2019 LICENSURE APPLICATION FOR HOME CARE, NURSING POOL, AND HOSPICE

A separate application is to be completed for each site from which home care (including home health), nursing pool, or hospice services are offered. Separate legal entities operated out of the same office must submit separate applications.

LEGAL IDENTITY OF APPLICANT: OWNER/CORPORATE IDENTITY

(Full legal name of corporation or partnership, individual, or other legal entity owning the enterprise or services.)

AGENCY NAME/DOING BUSINESS AS

(D/B/A) - Name(s) under which the facility or services are advertised or presented to the public:

Primary: ____________________________

AGENCY MAILING ADDRESS: If materials are to be mailed to another address list here:

P. O. Box___________________________

City ___________________________State_____________Zip_____________

AGENCY SITE ADDRESS:

Street_____________________________

City ______________State___________Zip__________County_____________

E-mail Address _______________________

Web Site __________________________

(If applicable) (If applicable)

Telephone (___) ____________Fax(___)

Administrator/Director: __________________________

Title: ____________________________

LICENSURE CATEGORIES APPLIED FOR: (CHECK ALL THAT APPLY)

1. ____Home Care Agency (G.S. 131E-138)
2. ____Nursing Pool (G.S. 131E-154.3)
3. ____Hospice Services (G.S. 131E-200)

(The information provided in this application will be used by the Department for the Certificate of Need and for planning processes.)

The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age, or disability in employment or the provision of services.)
SCOPE OF SERVICES:
In the columns below, check each service offered through this site.

YES  HOME CARE

____  Nursing Services
____  Infusion Nursing Services
____  **In-Home Aide Services** The division shall not issue any licenses for home care agencies that intend to offer In-Home Aide Services ending June 30, 2019
____  Medical Social Services
____  Physical Therapy
____  Occupational Therapy
____  Speech Therapy
____  Clinical Respiratory Services
  (including Pulmonary or Ventilation)
____  Home Medical Equipment (DME) Do you also have a medical equipment permit issued by the Board of Pharmacy?  Yes ___ No ___
  **Note:** Not required for Home Care Licensure or Nursing Pool

YES  NURSING POOL

____  Licensed Nursing Personnel, Nurse Aides or Allied Health Personnel

YES  HOSPICE

____  Hospice Home Services
  (Licensed hospice care services only)
____  Hospice In-patient Beds
  (List only if you operate licensed beds in your own facility)
  Number of Beds____
____  Hospice Residential Beds
  (List only if you operate licensed beds in your own facility)
  Number of Beds____
____  Do you have an agreement to operate Hospice licensed inpatient beds or hospice residential beds in another facility.  If so, list facility________________________________________
____  If you have contract for patients needing in-patient or residential accommodations, give the name of the contractor :________________________________________________________
___________________________________________________________________________

YES  COMPANION, SITTER AND RESPITE CARE

____  Companion./Sitter
____  Respite

ACCREDITATION INFORMATION

If home care licensure is being requested on the basis of deemed status as an accredited agency, attach a complete copy of accrediting organization’s inspection report (or findings) together with its decision, if surveyed within the last 12 months. Licensure based upon deemed status cannot be completed without full disclosure.
ACCREDITING ORGANIZATION EXP DATE

___ JCAHO (Joint Commission on Accreditation for Healthcare Organizations) __________
___ CHAP (Nat’l League for Nursing) __________
___ NCHC (Nat’l Home Caring Council) __________
___ ACHC (Accreditation Commission for Home Care, Inc.) __________
___ Other ____________________________________ __________

HOME CARE AGENCY APPLICANTS

1. If Medicare Certified Home Health, what is your provider number? ______

2. This agency is a Home Health Agency. Please check one.
   Parent_____ Branch _____ Sub-unit

HOSPICE APPLICANTS

1. If Medicare certified, what is your hospice provider number? ________________

2. Has this site been issued a Certificate Of Need to provide hospice services?
   Yes _____ No _____

NURSING POOL APPLICANTS ONLY

1. Nursing Pool applicants must attach a copy of the written administrative and personnel policies governing the provided services. (Initial applications only)

   All nursing pool applicants must attach a copy of the agency’s current general and professional liability insurance policy (binder acceptable). The document must show that the applicant is insured against loss, damage, and expense related to a death or injury claim resulting from negligence or malpractice in the provision of health care by the nursing pool and its employees.
OWNERSHIP DISCLOSURE (Please fill in any blanks and make changes where necessary).

Mark the term which describes the legal character of the operating ownership then proceed to the indicated block.

_______For-Profit
1. Proprietor (Proceed to Block I)
2. General Partnership (Proceed to Block II)
3. Limited Partnership (Proceed to Block II)
4. For Profit Corporation (Proceed to Block III)

______ Not-For-Profit
5. Not for Profit Corporation (Proceed to Block III)

6. Unit of Government (Proceed to Block IV)

BLOCK I. PROPRIETOR (unincorporated individual)

Proprietor’s Name______________________________________________

Proprietor’s Home Address and Telephone

Street __________________________________________________________

City/State/Zip __________________________________________________

Telephone (_____) _____________________________________________
**BLOCK II. PARTNERSHIP**

Partnership Name:______________________________________________________

Is it a general partnership? ____  Yes  ____  No  
Is it a limited partnership? ____  Yes  ____  No  
Is the partnership registered with the NC Secretary of State, Corporation Division? ____  Yes  ____  No  
If “Yes”, what is the exact wording of the partnership’s registered name?___________

_____________________________________________________________________

Where is the partnership registered?  State ______  County ______  
Address and Telephone Number of the Partnership:
Street/Box:____________________________________________________________
City/State/Zip__________________________________________________________
Telephone (____)_______________________________________________________

Give the name and address of the principal partners

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<tr>
<th>Name</th>
<th>Title</th>
<th>Percent Ownership</th>
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Attach additional sheets as needed

**BLOCK III. CORPORATION**

What is the exact wording of the Corporate Name on file with the Office of the NC Secretary of State? (Corporate Office)

___________________________________________________________________________________

In what state was the corporation originally established?____

Address and Telephone Number of the corporation:
Street/Box ________________________________________________________________
City/State/Zip ____________________________________________________________
Telephone (____)__________________________________________________________

List the names and addresses of ALL officers and/or any other persons with a controlling interest of 5% or more.

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Percent of Stock</th>
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(Attach additional sheets as needed)
BLOCK IV. UNIT OF GOVERNMENT

Name of the governmental unit which has the ownership responsibility and liability for the services offered:

____________________________________________________________________

Title of the official in charge of the governmental unit:

____________________________________________________________________

Check which best describes the type of governmental unit:

____ City _____ County _____ State _____ Authority

Health Dept._______
DSS _________
Other (Please Specify):_________.

MULTIPLE FACILITY AGENCY SYSTEMS

Yes ____ No _____ Is this agency part of a multiple facility/agency system in North Carolina? (A multiple facility/agency system is defined as two or more entities under the same management or ownership).

If you checked yes on the above question, list the name(s) of the other entities licensed in North Carolina by the Division of Health Service Regulation.

Name Location License #
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

(Attach additional sheets as needed)

Is your agency owned in whole or in part or operated by a hospital? Yes ____ No _____
If yes, please specify name of entity________________________________________

Is your agency managed by another entity? Yes _______ No _______
If yes, please specify name of entity________________________________________
I certify that this application and all attachments as submitted are accurate and true representations of the services offered as reported herein.

Signature
________________________________________________________

Typed Name ________________________________________________

Title ________________________________________________________

Date _______________________

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## SERVICE CATEGORIES FOR HOME CARE PROVIDERS

In the columns below, identify each service provided by county through this site. Also, identify by check mark whether the service is provided to your clients by contract with another agency, by in-house staff or both.

<table>
<thead>
<tr>
<th>County</th>
<th>Nursing</th>
<th>Infusion Nursing</th>
<th>In-Home Aide</th>
<th>Medical Social Services</th>
<th>PT</th>
<th>ST</th>
<th>OT</th>
<th>Clinical Respiratory</th>
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**IN-H** - In-House Staff  
**CTRT** - Service provided by contract  
* - Clinical Respiratory includes pulmonary and ventilation services

Please attach a list of all contractors and the service(s) provided by county under this arrangement. Do not list contracts you have with other agencies to provide services to their clients.
SERVICE CATEGORIES FOR HOSPICE HOME CARE, HOSPICE IN-PATIENT AND HOSPICE RESIDENTIAL PROGRAMS

In the columns below, identify each service provided by county through this site. Also, identify by check mark whether the service is provided to your clients by contract with another agency, by in-house staff or both.

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<tr>
<th>County</th>
<th>Nursing</th>
<th>Social Work</th>
<th>Add'l Counsel</th>
<th>Bereavement</th>
<th>Volunteers</th>
<th>Inpatient Care</th>
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<th>PT</th>
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<th>ST</th>
<th>Home Health Aide</th>
<th>Nutritional Assessment &amp; Dietary Counseling</th>
<th>Other Services</th>
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