

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 _____

2012 LICENSURE 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)
4. ___ Companion, Sitter Services, and Respite Care (G.S. 131E-136)

(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 Effective July 1, 2011, the division will not issue any licenses for new home care agencies that intend to offer In-Home Aide Services for a period of three years.

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 ___

Note: 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 : _____

YES

COMPANION, SITTER AND RESPITE CARE

Companion,/Sitter

Respite

ACCREDITATION INFORMATION

If home care licensure is being requested on the basis of deemed status as an accredited agency, **attach a complete 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 Telephone 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 _____

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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	CTRTR	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR

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

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.