



## APPLICATION FOR LICENSE TO OPERATE HOSPICE

Pursuant to the Hospice Program Licensing Act (210 ILCS 60/1) et seq. formerly known as ch. 111 1/2, pars. 6101 et seq.) and the rules and regulations of the Illinois Department of Public Health entitled "Hospice Programs" (77 Ill. Adm. Code 280)

Renewal     Change of Ownership

License # \_\_\_\_\_ Medicare # \_\_\_\_\_

Initial

License Expiration Date \_\_\_\_\_

Agency Name and Mailing Address

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Facility physical location (if different from above)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Hours \_\_\_\_\_ am to \_\_\_\_\_ pm

Agency Phone \_\_\_\_\_

Days of the Week

Agency Fax \_\_\_\_\_

E-mail Address \_\_\_\_\_

County \_\_\_\_\_

Name of Contact Person \_\_\_\_\_

Contact Phone \_\_\_\_\_

Type of Hospice

Comprehensive     Volunteer

**Volunteer, check services provided:**

Nursing                       Pastoral Counsel

Social Services               Dietary Counsel

Bereavement Counsel

**Multiple Hospice Locations.** A location or site from which the hospice program provides non-residential nursing, social, pastoral/counseling, bereavement or dietary services within a portion of the total geographic service area served by the hospice program. It is part of the hospice and located close enough to share administration, supervision and services in a manner that makes it unnecessary to require an independent license. *Inpatient care is provided in a hospital, skilled nursing facility or a hospice residence.*

Does your hospice maintain multiple hospice locations?     Yes     No

If yes, list address and phone number. Attach an additional sheet if more space is needed

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_



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### Type of Hospice Affiliation:

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

### Type of Control:

- Voluntary Non-Profit Non-Church
- Voluntary Non-Profit Church
- Government Agency
- Proprietary
- Other (Specify)
- Other \_\_\_\_\_

If type of control is "Proprietary" (corporation, sole proprietor, partnership or association), complete this section and complete and submit Attachment A(Statement of Ownership). If licensee/applicant is a corporation or limited partnership, list name and address of Illinois registered agent.

Name of Organization \_\_\_\_\_

President \_\_\_\_\_ Secretary \_\_\_\_\_

### Illinois registered agent or person(s) legally authorized to receive service of process for entity:

Registered Agent Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

### LICENSEE IS RESPONSIBLE FOR ADVISING IDPH OF ANY CHANGES IN THIS INFORMATION

**IMPORTANT NOTICE:** This agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 83--457. Disclosure of this information is mandatory.



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## Professional Staffing List

Include license or registration number when applicable and check if employee is full-time or part-time. Volunteers functioning in professional capacity must be included in this list. Include those employed by direct individual contract and identify by an asterisk (\*). Indicate the Social Security number for home health aides in the column headed "License/Registration Number." Attached additional sheets if more spaced is needed.

Name	Title	License/Regis. #	Full-Time	Part-Time (# of hours)	P-Paid V-Volunteer
_____	Administrator	_____	_____	_____	_____
_____	Medical Director	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Administrator's other affiliations with a licensed home health agency, hospital or nursing home

Facility Name \_\_\_\_\_

Address \_\_\_\_\_



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**Volunteers** (providing care or services not requiring licensure and not listed on Professional Staffing List)

Number of Volunteers \_\_\_\_\_ Total combined volunteer hours of care and services provided per week  
 (approximate hours) \_\_\_\_\_

Source of Income for Fiscal Year Ending \_\_\_\_\_ month/day/year \_\_\_\_\_ Estimated if new hospice

Source of Income	Percentage	Income
Medicare		
Part A		
Part B		
Medicaid		
Other Third Party Payors (Health Insurance, Champus, VA Worker's Comp, etc.)		
Fees from Patients		
Other (Grants, Contributions, Bequests, Fund Raising, etc.)		
<b>TOTAL</b>	100%	\$ _____

**List counties or portions of counties hospice is approved to serve (geographic service area).** If approved for a portion of a county, identify with an asterisk (\*) before county name.

\_\_\_\_\_

\_\_\_\_\_

Hospice census report for fiscal year ending (month, day, year) ONLY FOR RENEWAL APPLICATION \_\_\_\_\_

New Admissions during year \_\_\_\_\_ Average patient count during year \_\_\_\_\_

Patients Terminated \_\_\_\_\_ If hospice provides inpatient services, indicate

Deceased \_\_\_\_\_ Discharged \_\_\_\_\_ Total number of acute care days \_\_\_\_\_

Highest patient count during year \_\_\_\_\_

Lowest patient count during year \_\_\_\_\_ Total number of respite days \_\_\_\_\_



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Service Categories	Services Provided		Name of Outside Contractee
Physician Services*	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Nursing Services*	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Social Services*	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Pastoral Counseling*	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Bereavement Serv & Counseling*	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Dietary Counseling*	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Short-Term Inpatient (Respite)*	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Short-Term Inpatient (Acute)*	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Home Health Aide	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Homemaker	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Physical Therapy	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Occupational Therapy	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Speech/Language Pathology	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Medical Supplies	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Drugs & Biologicals	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____
Medical Equipment	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	_____

\* Services required to qualify as Full Hospice

**Contract - Hospice services provided indirectly through a contractual agreement.**

**Attach additional sheets if more space is needed**

**Service Categories** - Contracts must be available for review by Department staff at the time of the licensure survey. Short-term inpatient care can only be provided in a hospital licensed under the Hospital Licensing Act or a skilled nursing facility licensed under the Nursing Home Care Reform Act of 1979.



## APPLICATION FOR LICENSE TO OPERATE HOSPICE

The following are included as part of this application:

- Annual Hospice Service Plan (Initial & Renewal)
- Financial Audit for Current Fiscal Year (Renewal)
- Hospice Current Annual Budget (Initial & Renewal)
- License Fee

The license fee is as follows and must be submitted with the application:

**Comprehensive Hospice - Initial & Renewal fee of \$500    Volunteer Hospice - Initial & Renewal fee of \$250**

***I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge, and that I will comply with all rules and regulations governing the licensing of hospices in Illinois***

\_\_\_\_\_  
Authorized Signature of Applicant

\_\_\_\_\_  
Title

\_\_\_\_\_  
Name of Administrator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Individual Verifying Authorized Signature (if corporation or association, the second signature must be another corporate officer).

\_\_\_\_\_  
Title

\_\_\_\_\_  
Name of Second Signature

\_\_\_\_\_  
Date





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### APPLICATION ADDENDUM

This addendum must be completed as part of the following program/facility applications:

Ambulatory Surgical Treatment Center

Home Health Agency

Hospice Program

Hospital

Section 10-65(c) of the Illinois Administrative Procedure Act, 5 ILCS 100/10-65(c), was amended by P.A. 87-823, and requires individual licensees to certify whether they are delinquent in payment of child support.

APPLICANT IS AN INDIVIDUAL (SOLE PROPRIETOR)  Yes  No

**The following questions must be answered only if the applicant is an individual (sole proprietor):**

I hereby certify, under penalty of perjury, that I  am  am not more than 30 days delinquent in complying child support order.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FAILURE TO SO CERTIFY MAY RESULT IN A DENIAL OF THE LICENSE; MAKING A FALSE STATEMENT MAY SUBJECT THE LICENSEE TO CONTEMPT OF COURT (5 ILCS 100/10-65(c))**

The completed application, appropriate attachments, and required license fee, made payable to Illinois Department of Public Health (check or money order - no cash), should be sent to:

Illinois Department of Public Health  
Division of Financial Services  
Attention: Validation Unit  
535 W. Jefferson Street  
Springfield, IL 62761-0001

**The license fee is non-refundable. Filing an application is not a guarantee that a license will be issued.**

If you have questions regarding this application, please write or call:

Illinois Department of Public Health  
Division of Health Care Facilities & Programs  
525 W. Jefferson Street-4th Floor  
Springfield, IL 62761-0001  
Telephone 217-782-7412  
Fax 217-782-0382  
TTY number (for hearing impaired) 800-547-0466