 OIG-1:210, August 2022

**Application for Registration to Operate a Health Care Services Agency**

* If you have questions regarding this registration form, please call (502) 564–7963.
* Please answer all questions completely and accurately. Supporting documentation must be attached. An incomplete or illegible application will be returned without being processed.
* A non-refundable fee in the amount of $3,000 for initial registration or annual renewal must accompany this application. Approval will not be issued without receipt of this fee. *(A processing fee of $25 is required for a change of name. A processing fee of $100 is required for a change of location.)*
* All renewal registrations shall be filed sixty (60) days prior to the expiration date of the current registration.
* Please return the application, required documents, and a non-refundable registration fee payable to the Kentucky State Treasurer to:

Cabinet for Health and Family Services

Office of Inspector General

Division of Health Care

275 E. Main St., 5 E-A

Frankfort, KY 40621

The undersigned hereby registers to operate a Health Care Services Agency (HCSA) subject to the requirements of KRS 216.718 – 216.728, 216.785 – 216.793, and 906 KAR 1:210.

**A. Type of Application**

X Initial Certification X Annual Recertification

X Change of Name X Change of Location

**B. Identification**

Each separate location of a health care services agency shall have a separate registration pursuant to KRS 216.720(1).

1. Agency Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Agency Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (P.O. Box without a street address is not acceptable.)

3. Agency City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. After Hours Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Name of county in which the agency is located \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Name of county/counties in which the agency provides services \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Health Care Services Agency's Office Hours (e.g. 8:00 a.m.- 4:30 p.m.) |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |

**C. Ownership and Controlling Interest**

 **For Profit Non Profit**

X Individual X Church-related

X Partnership X Individual

X Corporation X Partnership

X Group X Corporation

X Limited Liability Company X Limited Liability Company

X Sole Proprietorship X Other Nonprofit Ownership \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List the name of the corporation, association, person, or partners legally responsible for the

 operation of this agency.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Federal ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Tax ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. If a corporation, list the date and place of incorporation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Attach a Certificate of Authority to do business in Kentucky if incorporated in another state.

4. If a corporation, attach copies of articles of incorporation and current by-laws.

5. President \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Agent(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Individual(s) authorized to transact business with the Cabinet for Health and Family Services and

upon whom all notices and orders shall be served. Include address if different from the above address. Please attach another sheet of paper if necessary.)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D. Management Agent (if different from owner)**

 Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E. Officers and Members of Governing Body**

Attach names and addresses of officers and members of the governing body, if applicable.

X Check if not applicable.

**F. Employee Licensing, Training and Continuing Education**

I verify, in accordance with KRS 216.722(1)(a), that all direct care staff meet the minimum licensing, certification, training, and continuing education standards for the position in which the staff person will be working.

Authorized Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**G. Renewal Applications Only**

Has your agency provided direct care staff in the past twelve (12) months to an assisted-living community, long-term care facility, or hospital?

X Yes X No

**H. Specific Information**

1. If the owner of the agency holds other licenses, please list all licenses below.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. When did the agency begin offering services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 MM/DD/YY

 3. Please check the type of direct care staff provided by your agency.

**Direct Care Staff** **Supplied to what type of facility (circle all that apply):**

X Registered Nurses Assisted-living community, long-term care facility, hospital

X Licensed Practical Nurses Assisted-living community, long-term care facility, hospital

X Nurse Aides Assisted-living community, long-term care facility, hospital

X Other, please specify Assisted-living community, long-term care facility, hospital

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X Other, please specify Assisted-living community, long-term care facility, hospital

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I. Verification**

I understand that I am required to report any change in the information provided within this application that affects my registration status to the Office of Inspector General and complete a new application at that time. I agree that this agency and all aspects of its operation shall be open at all times during regular business hours to allow state agency personnel entrance upon its premises for the purpose of inspection. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application shall result in the denial or revocation of registration.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Authorized Representative Title

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name (please print or type) Date

**J. Policies and Documentation**

Policies and documentation to be submitted with the initial registration application.

The following documents must be received before your application is considered complete:

* Policy and procedure that describes how the agency’s records will be immediately available to the Office of Inspector General upon request and that all records will be retained for five (5) calendar years.
* Certificate of Authority to do business in Kentucky if incorporated in another state.
* 1. Articles of Incorporation or Articles of Organization.

2. Current by-laws or operating agreement.

3. Names and addresses of officers and members of governing body, managers, members, officers, or

 directors.

4. A brief description of the organization structure of the agency, including a table of organization and

 relationship to any existing parent entity (if applicable).

* Evidence of professional and general liability insurance.
* Evidence of employee dishonesty bond in the amount of $10,000.
* Evidence of current workers’ compensation coverage for all direct care staff.

**HEALTH CARE SERVICES AGENCY CONTROLLING PERSON INFORMATION**

Legal Entity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Completed \_\_\_\_\_\_\_\_\_\_\_\_\_ Administrator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All Applicants:**

Please provide the names, titles, and addresses of all controlling persons and their percent of ownership.

KRS 216.718(3) defines a “controlling person” as:

* + A corporation, partnership, or other business entity, or an officer, program administrator or director thereof, whose responsibilities include the direction of the management or policies of a health care services agency; or
	+ An individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business entity that is a health care services agency.

Name of Controlling Persons Title Address Percent of Ownership if

 (Street, City, Zip) Proprietary (For Profit)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Attestation Statement Regarding the Registration and Operation of a**

**Health Care Services Agency**

*(Read this statement carefully before signing.)*

Based on my personal knowledge and belief, I attest that the responses on this statement regarding compliance with KRS 216.718 – 216.728, 216.785 – 216.793, and 906 KAR 1:210 related to the registration and operation of a Health Care Services Agency (HCSA) are true and correct.

(Type or print name of agency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a HCSA registered with the Kentucky Cabinet for Health and Family Services, declares that each temporary employee provided to an assisted-living community, long-term care facility, or hospital is an employee of the HCSA and is not an independent contractor.

(Type or print name of agency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a HCSA registered with the Kentucky Cabinet for Health and Family Services carries workers compensation insurance on its employees.

(Type or print name of agency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a HCSA registered with the Kentucky Cabinet for Health and Family Services has a bond of at least $10,000 to cover employee theft and dishonesty.

(Type or print name of agency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a HCSA registered with the Kentucky Cabinet for Health and Family Services retains all records for five (5) calendar years. All records of the HCSA must be immediately available to the Kentucky Cabinet for Health and Family Services.

(Type or print name of agency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a HCSA registered with the Kentucky Cabinet for Health and Family Services has separately registered each separate location of the business as required under KRS 216.720(1).

I understand that the Kentucky Cabinet for Health and Family Services may conduct an onsite visit at any time to examine records to validate that the statements made above are true and correct.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Typed or Printed)

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Authorized Representative)

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_