

MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
APPLICATION FOR RENEWAL OF LICENSURE OF A HOME HEALTH CARE SERVICE

FOR PERIOD: _____ TO _____

1. NAME OF AGENCY: _____

DOING BUSINESS AS: _____

LOCATED AT: _____

Street or Road

City or Town Zip Code

_____ County

_____ Telephone Number

E-Mail Address: _____

2. DIRECTIONS FOR REACHING AGENCY (If there are any changes in address(es), please attach specific directions; draw map if possible).

3. MAILING ADDRESS, IF DIFFERENT:

_____ Street or Road

_____ City or Town

_____ Zip Code

_____ County

4. OWNERSHIP: (Name & Address of Owner(s)--Individual, Partners, Corporation Name).

IDENTIFICATION NUMBER: _____

(Owner's Social Security No. or IRS Identification No.)

INSTRUCTIONS

A. If sole proprietor, list name of owner (see A below).

B. For business entities with business partnerships, the full name and address of each partner (see B on page 2).

C. If proprietary corporation, the name, address, and titles of each person, firm or corporation, having (directly or indirectly) and ownership interest of 5% or more in the agency (see C on page 2).

D. For not-for-profit organizations, the name and address of the President of the Board of Directors or appropriate municipal government representative (see D on page 2).

E. What is your fiscal year end date? _____

TYPE OF ENTITY

A. SOLE PROPRIETORSHIP

B. PARTNERSHIP

C. CORPORATION

D. NOT-FOR-PROFIT E. OTHER (specify) _____

A. IF SOLE PROPRIETORSHIP, List Name of Owner _____

B. IF PARTNERSHIP, list names and addresses of partners or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5% or more in the disclosing entity. Indirect ownership interest is ownership interest in an entity that has an ownership in any entity higher in a pyramid than the disclosing entity.

Name	Address
_____	_____
_____	_____
_____	_____

C. IF THE DISCLOSING ENTITY IS A CORPORATION, list names, addresses, and titles of the Officers and Directors.

A. Officer's Names	Title	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Directors	Title	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. IF THE DISCLOSING ENTITY IS NOT-FOR-PROFIT ORGANIZATION, list name and address of President of the Board of Directors or the appropriate Municipal Government Representative.

Name	Address
_____	_____
_____	_____

5. IF THE BUILDING(S) USED BY A HOME HEALTH CARE PROVIDER IS/ARE LEASED, a copy of each lease shall be attached to this application. Not needed if at same site(s) and met previous year.

6. **NAME AND TITLE OF PERSON IN CHARGE** _____

Home Address _____ Home Telephone No. _____ Office Telephone No. _____

7. **THE HOME HEALTH CARE AGENCY** is or is not Medicare certified.
Has been open since _____

Date _____

8. **IS THIS HOME HEALTH CARE AGENCY** **JCAHO ACCREDITED**
(Date) _____

CHAPS ACCREDITED (Date) _____

9. **LOCATION OF ALL FACILITIES (SUB-UNITS) UTILIZED BY THE HOME HEALTH CARE PROVIDER:**

Address _____ Telephone No. _____ Name of Owner of Bldg. _____

(1) _____

(2) _____

(3) _____

(4) _____

10. **PLEASE ATTACH A LETTER FROM APPROPRIATE MUNICIPAL OFFICIAL(S) THAT DEMONSTRATES COMPLIANCE WITH ALL LOCAL ORDINANCES RELATIVE TO ZONING AND BUILDING CODE REGULATIONS.** (Only needed if there has been a change of address).

11. **PLEASE CHECK EACH TYPE OF HOME HEALTH CARE SERVICE PROVIDED AND LIST DATE SERVICE STARTED.**

	<u>Check Here</u>	<u>Date</u>
1. SKILLED NURSING	<input type="checkbox"/>	_____
2. SPEECH PATHOLOGY	<input type="checkbox"/>	_____
3. PHYSICAL THERAPY	<input type="checkbox"/>	_____
4. OCCUPATIONAL THERAPY	<input type="checkbox"/>	_____
5. MEDICAL SOCIAL WORK	<input type="checkbox"/>	_____
6. HOME HEALTH AIDE	<input type="checkbox"/>	_____
7. CERTIFIED NURSING ASST.	<input type="checkbox"/>	_____
8. OTHER SERVICES PROVIDED	_____	_____

12. **TOTAL NUMBER OF FULL-TIME STAFF EMPLOYED BY THE AGENCY** (Do not

include companions, homemakers/PCA's) _____.

13. **FEES.** (Enclose a check with the application).

A basic fee of \$300.00 for all re-licensure applicants.

(Make checks payable to the **Treasurer, State of Maine**, and mail to:

**Division of Licensing and Regulatory Services
Medical Facilities Unit
41 Anthony Avenue Dr., #11 SHS
Augusta, Maine 04333-0011**

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

The Department of Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure. License is granted subject to survey findings.

I, _____, BEING DULY AUTHORIZED TO ASSUME RESPONSIBILITY FOR THE CONDUCT OF THE AGENCY HEREIN DESCRIBED, DO HEREBY APPLY FOR A LICENSE TO OPERATE THE AGENCY AND DO AGREE TO ASSUME RESPONSIBILITY THAT THE AGENCY WILL COMPLY WITH ALL THE CURRENT REGULATIONS OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES, AS AUTHORIZED BY TITLE 22, M.R.S.A. 2141-2148, AND M.R.S.A. 42.

Date

Signature of Provider (Administrator)

If space provided to completely respond to application is inadequate, please attach necessary information.

FOR OFFICE USE ONLY
FEE _____
APPROVED _____
CHECK # _____