2022

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.)

AGENT 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) 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) ______
___ AHC (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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<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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<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.

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<tr>
<th>Name</th>
<th>Location</th>
<th>License #</th>
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(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 / Companion Sitter Respite</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.

<table>
<thead>
<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>
<th>OT</th>
<th>ST</th>
<th>Home Health Aide</th>
<th>Nutritional Assessment &amp; Dietary Counseling</th>
<th>Other Services</th>
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