APPLICATION FOR LICENSE TO OPERATE A HOME HEALTH AGENCY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 8022 (R09-21)

DEPARTMENT USE ONLY

License Number

Telephone 701.328.2352

INSTRUCTIONS: Type or print clearly. Return one completed, notarized copy to: ND Department of Health, Division of Health Facilities, 1720 Burlington Dr, Suite A, Bismarck, ND 58504-7736. Keep a copy for your records.

Official Name of Home Health Agency			NPI Number	
Street Address	City		State	ZIP Code
Mailing Address	City		State	ZIP Code
County	Business Telephone Number		Fax Number	
E-Mail Contact Name	E-Mail Address			

TYPE OF APPLICATION

☐ Initial ☐ Renewal ☐ Change of Facility Ownership ☐ Change in Service Area ☐ Name Change
☐ Location Change ☐ Change in Services ☐ Change in Facility Operator ☐ Other Change:

MANAGEMENT AND PERSONNEL

TYPE OF CONTROL (Check One)				
GOVERNMENTAL	☐ State	☐ County	☐ County & City	☐ Municipal
NONPROFIT	☐ Association	☐ Corporation	☐ Religious Affiliation	
PROPRIETARY	☐ Individual	☐ Partnership	☐ Corporation	

Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)			
Mailing Address	City	State	ZIP Code

Has ownership of this home health agency changed in the last twelve months? ☐ No ☐ Yes	Has the legal entity responsible for operation of this home health agency changed in the last twelve months? ☐ No ☐ Yes	Do any owners have a 5% or more financial interest in the home health agency? ☐ No ☐ Yes
NAME OF OWNERS	ADDRESS	OFFICIAL POSITION

Name of Chairman of Governing Body			
Mailing Address	City	State	ZIP Code
Name of Administrator			
Nurse Executive/Director of Nursing		Nurse License Number	
Name and Title of Emergency Contact		Emergency Contact's Cell Phone Number	

Area Served (County)
Branch Office Locations (see definition below)
Services Provided at Each Location

DEFINITIONS

Home Health Agency	A public or private agency, organization, facility, or subdivision which is engaged in providing home health services to individuals and families where they are presently residing for the purpose of preventing disease and promoting, maintaining, or restoring health or minimizing the effects of illness or disability. Must be providing two professional services. ie. Nursing & physical therapy or nurse aide services or speech therapy or social services.
Branch Office:	(For Title18 & Title 19 Certification Purposes) A location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home heath agency

SIGNATURES AND AFFIDAVIT

NOTE: The person signing the application cannot be less than 18 years of age. The administrator of the home health agency shall not sign the application unless he/she is also a board member. The application must be signed by official {s} of the entity responsible for the operation of the home health agency. (If sole proprietorship, the owner shall sign the application; if a corporation, two of its officers shall sign; if a state, county, or municipal unit the application is to be signed by the head of the department having jurisdiction over the home health agency.)

The undersigned hereby makes application for a license to operate a home health agency subject to the provisions of North Dakota Century Code Chapter 23-17.3 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and all attachments and that to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

Signature	Date
Signature	Date

State	County

Signed and sworn to (or affirmed) before me on	Date

Name(s) of Individual(s) Making Statement	Affix Notary Stamp
Signature of Notary Public or Other Authorized Officer	
Commission Expiration Date (if not listed on stamp)	