



APPLICATION FOR LICENSE TO OPERATE A HOSPICE PROGRAM

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 8932 (R10-20)

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, 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

<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change of Facility Ownership	<input type="checkbox"/> Change in Service Area	<input type="checkbox"/> Name Change
<input type="checkbox"/> Location Change	<input type="checkbox"/> Change in Services	<input type="checkbox"/> Change in Facility Operator	<input type="checkbox"/> Other Change:	

Check Category:	<input type="checkbox"/> Home Hospice
<input type="checkbox"/> Inpatient Hospice: Number of Beds _____	Location, Physical Address: _____

OWNER-OPERATOR- MANAGEMENT

HOSPICE OPERATOR (Check One)				
<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Home Health Agency	<input type="checkbox"/> Freestanding Hospice	
TYPE OF CONTROL (Check One)				
GOVERNMENTAL	<input type="checkbox"/> State	<input type="checkbox"/> County	<input type="checkbox"/> County & City	<input type="checkbox"/> Municipal
NONPROFIT	<input type="checkbox"/> Association	<input type="checkbox"/> Corporation	<input type="checkbox"/> Religious Affiliation	
PROPRIETARY	<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	Has the legal entity responsible for operation of this hospice changed in the last twelve months: <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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

<p>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.)</p> <p>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.</p>			
Signature		Date	
Signature		Date	

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