State of Alaska
Department of Health
Home Health Agency
State Licensure Application

DUE DATE: 90 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE (AS 47.32.060)

Pursuant to the AS 47.32 Licensing Statute and the regulations of the Department of Health Health Facilities Licensing requirements (7 AAC 10 and 7 AAC 12).

This application can be used for initial licensure applications and biennial license renewals. Please check the appropriate box below to indicate the purpose of this application.

Type of License Applying for (select one)**:** ◯ Initial Provisional Licensing ◯ Biennial Renewal License

General Instructions:

1. Application should be complete, clear and legible. After this application is completed, it should be printed, signed in permanent ink and submitted to the State of Alaska, Health Facilities Licensing & Certification team. Contact info is located below.

2. If more space is needed, additional pages can be attached as necessary. This also applies to any information that does not fit within the given space and should indicate "see attached page #" or something similar.

3. This application must be executed and verified by the individual owner or by two officers in the case of a corporation, association or governmental unit or agency.

4. There are licensure fees associated with this application. Please see 7 AAC 12.615 for more information regarding the fees due for your facility. If there are any questions about these fees, please contact 907-334-2483.

5. A separate application is required for facility branches operated on separate premises if that facility operates under a separate license number. Separate applications are required for each individual facility that is licensed separately, even though ownership is the same.

1. FACILITY DEMOGRAPHIC

State Licensing Number: _____

Legal Name: _____

Doing Business as: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Primary Fax Number: _____ Secondary Fax Number: _____

Generic Email (*info@abcfacility.com*): _____

Other Locations Under Same Licensure:

Other locations under same licensure include facilities that are located in services area as the parent facility and shares administration, supervisors, and/or services with the parent facility on a daily basis.

Please provide the name and location of any secondary locations under the same established licensure:

Name:_____ Location: _____

Name:_____ Location: _____

Name:_____ Location: _____

2. ADMINISTRATION

Please provide the information below for all positions as they apply to your facility type.

a. Administrator (*required*):

Name: _____ Title:_____

Direct Phone: _____ Fax: _____

Email: _____

Does the administrator/manager have responsibilities for more than one Alaska agency? Yes*: ◯ No: ◯

*If yes, list additional agencies names & license number:

Agency Name: _____ License Number: _____

Agency Name: _____ License Number: _____

b. Medical Director / Director of Clinical Services (*if applicable*):

Name: _____ Title:_____

Direct Phone: _____ Fax: _____

Email: _____

Does the Director of Clinical Services have responsibilities for more than one Alaska agency? Yes*: ◯ No: ◯

*If yes, list additional agencies names & license number:

Agency Name: _____ License Number: _____

Agency Name: _____ License Number: _____

c. Supervising Nurse / Director of Nursing (*if applicable*):

Name: _____ Title:_____

Direct Phone: _____ Fax: _____

Email: _____

3. ACCREDITATION (if applicable)

Is the facility be fully approved by and accreditation organization? Yes*: ◯ No: ◯

If ***yes***, please provide the following information:

Accrediting Organization: _____

Date of last Accrediting Body Survey: _____Type of Survey: _____

Date Accreditation Expires: _____Frequency of Accreditation Cycle: _____

**Facilities with accreditation through a nationally recognized organization may be eligible to waive their biannual State licensing survey for the current/upcoming licensing period. To apply, and for more information, please see the State Licensing Survey Waiver Application attached at the end of this application.*

4. OWNERSHIP & CONTROL

Governmental: ◯ State ◯ Borough ◯ City/Community

Non for Profit: ◯ Church Operated or Affiliated ◯ Corporation

Proprietary: ◯ Individual ◯ Partnership ◯ Corporation

Other (please explain): _____

a. Individual or Partnership Owned (list all persons who own the facility)

Name: _____ Address: _____

Name: _____ Address: _____

Name: _____ Address: _____

Name: _____ Address: _____

b. Names under which person(s) in (a.) do business (other than the facility indicated on this application)

Name: _____ Business: _____

Name: _____ Business: _____

Name: _____ Business: _____

Name: _____ Business: _____

c. Corporate Ownership

Name of Corporation: _____

State where Parent Firm or Organization is Incorporated or Registered: _____

List title, name, and address of each corporate officer: _____

Title:_____ Name:_____ Address:_____

Title:_____ Name:_____ Address:_____

Title:_____ Name:_____ Address:_____

Title:_____ Name:_____ Address:_____

d. List names and addresses of each shareholder holding more than 5% of shares OR ownership

Name:_____ State of Residence: _____ Percent of Shares: _____

Name:_____ State of Residence: _____ Percent of Shares: _____

Name:_____ State of Residence: _____ Percent of Shares: _____

Name:_____ State of Residence: _____ Percent of Shares: _____

Name:_____ State of Residence: _____ Percent of Shares: _____

e. If the property or building this facility is operating in is on a lease or rental agreement, please specify ownership.

f. Trust or Endowment Operated

Trustee Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

g. Additional Facility Operations

If the legal entity designated as the operator/licensee operates any other facility of this type, list the name and address of each facility, and attach letters from each state (other than Alaska) verifying licensure and compliance are required.

Facility Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

h. Have any of the individuals listed on under this section been convicted of a felony or two or more misdemeanors involving moral turpitude in the last 5 years?

If *yes*, attach a list of names and explanations as **Exhibit I:** Yes: ◯ No: ◯

5. CRIMINAL BACKGROUND CHECKS

Does the facility have a system in place for performing criminal background checks in accordance with **AS 47.05** and **7 AAC 10.900 - 990** through the Alaska Background Check Program (BCP)? Yes: ◯ No: ◯

6. INSURANCE

Does this facility have current Malpractice Insurance? Yes: ◯ No: ◯

Company: _____

Address: _____

Expiration Date: _____

7. BRANCH OFFICES

Branch office is located in the same service area as the parent agency and shares administration, supervision, and service with the parent agency on a daily basis; a branch office **is not required to be separately licensed**.

Provide the name and location of any subunits or branch offices of the hospice agency:

Name	Location	Medicare Provider Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. AUTHORITY & SUPERVISION

If the hospice has established lines of authority or supervision, provide an organization chart that provides the line of authority or supervision.

If yes, attach chart and explanation as **Exhibit II**.

9. AGENCY CONTRACTS

Please note: SKILLED NURSING may not be contracted unless it is to cover vacations of regular staff or for specialized skills not routinely offered. SKILLED NURSING must be directly provided by the agency plus ONE OTHER RECOGNIZED SERVICE in order to qualify as a home health agency pursuant to Alaska law. If you contract SKILLED NURSING, please provide rationale. Add separate sheets if necessary

Name of Organization: ______________________________

Address of Organization: ______________________________

☐ Skilled Nursing ☐ Speech Therapy ☐ Medical Social Worker

☐ Physical Therapy ☐ Occupational Therapy ☐ Home Health Aide

Name of Organization: ______________________________

Address of Organization: ______________________________

☐ Skilled Nursing ☐ Speech Therapy ☐ Medical Social Worker

☐ Physical Therapy ☐ Occupational Therapy ☐ Home Health Aide

Name of Organization: ______________________________

Address of Organization: ______________________________

☐ Skilled Nursing ☐ Speech Therapy ☐ Medical Social Worker

☐ Physical Therapy ☐ Occupational Therapy ☐ Home Health Aide

Name of Organization: ______________________________

Address of Organization: ______________________________

☐ Skilled Nursing ☐ Speech Therapy ☐ Medical Social Worker

☐ Physical Therapy ☐ Occupational Therapy ☐ Home Health Aide

10. PERSONNEL/STAFFING

Provide full time equivalents (FTEs), part time equivalents (PTEs) & paid volunteers (PVs) for the following staffing areas. *If you indicate vacancies, please provide a yes or no response to the "actively recruiting" and "qualified person acting" column.

	FTE	PTE	PV	Vacancies*	Actively Recruiting	Qualified Person Acting
Administration	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Medical Director	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Physician on PAC	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
R.N.	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
L.P.N.	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Nurse Practitioner	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Physician Assistant	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Home Health Aide	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Personal Care Attendant	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Dietitian	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Occupational Therapist	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Physical Therapist	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Speech Pathologist	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Audiologist	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Medical Social Worker	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Health Care Professionals	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
Non-Health Care Professional	_____	_____	_____	_____	◯ Yes ◯ No	◯ Yes ◯ No
TOTAL	_____	_____	_____	_____		

11. GEOGRAPHICAL AREA SERVED

Please describe the geographical area served by the agency. Provide specific areas or regions. The Department will not accept descriptions such as "Southeast Alaska" or "South Central Alaska":

12. CLIENT CENSUS INFORMATION (if this is an initial application, skip this section)

Provide number of clients (unduplicated admissions) served during the last full calendar year (from January 1 through December 31): _____

Number of clients served in all age categories below for the last full calendar year (as indicated above):

	Under 5	5-17	18-44	45-64	65-74	Over 75	Total
Males	_____	_____	_____	_____	_____	_____	_____
Females	_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____	_____

During the time period indicated above, provide the following information:

Admitted _____ Discharged _____ Clients Terminated _____

Deceased _____ Respite Days _____ Acute Care Days _____

Highest Client Count _____ Lowest Client Count _____ Average Client Count _____

13. TYPE OF HOME HEALTH AFFLIATION

☐ Hospital ☐ Skilled Nursing Facility ☐ Hospice Agency ☐ Free Standing Home Health Agency

☐ Other: _____

14. SOURCE OF INCOME

Provide the information as requested below for source(s) of income:

Source(s)	**Percentage**	**Income**
Medicare Part A	_____	_____
Medicare Part B	_____	_____
Medicaid	_____	_____
Third Party Payers (Health Insurance, VA, Workers Comp, ect.)	_____	_____
Fees from Patients	_____	_____
Other (Grants, Contributions, Bequests, Fund Raising, ect)	_____	_____
TOTAL	**100%**	_____

15. SERVICES (attach additional sheet if more space is needed)

Service Category	Services Provided		Name of Outside Contractor
Physician Services	○ Direct	○ Contract	_____
Nursing Services	○ Direct	○ Contract	_____
Social Services	○ Direct	○ Contract	_____
Pastoral Counseling	○ Direct	○ Contract	_____
Bereavement Counseling	○ Direct	○ Contract	_____
Dietary Counseling	○ Direct	○ Contract	_____
Short-Term Inpatient (respite)	○ Direct	○ Contract	_____
Shor-Term Inpatient (acute)	○ Direct	○ Contract	_____
Home Aide Service	○ Direct	○ Contract	_____
PCA Services	○ Direct	○ Contract	_____
Physical Therapy	○ Direct	○ Contract	_____
Occupational Therapy	○ Direct	○ Contract	_____
Speech/Language Pathology	○ Direct	○ Contract	_____
Medical Supplies	○ Direct	○ Contract	_____
Drugs & Biologicals	○ Direct	○ Contract	_____
Medical Equipment	○ Direct	○ Contract	_____
Personal Care	○ Direct	○ Contract	_____
IV Infusion	○ Direct	○ Contract	_____
Other	○ Direct	○ Contract	_____
Other	○ Direct	○ Contract	_____
Other	○ Direct	○ Contract	_____

Short-Term inpatient care can only be provided in a licensed hospital or skilled nursing facility.

Contracts must be available for review by the Department staff at the time of licensure survey.

16. SCOPE OF SERVICE

7 AAC 12.500. Scope. A public or private entity that is primarily engaged in the provision of skilled nursing care and therapeutic services, but not the treatment of mental illness, in a patient's home is a home health agency, and must comply with **7 AAC 12.500 – 7 AAC 12.590**.

7 AAC 12.505. Home health agency services.

(a) A home health agency must provide skilled nursing services and at least one of the following additional services:

(1) physical therapy;
(2) occupational therapy;
(3) speech therapy; or
(4) home health aide services.

(b) A home health agency may provide additional services designed to maintain, improve, or restore a physical or mental condition. Additional services must be provided in accordance with generally accepted professional standards and identified in a plan of care established under **7 AAC 12.513**. Additional services may include

(1) nursing care under the supervision of a registered nurse;
(2) physical, occupational, speech, or respiratory therapy;
(3) medical social services;
(4) nutrition counseling;
(5) home health aide services;
(6) personal care services; and
(7) medical supplies, other than drugs and biologicals, and the use of medical appliances.

DOES THE HOME HEALTH AGENCY MEET ALL THE ABOVE SCOPE OF SERVICE REQUIREMENTS?

◯ Yes ◯ No*

**If not, please provided an explanation:*

State of Alaska

Department of Health

Home Health Agency
State Licensure Application

This form must be completed to finalize the transaction.

Licensing renewal fee amounts can be reviewed under **7 AAC 12.615**. For more information or for assistance calculating the fees for your facility, please contact HFLC at 907-334-2483 or by email at dhcs.hflc@alaska.gov

We accept payments by **check** and **credit card**.

To make a credit card payment by phone: **Call 907-334-2400, opt. 3**. You will be asked to provide the full facility name, state licensing number, and exact payment amount.

State Licensing Number: _____

Facility Type: Select One _____ **Payment Type:** Select One _____

Facility Name: _____

Facility Contact: _____ **Phone:** _____

Payment Amount (includes licensing and bed / branch fees if applicable): $ _____

Date of Credit Card Payment (indicated the date you made a payment by phone): _____

Payment by Check: **Check #**: _____ **Check Date**: _____

Make Checks Payable to: State of Alaska – HFLC

HFLC Mailing/Physical Address:
State of Alaska
Health Facilities Licensing & Certification
4601 Business Park Blvd. Bldg. K
Anchorage, AK 99503

For State of Alaska Accounting Use ONLY

DEPT: 06 **FUND**: 1004 **UNIT**: 4011 **APPR**: 062330704 **REVENUE**: 5101

Activity: ◯ 4HF0 - License/Renewal Fee ◯ 4HF1 - Revisit ◯ 4HF2 - Modification ◯ 4HF3 - Fine

Payment Received on: _____ Check # / CC Auth#: _____

Payment Received & Coded by: _____

Notes/Comments: _____

17. ATTESTATION

The applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that the contents of this application and the information provided with it are true, accurate, and complete.

In addition, the applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that he or she has reviewed the regulatory requirements contained in **7 AAC 10.900 – 990** (Barrier Crimes, Criminal History Checks, and Centralized Registry), **7 AAC 10.9500 - 9535** (General Variance), **7 AAC 10.9600 - 9620** (Inspections and Investigations), the applicable requirements for facility type and the applicable requirements of **7 AAC 12.600 - 990** (General Provisions).

The undersigned give assurance that the facility is in compliance to the best of his/her knowledge, and he/she is prepared for an on-site inspection to validate compliance.

_____ _____

Administrator or Designee Name **Date**

_____

Signature of Administrator or Designee

Submit this application and all required attachments via mail, hand delivered, faxed or email:

Health Facilities Licensing & Certification
4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503

Phone: (907) 334-2483 **Fax**: (907) 334-2682

Email: dhcs.hflc@alaska.gov

State of Alaska
Department of Health
Home Health Agency
State Licensure Application

State Licensure Survey Waiver Application

Facilities with accreditation through a nationally recognized organization may be eligible to waive their biannual State licensing survey for the current/upcoming licensing period. To learn more about the survey waiver an eligibility, please refer to **7 ACC 12.925** and **AS 47.32.030(a)(9)(A-C).** To apply, please provide the following information.

Facility Type: Select One _____ AK License Number: _____

Facility Name: _____

Satellite Locations: Yes*: ◯ No: ◯ (*if yes, inspection reports for those sites are also required)

Physical Address: _____

Mailing Address: _____

Primary Phone: _____ Primary Fax: _____

Email for facility distribution list: _____

Administrator: _____ Administrator's Phone: _____

Administrator's E-Mail: _____

Secondary Contact: _____ Title: _____

Secondary's Phone: _____ Secondary's E-Mail: _____

Name of Accrediting Organization (AO): _____

Date of last inspection: _____ Frequency of accreditation cycles: _____

Were any deficiencies identified during last inspection? Yes: ◯* No: ◯

*If yes, have the deficiencies been corrected? Yes: ◯ No: ◯

For surveys conducted in the past 2-3 months, in which the facility has not received the report or have an approved plan of correction – when do you expect to receive these documents? _____

Name of Person Completing Form: _____ Date: _____

*****A copy of your <u>last inspection report</u> and <u>plan of correction MUST be submitted with the application or the waiver will be denied</u>*****

FOR DIVISION USE ONLY

Date Application Received: _____ All attachments included: Yes: ☐ No: ☐

Application Reviewed by: _____ Date Reviewed: _____

Application is: Approved: ☐ Denied*: ☐

Reason for Denial: _____

Signature: _____ Date: _____