

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH SERVICE REGULATION  
LICENSURE /CERTIFICATION /ACUTE/HOME CARE SECTION  
SITE: 1205 UMSTEAD DRIVE  
RALEIGH, NORTH CAROLINA 27603  
MAILING: 2712 MAIL SERVICE CENTER  
RALEIGH, NORTH CAROLINA 27699-2712  
PHONE (919) 855-4620 FAX (919)715-3073

FOR OFFICIAL USE ONLY  
LICENSE NO. \_\_\_\_\_  
PC \_\_\_\_\_ DATE \_\_\_\_\_

INITIAL [ ]      CHOW [ ]      NAME CHANGE [ ]      [ ] OTHER \_\_\_\_\_

## 2021 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.)

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### 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 process.)

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
- \_\_\_\_\_        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

**LICENSE APPLICATION PROCESS: An applicant must be able to complete all necessary requirements within one year (12 months) from receipt of the initial application and fee date to obtain a license. After initial licensure, the agency must have the license renewed every year.**

**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

Name	Title	Percent Ownership
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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.

Name	Title	Percent of Stock
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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.

County	Nursing		Infusion Nursing		In-Home Aide / Companion Sitter Respite		Medical Social Services		PT		ST		OT		Clinical Respiratory *	
	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT

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.

County	Nursing		Social Work		Add'l Counsel		Bereavement		Volunteers		Inpatient Care	
	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR

County	PT		OT		ST		Home Health Aide		Nutritional Assessment & Dietary Counseling		Other Services	
	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR	IN-H	CTRTR

In-H In-House Staff  
 Ctrtr 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.