Reset Form

RENEWAL APPLICATION FOR LICENSE TO OPERATE A HOME HEALTH AGENCY

State Form 48851 (R7 / 6-26)
Indiana Department of Health-Division of Home & Community Based Care

Division of Home & Community Based Care Only

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

All questions on this application must be answered completely and legibly with printed or typed script with supporting documentation attached when applicable. Complete all sections on this application. AN INCOMPLETE OR ILLEGIBLE APPLICATION WILL BE RETURNED WITHOUT BEING PROCESSED. A non-refundable application fee in the amount of $250.00 must accompany this application. No license or approval shall be issued without receipt of this fee and/or completed application.

Please Type or Print Legibly.

SECTION I – FACILITY IDENTIFICATION	
Facility ID	CCN (If Applicable)
License #	License Expiration Date
If there is a change in the name of the facility submit Articles of Incorporation or Certificate of Assumed Business document from the State of Indiana Office of the Secretary of State.	
Complete all sections of the application.	

SECTION II – AGENCY NAME AND ADDRESS			
A. Practice Location *(agency)* ***Complete all sections below.***			
Legal Name of Agency			
Doing Business As *(The entity's name as registered with the secretary of state and that appears on the form/certificate)*			
Street address *(number and street)*			P.O. Box
City		County	ZIP code +4
Telephone number with area code	Fax number with area code	E-Mail address	Web address
B. Mailing Address *(if different from practice location)*			
Street Address			P.O Box
City	State		Zip Code +4

SECTION III – SERVICES PROVIDED UNDER HOME HEALTH LICENSE				
☐ Skilled Nursing	☐ Physical Therapy	☐ Occupational Therapy	☐ Speech Therapy	☐ Medical Social Services
☐ Home Health Aide Services	☐ PSA/Attendant Care	☐ Other (please list)		

SECTION IV – MANAGEMENT

Staffing - ***Complete all sections below.*** *(If there are changes in your staffing, attach a resume, current Indiana RN license, current limited criminal history check)*

Name of Administrator	Name of Alternate Administrator
Name of Nursing Supervisor	Name of Alternate Nursing Supervisor

SECTION V – BRANCHES

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 (*street address/city/ZIP code*)	Telephone Number

SECTON VI – OWNERSHIP INFORMATION

A. Applicant Entity (Owner / Operator) *Type or write in owner's name below.*

If a change of ownership occurred, you must request in writing a change of ownership application, complete and return to this Department.

Name of Applicant Entity-Licensee *(operator / owner of the facility)*	EIN number

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

Has the agency changed individuals with direct or indirect ownership? ☐ Yes ☐ No ***(If yes, complete below.)***

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. 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	Business Address *(street address/city/state/ZIP code)*	EIN Number

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

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ Partnership	☐ Individual	☐ County
☐ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☐ Corporation	☐ City / County
☐ Sole Proprietorship	☐ Limited Liability Company	☐ Hospital District
☐ Other *(specify)*_____	☐ Other *(specify)*_____	☐ Federal
		☐ Other *(specify)*_____

D. Directors / Officers / Partners / Managing Agents / Managing Employees *(Director owners)*

Has the agency 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. 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 / Partner / Director Name	Title	Business Address *(street address/city/state/ZIP code)*	Telephone Number

SECTON VII – CERTIFICATION OF APPLICATION

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

I swear or affirm that all statements made in this application, and any attachments thereto, are correct to the best of my knowledge and that I will comply with all laws, rules and regulations governing and licensing of home health agencies in Indiana.

Applicant's signature as indicated in Section II of this application, or signature of applicant's agent, should appear below.

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

Name of Authorized Representative *(typed / printed)*	Title
Signature of Authorized Representative	Date *(month, day, year)*

EMAIL APPLICATION TO HCBC@HEALTH.IN.GOV & A COPY OF PAYMENTRECEIPT.

NON-REFUNDABLE LICENSE FEE OF $250.00 PAYABLE ONLINE AT

Licensure Renewal: Health Public