ownership

Attach additional sheets as needed

BLOCK III. CORPORATION

What is the exact wording of the Corporate Name on file with the Office of the NC Secretary of State? (Corporate Office)

____

In what state was the corporation originally established?____

Address and Telehone Number of the corporation:

Street/Box ____

City/State/Zip ____

Telephone (____)____

List the names and addresses of **ALL** officers and/or any other persons with a controlling interest of 5% or more.

Name	Title	Percent of Stock

(Attach additional sheets as needed)

BLOCK IV. UNIT OF GOVERNMENT

Name of the governmental unit which has the ownership responsibility and liability for the services offered:

____

Title of the official in charge of the governmental unit:

____

Check which best describes the type of governmental unit:

_____ City _____ County _____ State _____ Authority

Health Dept.________

DSS ___________

Other (Please Specify):_________

MULTIPLE FACILITY AGENCY SYSTEMS

Yes____ No _____ Is this agency part of a multiple facility/agency system in North Carolina? (A multiple facility/agency system is defined as two or more entities under the same management or ownership).

If you checked yes on the above question, list the name (s) of the other entities licensed in North Carolina by the Division of Health Service Regulation.

Name Location License #

____

____

____

____

(Attach additional sheets as needed)

Is your agency owned in whole or in part or operated by a hospital? Yes ____ No _____
If yes, please specify name of entity____
Is your agency managed by another entity? Yes _______ No _______
If yes, please specify name of entity ____

I certify that this application and all attachments as submitted are accurate and true representations of the services offered as reported herein.

Signature ____

Typed Name ____

Title ____

Date ______________________

The NC Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age, or disability in employment or the provision of services.

SERVICE CATEGORIES FOR HOME CARE PROVIDERS

In the columns below, identify each service provided by county through this site. Also, identify by check mark whether the service is provided to your clients by **contract** with another agency, by **in-house** staff or both.

County	Nursing		Infusion Nursing		In-Home Aide		Medical Social Services		PT		ST		OT		Clinical Respiratory *	
	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT

IN-H - In-House Staff
CTRT - Service provided by contract
*** - Clinical Respiratory includes pulmonary and ventilation services**

PLEASE ATTACH A LIST OF ALL CONTRACTORS AND THE SERVICE(S) PROVIDED BY COUNTY UNDER THIS ARRANGEMENT. DO NOT LIST CONTRACTS YOU HAVE WITH OTHER AGENCIES TO PROVIDE SERVICES TO THEIR CLIENTS.

SERVICE CATEGORIES FOR HOSPICE HOME CARE, HOSPICE IN-PATIENT AND HOSPICE RESIDENTIAL PROGRAMS

In the columns below, identify each service provided by county through this site. Also, identify by check mark whether the service is provided to your clients by **contract** with another agency, by **in-house** staff or both.

County	Nursing		Social Work		Add'l Counsel		Bereavement		Volunteers		Inpatient Care	
	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT

County	PT		OT		ST		Home Health Aide		Nutritional Assessment & Dietary Counseling		Other Services	
	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT

In-H **In-House Staff**
Ctrt **Service provided by contract**
***** **Clinical respiratory includes pulmonary and ventilation services**

PLEASE ATTACH A LIST OF ALL CONTRACTORS AND THE SERVICE(S) PROVIDED BY COUNTY UNDER THIS ARRANGEMENT. DO NOT LIST CONTRACTS YOU HAVE WITH OTHER AGENCIES TO PROVIDE SERVICES TO THEIR CLIENTS.