Reset Form

APPLICATION FOR LICENSE TO OPERATE A HOME HEALTH AGENCY

State Form 4008 (R10 / 9-18)
Indiana State Department of Health - Division of Acute Care
(Pursuant to IC 16-27-1-7 and 410 IAC 17-10-1)

Division of Acute Care Use Only

Date Received _____ *(month, day, year)* **Date Reviewed** _____ *(month, day, year)* **Date Approved** _____ *(month, day, year)*

- **All questions on this application must be answered completely in printed or typed script. Supporting documentation must be attached to application. Complete all sections. AN INCOMPLETE OR ILLEGIBLE APPLICATION WILL BE RETURNED WITHOUT BEING PROCESSED.**
- **License renewal must be obtained annually.**
- **This application and the license are neither assignable nor transferable.**
- **Previous receipt of a license is not a guarantee that a license and/or approval will be issued.**
- **A non-refundable application fee in the amount of $250.00 must accompany this application. No license and/or approval will be issued without payment.**

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ **New Facility**

☐ **Change of Ownership *(Anticipated date of Sale / Purchase / Lease)*** *(month, day, year)*: _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Practice Location *(name of facility d/b/a of direct owner)*

If the d/b/a is different from the direct owner/entity the d/b/a must be registered with the Indiana Secretary of State. Submit "Certificate of Doing Business Name" document signed by the Indiana Secretary of State that lists owner / entity name and d/b/a.

Name of Agency			
Street address *(number and street)*			P.O. Box
City		County	ZIP code +4
Telephone number ( )	Fax number ( )	Facility's office hours *(i.e. 8:00 a.m. – 4:00 p.m. Monday - Friday)*	
E-mail address		Website address	

B. Licensee / Ownership Information

The owner / entity as registered with the Indiana Secretary of State (SOS) and appears on the Articles of Incorporation, etc. signed by the SOS. Submit Articles of Incorporation, etc. from the SOS and SS-4 form or other comparable document from the Internal Revenue Service (IRS) that reflects the owner / entity name, d/b/a if applicable and EIN number.

Licensee / Owner / Entity of the facility (d/b/a) *(The owner's name as registered with the SOS and appears on the document)*			
Street address *(number and street)*			P.O. Box
City		State	ZIP code+4
Telephone number ( )	Fax number ( )	EIN Number *(submit documentation to validate)*	Fiscal year end date *(mm/dd)*

C. Branch Offices *(as defined in 410 IAC 17-9-5) (Applicable for change of ownership only – do not complete if initial application.)*

Does the Agency have branches? ☐ Yes ☐ No

If yes, please provide the name, address, and telephone number of each branch location. (Use additional sheet if necessary.)

Name	Address *(number and street, city, state, and ZIP code)*	Telephone Number

D. Types of home health services to be provided *(Check all that apply.)*

☐ Home Health Aide ☐ Medical Social Services ☐ Nursing

☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy

☐ Other *(List all)* _____

_____

E. Types of personal services to be provided

Do you provide services as performed by a personal services agency under IC 16-27-4? ☐ Yes ☐ No *If yes, check the services provided.*

Homemaker Services	Companion Type Services	Assistance With Cognitive Tasks
☐ Shopping ☐ Laundry	☐ Transportation ☐ Letter writing	☐ Managing finances ☐ Planning activities
☐ Cleaning ☐ Seasonal chores	☐ Mail reading ☐ Escort services	☐ Making decisions

Attendant Care Services as defined under IC 16-27-1 and IC 16-27-4

☐ Attendant Care Services

Any other personal services performed that does not require under state law: a license, certification, registration, or permit

_____

_____

_____

_____

F. Provider Based

Is this facility a hospital and/or provider based facility (i.e. owned by a separately licensed entity)? Not applicable for freestanding facility.

☐ Yes ☐ No *(If yes, provide Medicare certification number.)*

SECTION III – STAFFING

A. Administrator *(as defined in 410 IAC 17-9-2)*

Name *(first, middle, last)*

1. Submit the following:
   - Current copy of the administrator's resume with complete employment history with month/year of employment and reason for leaving.
   - Current copy of any applicable license listed in 410 IAC 17-9-15
   - Current copy (within previous three (3) months) of applicable criminal history check as required by IC 16-27-2-4

2. List post-secondary education and health related experience.

_____

_____

3. Has the administrator ever been convicted of any criminal offense relating to, or in any way associated with, a dependent population?
☐ Yes ☐ No *(If yes, state on a separate sheet the facts of each case completely and concisely.)*

4. Has the administrator's license (if applicable) ever lapsed, been suspended or revoked? ☐ Yes ☐ No
(If yes, explain on a separate sheet of paper the place, date, and agency initiating action, action taken, and reason.)

B. Alternate Administrator

Name *(first, middle, last)*

1. Submit the following:
   - Current copy of the alternate administrator's resume with complete employment history with month/year of employment and reason for leaving.
   - Current copy of any applicable license listed in 410 IAC 17-9-15
   - Current copy (within previous three (3) months) of applicable criminal history check as required by IC 16-27-2-4

2. List post-secondary education and health related experience

_____

_____

3. Has the alternate administrator ever been convicted of any criminal offense related to, or in any way associated with, a dependent population?
☐ Yes ☐ No *(If yes, state on a separate sheet the facts of each case completely and concisely.)*

4. Has the alternate administrator's license (if applicable) ever lapsed, been suspended or revoked? ☐ Yes ☐ No
(If yes, explain on a separate sheet of paper the place, date, and agency initiating action, action taken, and reason.)

C. Clinical Supervisor *(as defined in 410 IAC 17-12-1(d))*

Name *(first, middle, last)*

Indiana license number *(please include a copy of license with application)*

Education *(Name of School of Nursing or School of Medicine)*

Degree	Year graduated

C. Clinical Supervisor *(as defined in 410 IAC 17-12-1(d))* ***(continued)***

1. Submit the following:
   - Current copy of the clinical supervisor's resume with complete employment history with month/year of employment and reason for leaving.
   - Current copy of any applicable license listed in 410 IAC 17-9-15
   - Current copy (within previous three (3) months) of applicable criminal history check as required by IC 16-27-2-4

2. List post-secondary education and health related experience.

_____

_____

3. Has the clinical supervisor ever been convicted of any criminal offense relating to, or in any way associated with, a dependent population?
☐ Yes ☐ No *(If yes, state on a separate sheet the facts of each case completely and concisely.)*

4. Has the clinical supervisor's license (if applicable) ever lapsed, been suspended or revoked? ☐ Yes ☐ No
(If yes, explain on a separate sheet of paper the place, date, and agency initiating action, action taken, and reason.)

D. Alternate Clinical Supervisor *(as defined in 410 IAC 17-12-1(d))*

Name *(first, middle, last)*	
Indiana license number *(please include a copy of license with application)*	
Education *(Name of School of Nursing or School of Medicine)*	
Degree	Year graduated

1. Submit the following:
   - Current copy of the alternate clinical supervisor's resume with complete employment history with month/year of employment and reason for leaving.
   - Current copy of any applicable license listed in 410 IAC 17-9-15
   - Current copy (within previous three (3) months) of applicable criminal history check as required by IC 16-27-2-4

2. List post-secondary education and health related experience.

_____

_____

3. Has the alternate clinical supervisor ever been convicted of any criminal offense relating to, or in any way associated with, a dependent population?
☐ Yes ☐ No *(If yes, state on a separate sheet the facts of each case completely and concisely.)*

4. Has the alternate clinical supervisor's license (if applicable) ever lapsed, been suspended or revoked? ☐ Yes ☐ No
(If yes, explain on a separate sheet of paper the place, date, and agency initiating action, action taken, and reason.)

SECTION IV - OWNERSHIP AND CONTROLLING INTEREST

A. Ownership Information *(officers / directors / managing agents / managing employees of the home health agency)*

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) or more in the applicant entity. Ownership interest in an entity that has an ownership interest in the disclosing entity or in an entity that has an indirect ownership interest in the disclosing entity constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name *(first, middle, last)*	Address *(number and street, city, state, and ZIP code)*	EIN Number

B. Type of Ownership *(Applicable for change of ownership only.) (Check appropriate type of ownership.)*

- ☐ Asset Purchase Agreement
- ☐ Assignment of Interest
- ☐ Lease
- ☐ Merger
- ☐ New Partnership
- ☐ Sale
- ☐ Termination of Lease
- ☐ Transfer of Asset Agreement
- ☐ Other _____

Submit a bill of sale or comparable document, which includes corporation/owner(s) name(s) and buyer/seller signature(s) and effective date of transaction.

C. Type of Entity *(Check appropriate item.)*

For Profit

- ☐ Individual
- ☐ * Partnership
- ☐ ** Corporation
- ☐ *** Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Other *(specify)* _____

NonProfit

- ☐ Church Related
- ☐ Individual
- ☐ * Partnership
- ☐ ** Corporation
- ☐ *** Limited Liability Company
- ☐ Other *(specify)* _____

Government

- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District
- ☐ Federal
- ☐ Other *(specify)* _____

* If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

** If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate of Authority to do Business in the State of Indiana" signed by the Indiana Secretary of State.

*** If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

If the doing business name (d/b/a) is different from the direct owner's name submit a "Certificate of Assumed Business Name" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Directors / Officers / Partners / Managing Agents / Managing Employees *(Direct owners)*

List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, president, vice president, secretary, etc). 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.)*

Name of Officer or Partner *(first, middle, last)*	Title	Address *(number and street, city, state, and ZIP code)*

B. Licensure / Operating History

1. Have the owners or managers of the agency operated any agency within Indiana or any other state which had a record of denial, revocation, or operation with less than a full license (i.e. probationary, provisional, denial of annual license renewal, etc.), or had payment of a civil penalty?
   ☐ Yes ☐ No *(If "Yes", Provide name of each agency on a separate sheet and explain the facts completely and concisely.)*

   a. If any applications or licenses have been denied, withdrawn, or revoked, so state with a full explanation. *(Use additional sheet if necessary.)*

   b. If any license has been granted, state the date granted and expiration date. *(Use additional sheet if necessary.)*

2. Are there any individuals or organizations having direct or indirect ownership or control interest in the agency of five percent (5%) or more who have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles 18, 19 or 20 (Medicare or Medicaid)?
   ☐ Yes ☐ No *(If "Yes", list each person or entity on a separate sheet and explain relationship.)*

3. Are there any directors, officers, agents or managing employees of the agency who have ever been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles 17, 18, 19 or 20 (Medicare or Medicaid)?
   ☐ Yes ☐ No *(If "Yes", list each person on a separate sheet and explain the facts completely and concisely.)*

SECTION VI – MANAGEMENT *(Managing Company)*

The name and address of the corporation, association, or other company this is responsible for the management of the home health agency, and the name and address of the chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency. ***(If not applicable, please state not applicable.)***

A. Name and address of corporation, association, or other company that is responsible for the management of the home health agency

Name of Corporation	Address of Corporation *(number and street, city, state, and ZIP code)*

B. Name, address and title of the chief executive officer and the chairman or equivalent position of the governing body of the managing company

Name *(first, middle, last)*	Address *(number and street, city, state, and ZIP code)*	Title

SECTION VII - CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate a home health agency 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 the home health agency statutes, IC 16-27 and the rules promulgated thereunder, 410 IAC 17 and will operate and maintain this agency in accordance with those rules.

I hereby certify that the operational policies of the home health agency precludes 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 laws, rules and regulations governing the licensing of home health agencies in Indiana.

APPLICANT'S SIGNATURE OR SIGNATURE OF THE APPLICANT'S AUTHORIZED AGENT MUST APPEAR BELOW.

If signed by any individual (e.g., the administrator) other than indicated in section IV.A or V.A. of this application, an affidavit must be submitted with the application affirming that said person(s) has/have been given the power to bind the applicant / licensee.

Name of authorized representative *(typed*) *(first, middle, last)*	Title
Signature of authorized representative	Date *(month, day, year)*

SECTION VIII – DOCUMENTATION THAT MUST BE SUBMITTED WITH THE LICENSE APPLICATION

1. A non-refundable license fee of **two hundred fifty dollars ($250)** made payable to the Indiana State Department of Health and mailed with application to:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE
2 NORTH MERIDIAN STREET, SUITE 2-C
INDIANAPOLIS, INDIANA 46204

Home Health Statute:
IC 16-27-1-7
The state department shall adopt rules under IC 4-22-2 to do the following:
(1) Protect the health, safety, and welfare of patients.
(2) Govern the qualifications of applicants for licenses.
(3) Govern the operating policies, supervision, and maintenance of service records of home health agencies.
(4) Govern the procedure for issuing, renewing, denying, or revoking an annual license to a home health agency, including the following:
(A) The form and content of the license.
(B) The collection of an annual license fee of not more than **two hundred fifty dollars ($250)** that the state department may waive.
(5) Exempt persons who do not provide home health services under this chapter.

Home Health Rules:
410 IAC 17-10-1 Licensure
(a) No home health agency shall: (1) be opened; (2) be operated; (3) be managed; (4) be maintained; or (5) otherwise conduct business; without a license issued by the department.

(b) A license is required for any home health agency providing care in Indiana where the parent agency is located in a state other than Indiana. The home health agency must: (1) be authorized by the secretary of state to conduct business in Indiana; and (2) have a branch office located in Indiana.

(c) Application for a license to operate a home health agency shall be: (1) made on a form provided by the department; and (2) accompanied by a nonrefundable fee of **two hundred fifty dollars ($250).**

2. Copies of the administrator's and alternate administrator's current Indiana license *(any applicable license if you are an administrator or health care professional as defined in 410 IAC 17-9-15, such as a nurse)*, resume and applicable criminal history check.) Copies of the clinical supervisor's and alternate clinical supervisor's current Indiana professional license, resume, and applicable criminal history check. Submit verification from the Indiana Professional Licensing Agency verifying active and current license.

3. Articles of Incorporation and/or other documents from the Indiana Secretary of State.

- If a Limited Partnership, submit a copy of the "Application for Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.
- If a Corporation, submit a copy of the "Articles of Incorporation" and Certificate of Incorporation" signed by the Indiana Secretary of State.
- If applicant is an out of state corporation (foreign corporation), submit a copy of the "Certificate of Authority to do Business in the State of Indiana" signed by the Indiana Secretary of State.
- If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.
- If the "doing business as" (d/b/a) name is different from the corporation's (direct owner's) name submit "Certificate of Assumed Business Name" that list the corporation/owner's name and d/b/a name signed by the Indiana Secretary of State.

4. Submit a SS-4 or other comparable document from the Internal Revenue Service (IRS) that reflects the owner/entity name, d/b/a if applicable and EIN number.