APPLICATION FOR LICENSE TO OPERATE A HOSPICE PROGRAM

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 8932 (R09-21)

DEPARTMENT USE ONLY

License Number

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 Hospice Program		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:

Check Category: ☐ Home Hospice

☐ Inpatient Hospice: Number of Beds _____ Location, Physical Address: _____

OWNER-OPERATOR- MANAGEMENT

HOSPICE OPERATOR (Check One)

☐ Hospital ☐ Nursing Facility ☐ Home Health Agency ☐ Freestanding Hospice

TYPE OF CONTROL (Check One)

GOVERNMENTAL	☐ State	☐ County	☐ County & City	☐ Municipal
NONPROFIT	☐ Association	☐ Corporation	☐ Religious Affiliation	
PROPRIETARY	☐ Individual	☐ Partnership	☐ Corporation	

Name of Hospice Program Owner			
Mailing Address	City	State	ZIP Code
Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)			
Mailing Address	City	State	ZIP Code
Name of Chairman of Governing Body			
Mailing Address	City	State	ZIP Code
Has ownership of this hospice changed in the last twelve months? ☐ No ☐ Yes	Has the legal entity responsible for operation of this hospice changed in the last twelve months: ☐ No ☐ Yes		

INSURANCE INFORMATION

Name of Hospice's General Liability Insurance Company			
Name of Agent			
Mailing Address of Agent	City	State	ZIP Code

HOSPICE PROGRAM PERSONNEL

Name of Administrator	Cell Phone Number
Is the administrator affiliated with a hospital, nursing facility, home health agency, or some other provider? ☐ No ☐ Yes – What facility	
Medical Director (Physician)	License Number
Nurse Supervisor (RN)	License Number
Name and Title of Emergency Contact	Emergency Contact's Cell Phone Number

List Hospice Services Provided Directly by the Hospice Program Below		
NAME OF PERSONS/ENTITIES PROVIDING DIRECT HOSPICE SERVICES (Do not list volunteers)		QUALIFICATIONS
Office Location (s) Other Than Primary Site: If yes, please list and include physical address of each		
Hospice Services Provided Indirectly Through A Contractual Agreement Yes _____ No _____		
NAME OF PERSONS / ENTITIES PROVIDING INDIRECT HOSPICE SERVICES		QUALIFICATIONS
Describe the Use of Volunteers in Providing Hospice Services		
Geographic Service Area – List the counties covered by each office location below		

Approximate Average Monthly Patient Census per office location		ATTACH A FINANCIAL STATEMENT FOR THE CURRENT FISCAL YEAR

SIGNATURES AND AFFIDAVIT

NOTE: The person signing the application cannot be less than 18 years of age. The administrator of the hospice program 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 hospice program. (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 hospice agency.)

The undersigned hereby makes application for a license to operate a hospice program subject to the provisions of North Dakota Century Code Chapter 23-17.4 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)	