Reset Form

RENEWAL OF APPLICATION FOR REGISTRATION TO OPERATE AN OUT OF STATE MOBILE HEALTH CARE ENTITY

State Form 55086 (8-12)
INDIANA STATE DEPARTMENT OF HEALTH-DIVISION OF ACUTE CARE

Division of Acute Care Use Only	**Facility Number:**
Date Received *(month, day, year)* _____	**Date Approved** *(month, day, year)* _____

All questions on this application must be answered completely and legibly in printed or typed script. Include all required documentation with the application when applicable. Complete all sections on the application. An incomplete or illegible application will be returned without being processed. No certificate of registration shall be issued without a completed approved application.

Please Type or Print Legibly

SECTION I - IDENTIFYING INFORMATION

A. Out of State Mobile Health Care Entity Parent Location

Name of mobile health care entity *(List the facility name in this section as it appears on the document from the Indiana Secretary of State.)*

Street address *(number and street)*		P.O. Box
City	State	ZIP Code +4

Telephone number ( )	Fax number ( )	Certificate of Registration Number *(located on certificate)*
E-mail address	Web address	

B. Mailing Address *(if different from practice location)*

Street address *(number and street)*		P.O. Box
City	State	ZIP Code +4

SECTION II – STAFFING

Mobile Medical Unit Manager

SECTON III - OWNERSHIP INFORMATION

A. Legal Entity (Owner/Operator) *Type or print name of legal entity (i.e. corporation, limited liability company, partnership) in this section. The name must be listed in this section as it appears on the documents from the IRS and associated with the EIN number and Indiana Secretary of State. If a change of ownership occurred, you must request in writing a change of ownership application. A change of ownership cannot be process on this renewal application.*

Name of legal entity *(List the legal name in this section as it appears on the document from IRS and associated with the EIN number and SOS.)*

Street address *(number and street)*		P.O. Box
City	State	ZIP Code+4

Telephone number ( )	Fax number ( )	
EIN Number		Fiscal year end date *(mm/dd)*

B. Ownership Information (officers/directors/managing agents/managing employees of the mobile health care entity)
Has the facility changed individuals with direct or indirect ownership? ☐ Yes ☐ No *(If yes, complete below.)*

List names, titles and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name and Title	Business Address *(street address/city/state/ZIP code)*	EIN Number

C. Officers: Directors/CEO/CFO/President/Vice President/Secretary/Treasurer/Partners/Managing Agents/Member
Has the facility changed officers, partners and/or directors? ☐ Yes ☐ No *(If yes, complete below.)*

List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. owner, director, CEO, president, vice president, secretary, treasurer, partner, member). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a limited liability company, list the name and title for all individuals associated with each member entity that forms the limited liability company. *(Use additional sheet if necessary.)*

Officers Names	Title	Business Address *(street address/city/state/ZIP code)*	Telephone Number

SECTON IV - CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a registration to operate a Mobile Health Care Entity in the State of Indiana, and in support of this application, represents and shows that the owners and operators are of reputable and responsible character, are able to comply with IC 16-41-42, and will operate and maintain this entity in accordance with those requirements.

I hereby certify that the operational policies of the entity will not provide for discrimination based upon race, color, creed or national origin.

I swear or affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws and rules governing the regulation of Mobile Health Care Entities in Indiana.

Owner/President *(Type/print the name as listed in section III.C. on this application.)*

Signature of Owner/President *(Signature of owner/president as listed in section III.C. on this application.)*	Date of Signature *(month, day, year)*

Mobile Medical Unit Manager *(Type/print the name as listed in section II on this application.)*

Signature of Mobile Medical Unit Manager *(Signature of manager as listed in section II on this application.)*	Date of Signature *(month, day, year)*

Return the application and required documentation to:

Indiana State Department of Health
Acute Care Division 4A-07
2 N. Meridian St.
Indianapolis, Indiana 46204