Application for License to Operate a Home Health Agency, Non-Residential Hospice, or Private Duty Nursing Agency

OIG 004 – January 2017 Edition

I. TYPE OF APPLICATION

(Write or type an X next to all that apply.)

____ Initial Licensure for Private Duty Nursing
____ Provisional Licensure for Home Health Agency or Hospice, nonresidential
____ Annual Re-licensure
____ Change in Number of beds
____ Change of Name
____ Change of Location
____ Change of Ownership

II. TYPE OF FACILITY OR SERVICE/CLINIC (Check the facility for which you are applying.)

☐ Private Duty Nursing Agency (PDNA)

☐ Home Health Agency (HHA)

☐ Hospice (HOS) (nonresidential)

III. IDENTIFICATION

License Number ______________________________
(Do not fill in License Number if this is an initial or provisional application for licensure)

Name of Facility ______________________________

Physical Location of Facility ______________________________
(Street) (City)
____
(County) (State) (Zip Code)

Mailing Address ______________________________
(If different from above) (Street) (City)
____
(County) (State) (Zip Code)

Telephone Number ______________________________

Email Address ______________________________
(Primary contact for correspondence)

Administrator Name ______________________________

Date facility began operating at current address ______________________________

Date facility began operating under current owner ______________________________

For home health agencies or non-residential hospice, please follow instructions below.

Provisional or initial license application: Under Section A, for additional locations/satellites other than the primary location listed on the previous page, please check the box under “Additional Location or Satellite Requested” for the appropriate level of care. For each location, please complete Section B.
Re-licensure application: Under Section A, report the number of existing locations/satellites under “Number of Locations or Satellites, Not Including Primary Location”. If adding a location, check the appropriate box under “Additional Location or Satellite Requested”, and complete Section B. Provide an attachment to this application as requested under Section C, if needed.
Addition of Location/Satellite application: Under Section A, report the number of existing locations/satellites under the “Number of Locations or Satellites, Not Including Primary Location”, then check the box marked “Additional Location or Satellite Requested”. Under Section B, complete the location information for each additional location/satellite.

A.

	NUMBER OF LOCATIONS OR SATELLITES, NOT INCLUDING PRIMARY LOCATION	**ADDITIONAL LOCATION OR SATELLITE REQUESTED**
Home Health Agency (HHA)	_______	_______
Nonresidential Hospice (HOS)	_______	_______

B. Additional Location Information: (If adding more than one location/satellite, attach to this application the same information as required below for each location.)

Name of Facility ____

Physical Location of Facility ____
(Street) (City)

____
(County) (State) (Zip Code)

Telephone number ____
(Include Area Code)

Administrator ____

If this is an additional Community Mental Health Center location, detail what services will be provided at the new location: ____

____

C. **<u>For licensure renewals and addition of location/satellites only</u>: Provide a detailed list of each existing location/satellite, not including the primary location, as an attachment to this application. The listing should include the same information requested in part B.**

IV. COUNTIES SERVED (Check all counties that your facility serves)

☐ **Statewide (do not check individual counties when checking Statewide)**

☐ Adair	☐ Allen	☐ Anderson	☐ Ballard	☐ Barren	☐ Bath
☐ Bell	☐ Boone	☐ Bourbon	☐ Boyd	☐ Boyle	☐ Bracken
☐ Breathitt	☐ Breckenridge	☐ Bullitt	☐ Butler	☐ Caldwell	☐ Calloway
☐ Campbell	☐ Carlisle	☐ Carroll	☐ Carter	☐ Casey	☐ Christian
☐ Clark	☐ Clay	☐ Clinton	☐ Crittenden	☐ Cumberland	☐ Daviess
☐ Edmondson	☐ Elliott	☐ Estill	☐ Fayette	☐ Fleming	☐ Floyd
☐ Franklin	☐ Fulton	☐ Gallatin	☐ Garrard	☐ Grant	☐ Graves
☐ Grayson	☐ Green	☐ Greenup	☐ Hancock	☐ Hardin	☐ Harlan
☐ Harrison	☐ Hart	☐ Henderson	☐ Henry	☐ Hickman	☐ Hopkins
☐ Jackson	☐ Jefferson	☐ Jessamine	☐ Johnson	☐ Kenton	☐ Knott
☐ Knox	☐ Larue	☐ Laurel	☐ Lawrence	☐ Lee	☐ Leslie
☐ Letcher	☐ Lewis	☐ Lincoln	☐ Livingston	☐ Logan	☐ Lyon
☐ Madison	☐ Magoffin	☐ Marion	☐ Marshall	☐ Martin	☐ Mason
☐ McCracken	☐ McCreary	☐ McLean	☐ Meade	☐ Menifee	☐ Mercer
☐ Metcalfe	☐ Monroe	☐ Montgomery	☐ Morgan	☐ Muhlenberg	☐ Nelson
☐ Nicholas	☐ Ohio	☐ Oldham	☐ Owen	☐ Owsley	☐ Pendleton
☐ Perry	☐ Pike	☐ Powell	☐ Pulaski	☐ Robertson	☐ Rockcastle
☐ Rowan	☐ Russell	☐ Scott	☐ Shelby	☐ Simpson	☐ Spencer
☐ Taylor	☐ Todd	☐ Trigg	☐ Trimble	☐ Union	☐ Warren
☐ Washington	☐ Wayne	☐ Webster	☐ Whitley	☐ Wolfe	☐ Woodford

V. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

VI. OWNERSHIP Name and address of direct owner:

NOTE: Provide the following supporting documentation as an attachment to this application:

- The of name, mailing address, email address and phone number each person or legal entity having an ownership interest in the facility;
- If owned by a corporation, the name, mailing address, email address and phone number of each officer or director of the corporation;
- If owned by a partnership, the name, mailing address, email address and phone number of each partner.

An incomplete application or failure to submit the applicable licensure fee may result in return of the application to the applicant. A completed application should not be submitted to the Office of Inspector General until the facility is ready for an inspection.

I understand that as a condition precedent to provisional licensure, this facility shall be in compliance with all state and federal statutes administrative regulations applicable to the license requested.

I understand that **any change** in the information provided in within this application affecting the licensure status of this facility or service will be reported to the Office of Inspector General and **a new application** will be completed at that time. I agree that this facility/service and all aspects of its operation shall allow all state agency licensure 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 may result in denial or revocation of licensure.

___________________________________ _____________________ ___________________

Signature of Authorized Representative Title Date

Submit the application, fee and supportive documentation to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

For Office Use Only: Check # _____________ Amount _____________