APPLICATION FOR LICENSE
TO OPERATE A HOME HEALTH AGENCY

State Form 4008 (R5 / 5-02)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-27-1-7 and 410 IAC 17-10-1)
Form Approved By State Board Of Accounts-2002

Division of Acute Care Use Only

Date Received_____ **Date Approved**_____ **Date Rejected** _____

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 *(facility)*

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		County	Zip Code +4

C. Licensee/Ownership Information

Licensee *(Operator(s) of the facility-applicant entity)* The licensee and the 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. Branch Offices *(as defined in 410 IAC 17-9-5)*

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)	Telephone Number

E. Types of services to be provided

Home Health Aide | Medical Social Services | Nursing

Occupational Therapy | Physical Therapy | Speech Therapy

Other (List all) _____

SECTION III – STAFFING

A. Administrator *(as defined in 410 IAC 17-9-2)*

Name *(enter full name)*

1. Submit a copy of the administrator's resume listing complete employment history, including the dates of employment and reason for leaving.
2. List post secondary education and health related experience

_____

_____

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3. Has the administrator ever been convicted of any criminal offense relating to, or any way associated with, a dependent population?
   Yes No *(If yes, state on a separate sheet the facts of each case completely and concisely)*
4. Has the administrator's license (if applicable) ever lapsed, been suspended or revoked? Yes No
   (If yes, explain on a separate sheet of paper the place, date and agency initiating action, action taken and reason.

Submit a <u>current</u> copy of the administrator's resume with complete employment history, criminal history check and any applicable license if you are an administrator or health care professional *as defined in 410 IAC 17-9-15*, such as a nurse.

B. Alternate Administrator

Name *(enter full name)*

1. Submit a copy of the alternate administrator's resume listing complete employment history, including the dates of employment and reason for leaving.
2. List post secondary education and health related experience

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3. Has the alternate administrator ever been convicted of any criminal offense related to, or in any way associated with, a dependent population?
   Yes No *(If yes, state on a separate sheet the facts of each case completely and concisely)*
4. Has the alternate administrator's license (if applicable) ever lapsed, been suspended or revoked? Yes No
   (If yes, explain on a separate sheet of paper the place, date and agency initiating action, action taken and reason.

Submit a <u>current</u> copy of the alternate administrator's resume with complete employment history, criminal history check and any applicable license if you are an administrator or health care professional *as defined in 410 IAC 17-9-15*, such as a nurse.

C. Director of Nursing (Supervising Physician or Registered Nurse)

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*

Education *(Name of School of Nursing or School of Medicine)*

Degree	Year Graduated

List of post-secondary and home health care experience

_____

_____

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Has the Director of Nurse's (nursing supervisor) license ever lapsed, been suspended or revoked? Yes No
(If yes, explain on a separate sheet of paper the place, date and agency initiating action, action taken and reason.

Submit a <u>current</u> copy of the nursing supervisor's resume with complete employment history, criminal history check and a Physician or RN license.

D. Alternate Director of Nursing ((Supervising Physician or Registered Nurse)

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*

Education *(Name of School of Nursing or School of Medicine)*

Degree	Year Graduated

List of post-secondary and home health care experience

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Has the Alternate Director of Nurse's (alternate nursing supervisor) license lapsed, been suspended or revoked? Yes No
(If yes, explain on a separate sheet of paper the place, date and agency initiating action, action taken and reason.

Submit a <u>current</u> copy of the alternate nursing supervisor's resume with complete employment history, criminal history check and a Physician or RN license.

E. Provider Based

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

SECTON IV - OWNERSHIP AND CONTROLLING INTEREST

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

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

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)	EIN Number

C. Type of Ownership

Asset Purchase Agreement	Assignment of Interest	Lease
Merger	New Partnership	Sale
Termination of Lease	Transfer of Asset Agreement	Other _____

D. Type of Entity

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)* _____
_____	_____	_____
_____	_____	_____

*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 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.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

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

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 or Partner Name	Title	Business Address (street address/city/state/zip)	Telephone Number

B. Licensure/Operating History

1. Have the owners or managers of the agency operated any agency within Indiana or any other state which had a record of denial of licensure or of operation with less than a full license (i.e. probationary, provisional, denial of annual license renewal, etc)?

   Yes No *(If "Yes", provide name of each agency on a separate sheet and explain the facts completely and concisely)*

   a. If any applications have been denied or withdrawn, so state with a full explanation. *(use additional sheet if necessary)*

   b. If any license has been granted, state the date granted and expiration date. *(use additional sheet if necessary)*

2. Are there any individuals or organizations having director or indirect ownership or control interest in the agency of five percent (5%) or more who have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles 18, 19 or 20 (Medicare or Medicaid)?

   Yes No *(If "Yes", list each person or entity on a separate sheet and explain relationship)*

3. Are there any directors, officers, agents or managing employees of the agency who have ever been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles 17, 18, 19 or 20 (Medicare or Medicaid)?

   Yes No *(If "Yes", list each person on a separate sheet and explain the facts completely and concisely)*

SECTION VI – MANAGEMENT *(Managing Company)*

The name and address of the corporation, association, or other company this is responsible for the management of the home health agency, and the name and address of the chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency. ***(If not applicable please state not applicable)***

A. Name and address of corporation, association, or other company that is responsible for the management of the home health agency

Name of Corporation	Address of Corporation (city/state/zip)

B. Name, address and title of the chief executive officer and the chairman or equivalent position of the governing body of the managing company

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

SECTION VII - CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate a home health agency 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 the home health agency statutes, IC 16-27, and the rules promulgated thereunder, 410 IAC, 17 and will operate and maintain this agency in accordance with those rules.

I hereby certify that the operational policies of the home health agency 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 laws, rules and regulations governing the licensing of home health agencies in Indiana.

Applicant's signature or signature of the applicant's authorized agent should appear below.

If signed by any individual (e.g., the administrator) other than indicated in section V.A.1. Of this application, an affidavit must be submitted with the application, affirming that said persons has been given the power to bind the applicant/licensee.

Name of Authorized Representative *(Typed)*	Title

Signature of Authorized Representative	Date

RETURN APPLICATION AN ALL ATTACHMENTS WITH CHECK OR MONEY ORDER MADE PAYABLE TO:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER, 2ND FLOOR
2 NORTH MERDIAN STREET
INDIANAPOLIS, INDIANA 46204-3003

SECTION VIII – DOCUMENTATION THAT MUST BE SUBMITTED WITH THE LICENSE APPLICATION

1. The non-refundable license fee ($100.00)

2. Copies of the Administrator's and Alternate Administrator's current Indiana license, resume and criminal history check. Copies of the Director of Nurse's (Nursing Supervisor) and Alternate Director of Nurse's (Nursing Supervisor) current Indiana RN license, resume and criminal history check. Submit a **legible wallet size** copy of current Indiana license(s) that shows the expiration date.

3. If the applicant is an Indiana corporation or LLC, you must submit the following:

   a. Copy of the "Certificate of Incorporation" signed by the Secretary of State; or

   b. Copy of the "Certificate of Organization" signed by the Indiana Secretary of State.

4. If the applicant is an out-of –state corporation you must submit the following:

   a. Copy of the "Certificate of Authority" signed by the Indiana Secretary of State.

5. Completed limited criminal history form(s) from the Indiana Central Repository pursuant to IC 5-2-5. (If licensee is a corporation or LLC, then form to be completed by administrator.)