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

State Form 53398 (R2 / 2-18)
INDIANA STATE DEPARTMENT OF HEALTH-DIVISION OF ACUTE CARE

Division of Acute Care Use Only

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. Complete all sections on the application. An incomplete or illegible application will be returned without being processed. This application and the certificate of registration, and/or approval which may be issued as a result are neither assignable nor transferable. Renewal of certificate of registration must be obtained annually.

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATON

Type of application is required to be checked.

☐ **Change of Ownership *(Anticipated date of Sale/Purchase/Lease)*** ________________________ ☐ **New Facility**
Include a copy of the facility's certificate of registration the applicant is purchasing.

SECTION II - IDENTIFYING INFORMATION

A. Out of State Mobile Health Care Entity Parent Location *(Type name of facility.)*

Submit applicable document from the Indiana Secretary of State (SOS) office. If the d/b/a name is different from the legal entity name (i.e corporation or limited liability company) submit a "certificate of assumed business" name document from the (SOS). The document will reflect the legal entity and the "doing business as" names.

Name of facility *(List the facility name in this section as it appears on the SOS document.)*			
Street address *(number and street)*			
City	State	ZIP Code +4	
Telephone number ( )	Fax number ( )	E-mail address	Web address

B. Facility's office hours *(i.e. 8:00 a.m. – 4:00 p.m.)*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

C. Mailing Address *(if different from the parent location)*

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

D. Ownership Information *(legal entity name)*

The legal entity name (i.e corporation, limited liability company or other entity type) must register with the Indiana Secretary of State (SOS) for doing business in Indiana. Submit applicable document (articles of incorporation, certificate of incorporation or certificate of organization, certificate of assumed business name, etc). Submit document from the Internal Revenue (IRS) that reflects the legal entity's name and EIN number.

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

E. Name of company(s) affiliated with Out of State Mobile Health Care Entity *(IC 16-41-42-5)*

Name	Address *(street address/city/ZIP Code)*	Telephone Number

F. Name of Officers/President/CEO affiliated with Out of State Mobile Health Care Entity

Last	First	Initial	Title

SECTION III - LICENSURE-REGISTRATION

A. States, foreign countries or provinces entity is registered or licensed in. Provide copy of each state/country/province registration or license with the application. *(IC 16-41-42-1)*

State of Certification, License or Registration	List Type *(certification, license or registration)*

SECTION IV – STAFFING

A. Employees currently in good standing licensed, certified, or registered in a health care profession in Indiana or any other state. Provide copy of employee's license, certification or registration with the application. (*IC16-41-42-5*) *If employees are providing services in Indiana, employees must be licensed in Indiana.*

Name of Employee	Services Provided	List Type *(certification, license or registration)*

B. Mobile Medical Unit Manager *(List the manager of the mobile medical unit.)*

Last Name	First Name	Initial

SECTION V – SERVICES AND EQUIPMENT

A. Health Care services to be provided under a contract *(IC 16-41-42-5)* **Provide copy of contract and license/certification/registration with application.** *The staff must be licensed/certified/registered in the state the test results are read.*

Name of Contract Entity or Individual	Services Provided	List Type *(certification, license or registration)*

B. Health care services, health care tests and equipment that the health care entity will perform or use. *(IC 16-41-42-5(4))*

Health Care Services Provided	Health Care Tests Performed	Equipment Used

C. Describe the manner in which test results and recommendations for health care based on the results are disclosed to the patient. *(IC 16-41-42-5)* **Provide copy of a sample report with the application.** *The staff must be licensed/certified/registered in the state the test results are read.*

Name of individual reading test results	Is the staff license in the state the test results are read? ☐ Yes ☐ No

Describe the manner in which test results and recommendations for health care based on the results are disclosed to the patient.

SECTON VI - TYPE OF OWNERSHIP

A. Type of Agreement ***(Applicable for change of ownership only – do not complete if initial application.)***

☐ Asset Purchase Agreement
☐ Merger
☐ Termination of Lease
☐ Assignment of Interest
☐ New Partnership
☐ Transfer of Asset Agreement
☐ Lease
☐ Sale
☐ 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.

B. Type of Entity

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
☐ Federal
☐ Other *(specify)* _________________

SECTION VII - 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 name as listed in section II.F. on this application.)*

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

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

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

SECTION VIII - REQUIRED DOCUMENTS TO BE SUBMITTED WITH REGISTRATION APPLICATION

Submit all documentation requested in this application.

- Section IV.A.
  - Submit a copy of each state, foreign country or province certification, license or registration that the legal entity is certified, license or register in.

- Section V.A.
  - Submit a copy of employee's certification, licenses and/or registration.

- Section VI.A.
  - Submit copy of contract and certification, license and/or registration.

- Section VI.C.
  - Submit copy of a sample reports.

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

Submit applicable document from the Internal Revenue Services.

- Submit a document from the Internal Revenue Service that reflects the legal entity's name and EIN number.

Return the application and required documentation to:

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