APPLICATION FOR HOSPICE LICENSURE
IDENTIFYING INFORMATION

Name of Entity _____

D/B/A _____

Street Address _____

City, County, State _____ Zip Code _____

Telephone ( ) _____ Fax ( ) _____ Medicare Provider Number _____

Number of Direct Inpatient Care Beds: _____ Location of Beds: _____

E-Mail Address (if available) _____

Administrator _____ Effective Date _____

Social Security No. _____

PAYMENT

THE FEE FOR A REGULAR LICENSE IS $250.00.
A CHECK OR MONEY ORDER PAYABLE TO THE "COMMONWEALTH OF PENNSYLVANIA" FOR THE AMOUNT OF THE FEE MUST ACCOMPANY THIS APPLICATION. CURRENCY IS NOT ACCEPTABLE.

COMPLETION OF FORMS

Prior to the issuance of a license, applicants must complete and return the following: Application for Hospice Licensure, Department of Health Disclosure of Ownership and Control Interest Statement, Civil Rights Survey; and Written Survey Form (if applicable).

AGREEMENT

Application is made to operate a Hospice facility in accordance with Chapter 8 of the Health Care Facilities Act (35 P.S. ∋448.101 et. seq.), as amended by Act 95 of 1998. This application includes Facility Identifying Information (Application), Department of Health Facility Disclosure of Ownership and Control Statement, Civil Rights Survey, and Written Survey Form (if applicable).

I agree that all of the identifying facility information on this form, information furnished on the aforementioned attached documents and all other material submitted is complete and true. I further agree to operate said facility in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Pennsylvania Department of Health.

AFFIRMATION

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

_____
Name of Authorized Representative (Printed) Title

_____
Signature Date

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