



**APPLICATION FOR HOME CARE AGENCY OR  
HOME CARE REGISTRY LICENSE**

Please check the one that applies:

- Home Care Agency
- Home Care Registry
- Home Care Agency & Home Care Registry

**IDENTIFYING INFORMATION**

Name of Entity: \_\_\_\_\_

D/B/A: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City Zip Code

Site Address: \_\_\_\_\_  
Street City Zip Code

County: \_\_\_\_\_

Telephone (Including area code): ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail address: \_\_\_\_\_

**PAYMENT**

A CHECK OR MONEY ORDER PAYABLE TO “COMMONWEALTH OF PENNSYLVANIA” FOR THE AMOUNT OF THE FEE MUST ACCOMPANY THIS APPLICATION. CURRENCY IS NOT ACCEPTABLE. THE REGULAR FEE PER LICENSE IS \$100.00.

Mail check or money order, along with the completed application to the Pennsylvania Department of Health, Division of Home Health, 132 Kline Plaza, Suite A, Harrisburg, PA 17104.

**COMPLETION OF FORMS / SUBMISSION OF DOCUMENTATION**

Applicants must complete and submit, prior to licensure: Initial Application Form with payment, Disclosure of Ownership and Control Interest Statement, Civil Rights Survey, Information requested of Health Care Providers applying for a license, and Initial Home Care Agency / Registry Licensure Survey.

**AGREEMENT**

Application is made to operate a Home Care Agency/Home Care Registry in accordance with Chapter 8 of the Health Care Facilities Act (35 P.S. §448.101 et. seq.). Application includes Initial Application Form with payment, Disclosure of Ownership and Control Interest Statement, Civil Rights Survey, Information requested of Health Care Providers applying for a license, and Initial Home Care Agency / Registry Licensure Survey.

I agree that all of the identifying information on this form and information furnished on the aforementioned attached documents and all other materials submitted is complete and true. I understand that incomplete or inaccurate information IS REASON FOR DENYING THE ISSUANCE OF A LICENSE. I further agree to conduct said facility in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Department of Health.

**AFFIRMATION**

The undersigned hereby affirms that the foregoing information is true and correct to the best of said persons knowledge, information and belief; said affirmation being made subject to the penalties prescribed by 18 Pa. C.S.A. §4904 (unsworn falsifications to authorities).

_____ Authorized Representative's Signature*	_____ Date
_____ Print Name of Authorized Representative	_____ Title

Return the **completed** and **signed** application to the PA Department of Health, Division of Home Health, 132 Kline Plaza, Suite A, Harrisburg, PA 17104.

*\*Authorized Representative - the individual within the Applicant organization with the legal authority to give assurances, make commitments, enter into contracts, and execute documents on behalf of the Applicant, including this Application. The signature of the Authorized Representative certifies that commitments made on this Application will be honored and ensures that the Applicant agrees to conform to applicable law and regulations.*