APPLICATION FOR LICENSE
APPROVAL TO OPERATE A HOSPICE PROGRAM

State Form 43813 (R5/5-05)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-25-3)
Form Approved By State Board Of Accounts-2005

Division of Acute Care Use Only	
Date Received_____________________	**Date Approved**_____________________

- **All questions on this application must be answered completely in printed or typed script. Supporting documentation must be attached. An incomplete or illegible application will be returned without being processed.**
- **License and/or approval renewal must be obtained annually.**
- **This application and the license, and/or approval which may be issued as a result, are neither assignable nor transferable.**
- **Previous receipt of a certification is not a guarantee that a license and/or approval will be issued.**
- **A non-refundable application fee in the amount of $100.00 must accompany this application. No license and/or approval shall be issued without receipt of this fee.**

Please Type or Print Legibly

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***___________________ ☐ **New Facility**

Submit a dated and signed copy of the bill of sale, lease or other document of transfer

☐ **Medicare** ☐ **Medicare and Medicaid** ☐ **State License Only**

SECTION II - IDENTIFYING INFORMATION

A. Practice Location *(facility/dba)*

If the d/b/a is different from the direct owner submit Articles of Incorporation from the Office of the Secretary of State listing the d/b/a. The d/b/a should be registered with the Office of the Secretary of State and appear on the Articles of Incorporation submitted to ISDH with the application.

Name of Facility			
Street Address			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)*	

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

Street Address		P.O. Box
City	State	Zip Code +4

C. Licensee/Ownership Information ***(owner)***

The owner/entity as registered with the Office of Secretary of State and appears on the Articles of Incorporation form submitted to ISDH. Submit Articles of Incorporation from the Office of Secretary of State along with a W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.

Licensee/Owner/Entity of the facility d/b/a *(The entity's name as registered with the secretary of state and that appears on the form/certificate)*			
Street Address			P.O. Box
City		State	Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number *(submit documentation to validate)*	Fiscal Year End Date *(mm/dd)*

D. Site Offices ***(applicable for change of ownership – do not complete if initial application)***

Does the facility have other sites? ☐ Yes ☐ No

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

Name	Address (street address/city/zip)	Telephone Number

E. Type of Hospice

Is this facility a provider based facility? *(owned by a separately licensed entity)* ☐ Yes ☐ No

If yes, provide Medicare number ____________________

If yes, include a copy of the license with the application

License number of licensed entity ____________________________ Date issued_____________________ Date expires____________________

Please mark appropriate box for the type of hospice you are providing.

☐ Home Health Agency ☐ Hospital ☐ Intermediate Care Facility

☐ Skilled Nursing Facility ☐ Freestanding Hospice

SECTION III – STAFFING

A. Home Health Aides

Does the applicant employ, contract, or use home health aides in providing services to its patients? ☐ Yes ☐ No

If yes, please provide a list of all home health aides presently employed, contracted, or used by the applicant, along with a copy of the current criminal history check and documentation of the applicant's inquiry of the State Nurse Aide Registry for each aide.

B. Volunteers

Does the applicant use volunteers in providing services to its patients? ☐ Yes ☐ No

If yes, please provide a list of all volunteers used by applicant, along with a copy of the documentation of the current criminal history check for all volunteers with patient contact and documentation of applicant's inquiry of the State Nurse Aide Registry for each such volunteer who acts as a home health aide.

C. Medical Director *(physician)*	
Name (enter full name)	Indiana license number

1. Submit a current copy of the Medical Director's *(Physician)* Indiana license and current criminal history check.

2. Has the Medical Director *(Physician*) ever been convicted of any criminal offense relating to, or in any way associated with, the provision of health services?

   ☐ Yes ☐ No *(If yes, attach a separate sheet of paper, that explains the facts of each case, completely and concisely and how it was resolved.)*

3. Has the Medical Director's *(Physician*) license ever lapsed, been suspended, or revoked? ☐ Yes ☐ No

   (If yes, attach on a separate sheet of paper that explains the place, date, and agency initiating the action, action taken, and the reason.)

D. Administrator
Name *(enter full name)* *Submit a copy of the administrator's resume and current criminal history check.*

E. Patient/Family Care Coordinator		
Name *(enter full name)*		Indiana license number *(if applicable)*
Education (Name of School)	Degree	Year Graduated

List of post-secondary and hospice experience

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1. Submit a current copy of any applicable Indiana license, resume with complete employment history and current limited criminal history check.

2. Has the coordinator ever been convicted of any criminal offense relating to, or in any way associated with, the provision of health care services?

   ☐ Yes ☐ No *(If yes, attach a separate sheet of paper, that explains the facts of each case, completely and concisely and how it was resolved.)*

3. Has the coordinator's license (if applicable) ever lapsed, been suspended, or revoked? ☐ Yes ☐ No ☐ NA

   (If yes, attach a separate sheet of paper that explains the place, date, agency initiating the action, action taken, and the reason.)

SECTON IV – DISCLOSURE OF APPLICANT ENTITY

A. Directors/Officers/ Partners/Managing Agents/Managing Employees

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)***

Officer or Partner Name	Title	Business Address (*street address/city/state/zip*)	Telephone Number

B. Type of Ownership *(applicable for change of ownership – do not complete if initial application)*

☐ 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 with the application.

C. Type of Entity

For Profit

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

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NonProfit

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

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Government

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

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*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.

C. Licensure/Operating History

Have the owners or managers of the facility operated any facility within Indiana, or any other state that had a record of denial of licensure or operation with less than a full license (i.e. probationary, provisional, denial of annual license renewal, etc)? ☐ Yes ☐ No

(If "Yes", attach a separate sheet of paper that identifies the name of each facility, and explains the facts completely and concisely)

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

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

SECTION V – GOVERNING BODY

List the name and addresses of the Governing Body Officers

Name	Business Address of Officer (street address/city/state/zip)

SECTION VI - CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate a hospice in the State of Indiana and, in support of this application, represents and shows that the applicant is able to comply with the hospice licensure/approval Statute, IC 16-25-3 and accompanying regulations.

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 hospice programs in Indiana.

Applicant's signature or signature of the applicant's authorized agent should appear below.

If signed by any individual (e.g., the administrator) other than indicated in section II.B. Of this application, an affidavit must be submitted with the application, affirming that said person has been given the power to bind the applicant/licensee.

Name of Authorized Representative *(Typed)*	Title

Signature of Authorized Representative	Date

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

1. The non-refundable license fee ($100.00).

2. Disclosure document (refer to page 7 of this application).

3. A copy of the Medical Director's (Physician) current Indiana physician's license (a **legible wallet size** that shows the expiration date), resume and current limited criminal history check.

4. A copy of the Administrator's current limited criminal history check.

5. A copy of the Patient/Family Care Coordinator's license (**legible wallet size** copy of current Indiana license(s) that shows the expiration date), resume and current limited criminal history check.

6. Completed limited criminal history checks from the Indiana State Police Central Repository must be submitted with the application for Medical Director, Administrator, and Patient Family Care Coordinator.

7. Articles of Incorporation and/or other documents from the Office of the Secretary of State must be submitted:

   - 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" (dba) name is different from the corporation's (direct owner) name submit "Certificate of Assumed Business Name" or "Articles of Incorporation" that list the d/b/a name signed by the Indiana Secretary of State that list the d/b/a name.

8. Submit a W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.

9. Submit copies of all contracts on services provided by contract. The contracts must be identified by dividers, signed and dated.

10. A list of each and every home health aide employed, contracted, or utilized (this includes volunteers) by the applicant at the time of the application.

11. A list of each and every volunteer utilized by the applicant at the time of the application, including the date the individual volunteered services.

12. Documentation of the inquiry with the State Nurse Aide Registry regarding each home health aide listed included in the application. Documentation must include:

    - Name and title of individual conducting the Health Health Aide check;
    - Date of check;
    - Name and social security number of the home health aide;
    - Results of check ("Finding", "No Finding"; "Not listed"); and
    - If a finding exists, the nature of that finding, and whether it is being contested.

SECTION VIII – DISCLOSURE STATEMENT

In order for the Department to grant an application for licensure or approval of a hospice program, the applicant must be able to demonstrate its ability to comply with the minimum standards established by IC 16-25-3, effective July 1, 1999. This ability to comply is demonstrated by the applicant through what is known as a “Disclosure Statement”, which is submitted each year along with the initial or renewal application.

There is no required format for a Disclosure Statement; however, two (2) topics, services and supplies and patient rights, must be addressed. In addition, a toll free number for the facility must be provided should an individual have any questions or comments about a program.

Listed below are those minimum standards that must be included in the applicant’s Disclosure Statement. Additional information may be included.

1. A description of all hospice services to include:

   a. **Core Services:**
      (1) Physician services;
      (2) Nursing services;
      (3) Medical social services; and
      (4) Counseling Services.

   b. **Other services**, including but not limited to:
      (1) Physical therapy;
      (2) Occupational therapy;
      (3) Speech therapy;
      (4) Home health aide;
      (5) Homemaker;
      (6) Medical supplies; and
      (7) Short term inpatient care.

2. A description of supplies provided to clients, including how those supplies are made available or Delivered.

3. A statement of patient rights, to include:

   a. Acknowledgement that hospice services and supplies shall be dispensed on a patient’s individual needs.

   b. Description of an internal dispute resolution process to include:

      (1) How the dispute resolution process is initiated;
      (2) The name of the ultimate decision-maker; and
      (3) How the patient may appeal a decision rendered under this procedure

   c. A statement that patient has the right to participate in the planning of his care

   d. A statement that the patient has the right to refuse any component of the hospice’s services or supplies.

   e. The Indiana State Department of Health’s hot line toll-free number: 1-800-227-6334.