RENEWAL APPLICATION FOR LICENSE TO OPERATE A PERSONAL SERVICES AGENCY

State Form 53591 (R2 / 7-16)
Approved by State Board of Accounts, 2016
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-27-4)

Acute Care Division Use Only	Facility Number		Expiration Date *(month/day/year)*	
Date Received *(month/day/year)*		Date Approved *(month/day/year)*		

Read instructions prior to the completion of the renewal application.

COMPLETE *all sections on the application in printed or typed script. An incomplete or illegible application will be returned without processing. Submit the renewal application, required documentation and the $250.00 licensure fee, payable to the Indiana State Department of Health within fifteen (15) days prior to the expiration date of the current license. The required documentation and the non-refundable licensure fee must accompany the application and be approved by the department prior to the issuance of a license.* ***If the license application, required documentation and licensure fee is not received in our office and approved by the expiration date of your license, the agency may be subject to a civil penalty for non-compliance with IC 16-27-4-6.***

DO NOT SUBMIT *stock transfer changes, change in ownership, branch (additions/address changes) and legal-d/b/a name changes with the renewal application.* ***These changes will not be processed with the renewal application.*** *These changes require additional information that may not be available by the expiration date of your license. Submit changes as they occur to expedite the processing of your renewal licensure application and the issuance of license.*

Please Type or Print Legibly.

SECTION I - AGENCY NAME AND ADDRESS

Personal Services Agency Parent Practice Location

Name of agency *(List the name in this section as it appears on Indiana Secretary of State document, if dba name list the dba name.)*		
Street address *(number and street)*		
City	County	ZIP code +4
Telephone number (*agency specific*) ( )	Fax number ( )	License Number (*located on agency's license)*
E-Mail address *(agency specific)*		

Mailing Address *(Complete this section if the address is different from the practice location.) All correspondences will be sent to the mailing address.*

Street address *(number and street)*		
City	State	ZIP code +4

SECTION II- MANAGERS

If there are changes in staffing, submit a current (within the past three (3) months) lifetime expanded or lifetime national criminal history report. An expanded criminal history report shall contain the results of the search (i.e. no record found, clear; or if a record, the results of the record) and include the requirements of IC 20-26-2-1.5.

Name of Manager	
Name of Alternate Manager	Name of second Alternate Manager, *if applicable*

SECTION III – APPROVED BRANCHES

List the name, complete address, county, and telephone number of each previously approved branch. *Do not include branch additions or address changes in this section.* Branch additions and relocations require additional information for review and approval prior to being added to a license.

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

SECTON IV - OWNERSHIP INFORMATION

A. Licensee (Owning Entity): ***Type or print name of owning legal entity (i.e. a corporation name such as ABC Inc) and EIN Number.***

Name of Licensee *(List the name in this section as it appears on the Internal Revenue Service document.)*	EIN number

B. Ownership Information: Has the agency changed individuals with direct or indirect ownership? ☐ Yes ☐ No
If "YES" complete the information below. If "NO" do not complete this section. Changes of individuals with direct or indirect ownership must be on record with the Indiana State Department of Health.

List names and addresses of individuals or organizations having direct or indirect ownership 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. Officers: Has the agency changed officers - Directors/CEO/CFO/President/Vice President/Secretary/Treasurer? ☐ Yes ☐ No
If "YES" complete the information below to include all officers. If "NO" do not complete this section.

If the licensee (legal entity) is a corporation list the names, titles and addresses and telephone numbers of officers *(Directors/CEO/CFO/President/Vice President/Secretary/Treasurer).* If a partnership, list the partner's names, addresses and telephone numbers. If anything other than a corporation or partnership list the names, titles, addresses and telephone numbers. *(Use additional sheet if necessary.)* If a change in officers occurred, submit a current criminal history report for each new officer**.**

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

SECTON V - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the agency will not discriminate based upon race, color, creed or national origin.

The undersigned hereby makes renewal application for a license to operate a Personal Services Agency (agency) in the State of Indiana; and in support of this application, represents and demonstrates that the owners and operators are of reputable and responsible character. The owners and operators have read and understand the personal services agency State statute IC 16-27-4, will comply with the statute and will operate and maintain the agency in accordance with those requirements.

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 licensing of personal services agencies in Indiana.

Include typed/printed name and signature for one owner, CEO or president and for one manager below.

Owner/CEO/President ***(Type/print)***	
Owner/CEO/President ***(Signature)***	Date *(month/day/year)*
Personal Services Agency Manager (***Type/print*** *manager's name as listed in section II on this application.)*	
Personal Services Agency Manager (***Signature*** *of manager as listed in section II on this application.)*	Date *(month/day/year)*

RETURN APPLICATION AND A NON-REFUNDABLE $250.00 LICENSE FEE DIRECTLY TO THE CASHIER'S OFFICE AT THE ADDRESS BELOW:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER, 2ND FLOOR
P.O. BOX 7236
INDIANAPOLIS, INDIANA 46207