State of Illinois
Illinois Department of Public Health

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

◯ IInitial

License # _____ Medicare # _____

License Expiration Date _____

Agency Name and Mailing Address

Name _____

Address _____

City _____ Statee _____ Zip Code _____

Facility physical location (if different from above)

Address _____

City _____ Statee _____ Zip Code _____

Business Hours _____ am to _____ pm

Days of the Week

Agency Phone _____

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				

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.)		
TOTAL	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 _____

Patients Terminated _____

Deceased _____ Discharged _____

Highest patient count during year _____

Lowest patient count during year _____

Average patient count during year _____

If hospice provides inpatient services, indicate

Total number of acute care days _____

Total number of respite days _____

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Service Categories	Services Provided		Name of Outside Contractee
Physician Services*	☐ Direct	☐ Contract	_____
Nursing Services*	☐ Direct	☐ Contract	_____
Social Services*	☐ Direct	☐ Contract	_____
Pastoral Counseling*	☐ Direct	☐ Contract	_____
Bereavement Serv & Counseling*	☐ Direct	☐ Contract	_____
Dietary Counseling*	☐ Direct	☐ Contract	_____
Short-Term Inpatient (Respite)*	☐ Direct	☐ Contract	_____
Short-Term Inpatient (Acute)*	☐ Direct	☐ Contract	_____
Home Health Aide	☐ Direct	☐ Contract	_____
Homemaker	☐ 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	_____

*** 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.

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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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ATTACHMENT A

☐ Non-Applicable

STATEMENT OF OWNERSHIP

Name of Hospice _____

List name, telephone number, and occupation of every person who has entered into contract to manage,operate or who owns or controls, directly or indirectly, any of the shares of stock of, or any other financial interest in, the hospice:

Name/Address	Telephone Number	Occupation	% of Interest

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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 pentaly 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
Divison 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