

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION

1 DAVIS SQUARE

SUITE 101

CHARLESTON, WEST VIRGINIA 25301

APPLICATION FOR HOSPICE CARE PROGRAM LICENSE

Instructions

Please complete the application in full. Use a typewriter or print legibly.

Application for a hospice care program license may be made by an individual owner or administrative officer on behalf of a corporation or by its managing agents on whom rests responsibility for maintaining approved standards for the program.

The application shall be verified before an officer of the State authorized to administer oaths, by the individual, or by a member of the firm or association or an officer of the corporation making this application.

A non-refundable license fee of one hundred dollars (\$100.00) must be submitted with Initial and Change of Ownership applications. A license fee of one hundred dollars (\$100.00) for programs with an average yearly caseload of ten or more patients or a license fee of fifty dollars (\$50.00) for programs with an average yearly caseload of less than ten patients must be submitted with license renewal applications. This same license fee also applies to any branch office. Check or money order should be made payable to the West Virginia Department of Health and Human Resources. Cash cannot be accepted.

Type of Application: () Initial () Change of Ownership () Renewal

The undersigned hereby makes an application for a license to operate a hospice care program.

I. NAME AND LOCATION

Name of Program _____

Address _____

Telephone Number _____

Name of Lessor (if applicable) _____

Is There Any Direct or Indirect Financial Interest or Applicant with Lessor:

() Yes () No

If Yes, Explain: _____

II. MANAGEMENT AND PERSONNEL OF PROGRAM

Program Operated By (Check One):

- A. Public: () County () County and City () Municipal
- B. Private: () Individual () Partnership () Corporation
- () Association () Church () Other

(If by any other than individual or partnership, state whether profit or non-profit).

C. Give Exact Name of Individual, Partnership, or Organization Conducting Program:

D. Give Name of Governing Body (Board of Directors, Trustees, Etc.):

E. List Name, Address, Principal Occupation, and Official Position of Members of Governing Board:

	<u>Name and Address</u>	<u>Occupation</u>	<u>Position</u>
1.	_____	_____	_____

2.	_____	_____	_____

3.	_____	_____	_____

4.	_____	_____	_____

5.	_____	_____	_____

6.	_____	_____	_____

E. Continued:

	<u>Name and Address</u>	<u>Occupation</u>	<u>Position</u>
7.	_____		

8.	_____		

9.	_____		

10.	_____		

F. Name and Title of Program Director:

G. Name of Medical Director:

III. APPLICANT

_____, 20____

A. SIGNATURE OF Individual Applicant _____

Title or Position _____

B. If other than Individual or Administrative Officer:

	<u>Name</u>	<u>Address</u>
1.	_____	_____
2.	_____	_____

STATE OF WEST VIRGINIA

County of _____)

_____, being by me duly sworn on his/her oath, deposes and says that he/she has read the foregoing application and knows the contents thereof; that the statements concerning the above hospice care program, therein contained, are correct and true of his/her own knowledge.

(Signature of Individual Applicant)

Subscribed and sworn to before me this _____ day

of _____, 20_____.

(Notary Public)

My commission expires _____, 20_____