



**State of Alaska**  
 Department of Health & Social Services  
**Home Health Agency**  
 Initial or Renewal Licensure Application



**DUE DATE: 90 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE (AS 47.32.060)**

<b>Department Use Only</b>
License Number _____

Pursuant to the [AS 47.32 Licensing Statute](#) and the regulations of the Department of Health & Social Services Home Health Agency Licensing requirements ([7 AAC 10](#) and [7 AAC 12](#))

BEFORE ATTEMPTING TO COMPLETE THE APPLICATION, PLEASE REVIEW THE HOME HEALTH LICENSING RULES AND REGULATIONS. The rules and regulations can be downloaded from links noted in section IX on the last page of this application.

Note: Retain a copy of the application for future reference.

IF YOU DO NOT TYPE THE APPLICATION USING ADOBE AND CHOOSE TO COMPLETE THE APPLICATION IN WRITING, **BE SURE TO MAKE NOTE OF DROP-DOWN BOXES** TO PROPERLY COMPLETE THIS APPLICATION.

THE DEPARTMENT IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER [AS 47.32.040](#)

**I. TYPE OF LICENSE APPLYING FOR** License #  Medicare #

Choose One  License Expiration Date

**II. NAME AND LOCATION OF HOME HEALTH AGENCY**

Exact Legal Name:

Mailing Address:

City  State  Zip Code

Premises Located (If different from above):

City  State  Zip Code

Main Phone Number for Public Use:

Administration Phone Number for HFL&C Use:

Administration Fax Number for HFL&C Use:

E-Mail Address for HFL&C Use:

Business Hours  am to  pm

Days of the Week  If Other, Explain

Fiscal Period (i.e. MONTH/DAY)  to (MONTH/DAY)



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**III. OWNERSHIP AND ADMINISTRATION**

A. Type of Control (check one)

GOVERNMENTAL  **(Add appropriate response from drop down box)**

NON-PROFIT

PROPRIETARY

Other (Explain)

B. If Individual or Partnership owned (list all persons who own the Home Health Agency)

Name	Address
<input type="text"/>	<input type="text"/>

C. Names under which persons in B. do business (other than this Home Health Agency)

Name	Business
<input type="text"/>	<input type="text"/>

D. Corporate Ownership

(1) Name of Corporation

(2) State where Parent Firm or Organization is Incorporated or Registered



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(3) List title, name and address of each corporate officer

Title	Name	Address

E. List names and address of each shareholder holding more than 5 percent of shares

Name of Stockholder	Address	Percent of Shares

F. For other than individual ownership, list the name and address of the Alaska agent or the person(s) legally authorized to receive service of process for the facility.

Name of Agent	Address

G. List the names and addresses of all persons under contract to manage or operate the Home Health Agency.

(Check here if not applicable)




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H. Have any of the following been convicted of a felony or of two or more misdemeanors involving moral turpitude in the last five years? **(If yes, attach explanation as Exhibit I.)**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Applicant                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Any member of a firm or partnership      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Any officer or director of a corporation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Administrator or manager of the Hospice  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

I. If the Home Health Agency has established lines of authority or supervision, please provide an organization chart that provides that information. **(If yes, attach explanation as Exhibit II.)**

**IV. GOVERNING BODY**

Identify the officers of the governing body of your agency. The governing body has legal authority and responsibility for the conduct of the agency.

Office	Name	Address	State	ZIP Code
President	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Vice President	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Secretary	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Treasurer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**V. ADMINISTRATION**

A. Administrator

Name

Address

Telephone Number

License or Certification Number (if applicable)

Does the **administrator/agency manager** have responsibility for more than one Alaska agency? If yes, list additional license numbers & agency names.

Agency Name  License Number

Agency Name  License Number



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**B. Director of Clinical Services**

Name

Address

Telephone Number  License Number

Does the **Director of Clinical Services** have responsibility for more than one Alaska agency? If yes, list additional license numbers & agency names.

Agency Name  License Number

Agency Name  License Number

**C. Medical Social Worker (if applicable)**

Name

Address

Telephone Number  License Number

**D. Dietary Therapist (if applicable)**

Name

Address

Telephone Number  License Number

Registered by

**VI. BRANCH OFFICES**

**Note:** (1) a **branch office** is located in the same service area as the parent agency and shares administration, supervision, and services with the parent agency on a daily basis, a branch office **is not required to be separately licensed**.

Please provide the name and location of any branch offices of the Hospice.

Name	Location	<input type="checkbox"/>	<input type="checkbox"/>	Medicare Provider #
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	# <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	# <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	# <input type="text"/>



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**VII. CLIENT CENSUS INFORMATION** *(If this is an Initial Application, skip this section)*

A. Enter the total number of clients (unduplicated admissions) served during January 1st through December 31st of the past calendar year.

B. Indicate by age (years old) categories below, number of clients served in all categories during time period indicated in A.

	Under 5	5-17	18-44	45-64	65-74	Over 75	TOTAL
MALES	<input style="width: 80px; height: 25px;" type="text"/>						
FEMALE	<input style="width: 80px; height: 25px;" type="text"/>						
TOTAL	<input style="width: 80px; height: 25px;" type="text"/>						

C. During the time period indicated in A please indicate the total number:

Admitted during the year	<input style="width: 100%; height: 25px;" type="text"/>	Discharged	<input style="width: 100%; height: 25px;" type="text"/>
Patients Terminated	<input style="width: 100%; height: 25px;" type="text"/>	Deceased	<input style="width: 100%; height: 25px;" type="text"/>
Respite days	<input style="width: 100%; height: 25px;" type="text"/>	Acute care days	<input style="width: 100%; height: 25px;" type="text"/>
Highest patient count	<input style="width: 100%; height: 25px;" type="text"/>	Lowest patient count	<input style="width: 100%; height: 25px;" type="text"/>
Average patient count	<input style="width: 100%; height: 25px;" type="text"/>		

**VIII. TYPE OF HOME HEALTH AFFILIATION**

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

**IX. AGENCY CONTRACTS**

(Add separate sheets if necessary)

Please note: SKILLED NURSING may not be contracted unless it is to cover vacations of regular staff or for specialized skills not routinely offered. SKILLED NURSING must be directly provided by the agency plus ONE OTHER RECOGNIZED SERVICE in order to qualify as a home health agency pursuant to Alaska law. If you contract SKILLED NURSING, please provide rationale.

Legal Name and Address of Organization



Drop-down List



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Legal Name and Address of Organization

  
  


Drop-down List

**X. GEOGRAPHICAL SERVICE AREA** (Please describe the geographical service area of the agency)



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**XI. STAFFING LIST**

Indicate the Full Time Equivalents for each of the following as of the completion date of this application:

**\*If you indicate a vacancy in any of these, please indicate:**

**A. Actively recruiting ( ) yes ( ) no**

**B. Do you have a qualified person acting in the capacity of each vacancy ( ) yes ( ) no**

Title	Full Time	Part Time	Paid Volunteer	Vacancies*	Actively Recruiting		Qualified Person Acting	
					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Administrator	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Director	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician on Professional Advisory Committee	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Director of Clinical Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Registered Nurse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
LPN	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nurse Practitioner or Physician Assistant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Home Health Aide	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Care Attendant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dietitian	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Occupational Therapist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Therapist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speech Pathologist & Audiologist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Social Worker	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
All Other Health Professionals and Technical Personnel	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
All Non-Health Professionals and Technical Personnel	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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**XII. SOURCE OF INCOME**

SOURCE	PERCENTAGE	INCOME
Medicare		
Part A		
Part B		
Medicaid		
Other Third Party Payors (Health Insurance, VA, Worker's Comp, etc..)		
Fees from Patients		
Other (Grants, Contributions, Bequests, Fund Raising, etc.		
<b>TOTAL</b>	<b>100%</b>	

**XIII. ACCREDITATION**

A. Is the Home Health Agency fully approved by an approved accrediting body?

- Yes       No       Full       Provisional

B. Has the Home Health Agency requested appraisal by an accrediting body?

- Yes       No

C. Accrediting body

D. Date of last Accrediting Body Survey

E. Type of survey

D. Date accreditation expires

**XIV. CRIMINAL BACKGROUND CHECKS**

Does the facility have a system in place for performing criminal background checks in accordance with AS 47.05 and 7 AAC 10.900 - 990 through the Alaska Background Check Program (BCP)?

- Yes       No



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**XV. SERVICES (Attach additional sheets if more space is needed)**

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 Services	<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	
PCA Services	<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	
Personal Care	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	
IV Infusion	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	
Other	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	
Other	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	
Other	<input type="checkbox"/> Direct	<input type="checkbox"/> Contract	

**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 licensed hospital or a skilled nursing facility.**



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**XVI. SCOPE OF SERVICE**

**7 AAC 12.500. Scope.** A public or private entity that is primarily engaged in the provision of skilled nursing care and therapeutic services, but not the treatment of mental illness, in a patient's home is a home health agency, and must comply with **7 AAC 12.500 - 7 AAC 12.590.**

**7 AAC 12.505. Home health agency services.** (a) A home health agency must provide skilled nursing services and at least one of the following additional services:

- (1) physical therapy;
- (2) occupational therapy;
- (3) speech therapy; or
- (4) home health aide services.

(b) A home health agency may provide additional services designed to maintain, improve, or restore a physical or mental condition. Additional services must be provided in accordance with generally accepted professional standards and identified in a plan of care established under **7 AAC 12.513.** Additional services may include

- (1) nursing care under the supervision of a registered nurse;
- (2) physical, occupational, speech, or respiratory therapy;
- (3) medical social services;
- (4) nutrition counseling;
- (5) home health aide services;
- (6) personal care services; and
- (7) medical supplies, other than drugs and biologicals, and the use of medical appliances.

**DOES THE HOME HEALTH AGENCY MEET ALL THE ABOVE SCOPE OF SERVICE REQUIREMENTS?**

- Yes                       No

**If not, please provide an explanation.**



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**State Licensure Attestation**  
 Attestation Form



**ATTESTATION**

The applicant, or the person authorized to submit this application on behalf of an applicant that is not an individual, declares and certifies that the contents of this application and the information provided with it are true, accurate, and complete.

In addition, the applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that he or she has reviewed the regulatory requirements contained in [7 AAC 10.900 - 990](#) (Barrier Crimes, Criminal History Checks, and Centralized Registry), [7 AAC 10.9500 - 9535](#) (General Variance), [7 AAC 10.9600 - 9620](#) (Inspections and Investigations), the applicable requirements for facility type and the applicable requirements of [7 AAC 12.600 - 990](#) (General Provisions).

**The undersigned gives assurance that the facility is in compliance to the best of his/her knowledge and he/she is prepared for an on-site inspection to validate compliance.**       Yes       No

**If the facility is not yet in compliance or is not prepared for an on-site inspection, please give the expected date the facility will be in compliance.**

Date Full Compliance with Licensure is expected:

Printed Name of Administrator or Designee:

Signature of Administrator or Designee:  Date:

**Please submit this application and associated licensing fees to:**

Health Facilities Licensing & Certification  
 ATTN: Administrative Assistant  
 4501 Business Park Blvd. Suite 24 Bldg. L Anchorage, AK  
 99503

Phone: (907) 334-2483  
 Secure Fax: (907) 334-2682  
 Email: [dhcs.hflc@alaska.gov](mailto:dhcs.hflc@alaska.gov) (\*NOT secure)

**Note: To submit by E-mail, print, sign above and scan as a PDF file. The signed and completed application and associated documentation can be attached to an email and sent to [dhcs.hflc@alaska.gov](mailto:dhcs.hflc@alaska.gov).**



**State of Alaska**  
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**Payment Submission Form**  
 Licensure Fee Payments



**Licensure Fee Payment Submission Form**

Remit this form along with payment – see [7 AAC 12.615](#) for specific fees due

<b>Facility Type:</b>		<b>Date:</b>	
<b>Brief Payment Description:</b>			
<b>Facility Name:</b>			
<b>Facility Location:</b>			
<b>Facility Contact:</b>			
<b>Contact Number:</b>			
<b>License Number:</b>			
<b>Licensure Fee:</b>			
<b>Provisional Licensure Fee:</b>			
<b>Bed Fee (if applicable):</b>			
<i>Number of Beds/FTE's (if applicable):</i>			
<b>Revisit Fee:</b>			
<b>Modification Fee:</b>			
<b>Fine Amount:</b>			
<b>Total Amount of Payment Due:</b>			

**Make checks payable to: State of Alaska - HFLC**

**For State of Alaska accounting use only**

**Unit:** 4011    **Fund:** 1004    **Dept:** 06    **Appropriation:** 062330704    **Revenue:** 5101  
**Activity:**    4HF0 License Fee     4HF1 Revisit Fee     4HF2 Modification Fee     4HF3 Fine

Check #		Deposit number:	
Date received:		Deposit date:	
Received by:		IRIS document code:	
Info to TPL for processing:			
Return check date:			
Reason for return:			



# State of Alaska

Department of Health & Social Services

## State Licensing Survey Waiver Application

[7 AAC 12.925](#)



Facilities with accreditation through a nationally recognized organization may be eligible to waive their biannual State licensing survey for the current/upcoming licensing period. To learn more about the survey waiver an eligibility, please refer to [7 ACC 12.925](#) and [AS 47.32.030\(a\)\(9\)\(A-C\)](#). To apply, please provide the following information.

Facility type: \_\_\_\_\_ AK License Number: \_\_\_\_\_

Facility name: \_\_\_\_\_

Satellite locations:      Yes                      No                      (*\*\*If yes, inspection reports for these sites are also required*)

Physical address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Primary phone: \_\_\_\_\_ Primary fax: \_\_\_\_\_

Email for facility distribution list: \_\_\_\_\_

Administrator: \_\_\_\_\_ Administrator phone: \_\_\_\_\_

Administrator email: \_\_\_\_\_

Secondary contact: \_\_\_\_\_ Title: \_\_\_\_\_

2nd Contact phone: \_\_\_\_\_ 2<sup>nd</sup> Contact email: \_\_\_\_\_

Name of accrediting organization: \_\_\_\_\_

Date of last inspection: \_\_\_\_\_ Frequency of accreditation cycle (years/months): \_\_\_\_\_

Were any deficiencies identified during the last inspection?                      Yes                      No

*If yes, have the deficiencies been corrected?*                      Yes                      No

For any surveys completed in the past 2-3 months, in which the facility has not received the report or plan of correction has not been submitted, when do you expect to receive the survey report or submit the facility's plan of correction? \_\_\_\_\_

Person completing this form: \_\_\_\_\_

Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**\*\*\*A copy of your last inspection report and plan of correction MUST be submitted with this application or the waiver will be denied.**

Application can be submitted by fax to 907-334-2682 or by email to [dhcs.hflc@alaska.gov](mailto:dhcs.hflc@alaska.gov)

### FOR DIVISION USE ONLY

Date Application Received: \_\_\_\_\_ Includes requested attachments?      Yes      No

Application Reviewed by: \_\_\_\_\_ Date reviewed: \_\_\_\_\_

Application is:      Approved      Denied      Approving Signature: \_\_\_\_\_