SUPPLEMENTARY INFORMATION TO FEDERAL APPLICATION
RURAL HEALTH CLINIC (RHC)

State Form 51054 (R/4-05)
INDIANA STATE DEPARTMENT OF HEALTH - DIVISION OF ACUTE CARE

Division of Acute Care Use Only

Date Received_____ **Date Approved**_____

THE APPLICTION MUST BE COMPLETED IN ITS ENTIRETY IN ORDER FOR ISDH TO PROCESS THE APPLICATION

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** ☐ **Other**

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-practice location)d/b/a of direct owner (entity)*

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 Agency		
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. Ownership Information *(direct owner (entity) of the rural health clinic (d/b/a)*

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.

Ownership *(Operator(s) of the facility-practice location) The owner-applicant entity as registered with the secretary of state*			
Street Address			P.O. Box
City	State		Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

D. Provider Based

Is this facility a provider based facility? ☐ Yes ☐ No *(Is yes, provide provider Medicare number)*

If yes, please submit the documentation requested on the enclosed **Provider Based Designation** letter.

SECTION III - UDERSERVED AREA

Is the clinic designated as in underserved area? ☐ Yes ☐ No

SECTION IV – STAFFING AND STAFFING RESPONSIBILITIES

A. Administrator (office manager)

Name *(enter full name)*

B. Physician/MD

A physician is present for sufficient periods of time, at least once in every 2 week period *(except in extraordinary circumstances*), to provide the medical direction, medical care services, consultation and supervision and is available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. **Refer SOM: 491.8 Staffing and Staff Responsibilities.**

Name *(enter full name)* ***Submit a current copy of the physician's Indiana license (billfold size)***	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

C. Physician Assistant/Nurse Practitioner/Certified Nurse Midwife

A nurse practitioner or a physician assistant must be available to furnish patient care services at least 60 percent of the time the clinic operates. **Refer SOM: 491.8 Staffing and Staff Responsibilities.**

A physician assistant or nurse practitioner in addition to the physician is required for clinic eligibility. *(select appropriate box)*

☐ Physician Assistant ☐ Nurse Practitioner ☐ Certified Nurse Midwife

Submit a current copy of the physician assistant, nurse practitioner and/or certified nurse midwife Indiana license (billfold size).

Name of Physician Assistant *(enter full name)*	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

Name of Nurse Practitioner *(enter full name)*	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

Name of Certified Nurse Midwife *(enter full name)*	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

SECTON V - OWNERSHIP OF APPLICANT ENTITY

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

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	Title	Business Address (street address/city/state/zip)

B. Type of Change in Ownership *(applicable for change of ownership only – 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 _____

C. Type of Entity *(Complete for initial and change of ownership applications)*

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 to do Business in the State of Indiana" signed 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 "Articles of Incorporation" signed by the Indiana Secretary of State that list the d/b/a name.

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.*

Applicant's signature or signature of authorized agent should appear below	
Signature of Authorized Representative	
Title	**Date**

NOTIFY THE INDIANA STATE DEPARTMENT OF HEALTH IN WRITING OF ANY CHANGES IN YOUR STAFF AND/OR SERVICES

SUBMIT CHANGES TO:

INDIANA STATE DEPARTMENT OF HEALTH
ACUTE CARE DIVISION
PHNSS-PROGRAM DIRECTOR
2 NORTH MERIDIAN STREET
SECTION 4A 07
INDIANAPOLIS IN 46204