State of Alaska

Department of Health & Social Services

Hospice Agency

Licensure Application

Print Form

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

Department Use Only
License Number _____

Pursuant **to** the AS 47.32 **Licensing Statute and the regulations of the Department of Health & Social Services Hospice Agency Licensing requirements** (7 AAC 10 **and** 7 AAC 12**)**

I. TYPE OF LICENSE APPLYING FOR

License # _____ Medicare # _____

Choose One _____ License Expiration Date _____

II. TYPE OF HOSPICE

Choose One _____

III. NAME AND LOCATION OF HOSPICE 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 _____

IV. OWNERSHIP AND ADMINISTRATION

A. Type of Control (check one)

GOVERNMENTAL ☐ State ☐ Borough ☐ City

NOT FOR PROFIT CORPORATION ☐ Church Operated or Affiliated ☐ Other Non-Profit

PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation

☐ Other (Explain) _____

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THE DEPARTMENT IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER AS 47.32.040

B. If Individual or Partnership owned (list all persons who own the Hospice)

Name	Address

C. Names under which persons in B. do business (other than this Hospice)

Name	Business

D. Corporate Ownership

(1) Name of Corporation

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

(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 Hospice.

☐ (Check here if not applicable)

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 ☐ Yes ☐ No
2. Any member of a firm or partnership ☐ Yes ☐ No
3. Any officer or director of a corporation ☐ Yes ☐ No
4. Administrator or manager of the Hospice ☐ Yes ☐ No

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

V. ADMINISTRATION

A. Administrator

Name

Address

Telephone Number

License or Certification Number (if applicable)

B. Medical Director

Name

Address

Telephone Number License Number

C. Registered Nurse Coordinator

Name

Address

Telephone Number License Number

VI. SUBUNITS AND BRANCH OFFICES

Note:
*(1) a **branch office** is located in the same service area as the parent agency and shares administration, supervision, and service with the parent agency on a daily basis; a branch office **is not required to be separately licensed**; and*
*(2) a **subunit** is located outside the service area where the parent agency is located, and does not share administration, supervision, and services with the parent agency on a daily basis; a subunit must be separately licensed under this chapter. **A separate application must be submitted for each subunit**.*

A. Does the agency have any subunits or branch offices? ☐ Yes ☐ No

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

Name	Location	Branch	Subunit
		☐	☐
		☐	☐
		☐	☐

VII. FULL SERVICE AGENCY *(As of completion date of this application)*

☐ Yes ☐ No The agency has a governing body?

☐ Yes ☐ No The agency has quality assurance and risk management programs?

☐ Yes ☐ No The agency has a program director?

☐ Yes ☐ No The agency maintains client records that includes copies of the client's care plan, progress notes, assessments and description of services provided to the client and client's family?

☐ Yes ☐ No The agency has an orientation and staff development program for all paid and non-paid staff?

☐ Yes ☐ No The agency maintains records of licensure of professional employees?

☐ Yes ☐ No The agency has a registered nurse who coordinates therapeutic services?

☐ Yes ☐ No The agency has an interdisciplinary team?

Please List disciplines:

VIII. 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							
FEMALE							
TOTAL							

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

Admitted during the year		Discharged	
Patients Terminated		Deceased	
Respite days		Acute care days	
Highest patient count		Lowest patient count	
Average patient count			

IX. TYPE OF HOSPICE AFFILIATION

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

X. 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
Administrator					☐ Yes ☐ No	☐ Yes ☐ No
Medical Director					☐ Yes ☐ No	☐ Yes ☐ No
Physician on Professional Advisory Committee					☐ Yes ☐ No	☐ Yes ☐ No
Pastor/Spiritual Counselor					☐ Yes ☐ No	☐ Yes ☐ No
Registered Nurse Coordinator					☐ Yes ☐ No	☐ Yes ☐ No
Registered Nurse					☐ Yes ☐ No	☐ Yes ☐ No
LPN					☐ Yes ☐ No	☐ Yes ☐ No
Nurse Practitioner or Physician Assistant					☐ Yes ☐ No	☐ Yes ☐ No
Home Health Aide					☐ Yes ☐ No	☐ Yes ☐ No
Personal Care Attendant					☐ Yes ☐ No	☐ Yes ☐ No
Dietitian					☐ Yes ☐ No	☐ Yes ☐ No
Occupational Therapist					☐ Yes ☐ No	☐ Yes ☐ No
Physical Therapist					☐ Yes ☐ No	☐ Yes ☐ No
Speech Pathologist & Audiologist					☐ Yes ☐ No	☐ Yes ☐ No
All Other Health Professionals and Technical Personnel					☐ Yes ☐ No	☐ Yes ☐ No
All Non-Health Professionals and Technical Personnel					☐ Yes ☐ No	☐ Yes ☐ No

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

Facility Name	
Address	

XI. 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) _____

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.		
TOTAL	100%	

XIII. ACCREDITATION

A. Is the Hospice fully approved by an approved accrediting body?

☐ Yes ☐ No ☐ Full ☐ Provisional

B. Has the Hospice 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

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

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 Services*	☐ 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	
Personal Care	☐ Direct	☐ Contract	
IV Infusion	☐ Direct	☐ Contract	

*** Services required to qualify as a Full Service Hospice**

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.

XVI. GEOGRAPHICAL AREA SERVED

XVII. SCOPE OF SERVICE

A. Full Service Hospice Agency Only

7 AAC 12.316. Scope of service: full-service hospice agency. (a) A full-service hospice agency shall provide

(1) physician or advanced nurse practitioner services to provide directed medical care that meets the client's medical needs for palliative care and management of terminal illness;

(2) nursing care and services provided by or under the supervision of a registered nurse;

(3) social work services provided in accordance with 7 AAC 12.335;

(4) spiritual and emotional counseling services in accordance with 7 AAC 12.337 to the client, the client's family, and caregivers if these services are desired during the time the client is receiving hospice care;

(5) bereavement counseling services in accordance with 7 AAC 12.337 to the client's family and caregivers after the client's death;

(6) volunteer services in accordance with 7 AAC 12.336;

(7) dietary counseling services in accordance with 7 AAC 12.337;

(8) pharmaceutical hospice services in accordance with 7 AAC 12.343;

(9) services related to the referral and transfer of clients for laboratory services that are provided by an organization other than the hospice; the referral and transfer services must be provided in accordance with a written plan that delineates available services and the procedures for referring and transferring clients;

(10) services related to the transfer of specimens for laboratory services that are provided by an organization other than the hospice; the transfer services must be provided in accordance with a written plan that delineates available services and the procedures for transferring specimens; and

(11) short-term respite care to the client's family for the relief of the client's daily care.

(b) In addition to meeting the requirements of (a) of this section, the hospice agency shall evaluate each client's

(1) access to emergency medical services, including ambulance service;

(2) access to service, equipment, and supplies;

(3) safety and emergency preparedness within the client's place of residence.

(c) The hospice agency shall make nursing services, physician or advanced nurse practitioner services, and drugs and biologicals available on a 24-hour basis to the extent necessary to meet the client's needs for palliative care and management of terminal illness and related conditions.

(d) The hospice agency shall arrange for short-term inpatient care if home care is not feasible for pain control, symptom management, and respite purposes. The agency shall ensure that any short-term inpatient care is provided in a licensed facility that is most appropriate to meet the client's needs.

(e) The hospice agency shall offer hospice care in the least costly setting that can assure the quality of care and each type and amount of service that is necessary to meet the client's needs.

(f) The hospice agency shall have a risk management program that includes procedures to investigate, analyze, and respond to client grievances related to client care.

(g) The hospice agency shall develop and implement written policies and procedures consistent with this chapter that govern each service provided by the agency, including policies relating to confidentiality, training, and admissions. The policies and procedures must accurately describe the agency's goals, the methods by which the goals are achieved, and the mechanisms by which basic hospice care services are delivered. The agency shall review its policies and procedures at least annually. The program director shall document each review by dating and signing an attestation. The agency shall revise its policies and procedures if determined necessary by the agency or by the department to ensure that each policy and procedure is current and adequate for purposes of carrying out the agency's functions and maintaining consistency with this chapter.

DOES THE FULL SERVICE HOSPICE AGENCY MEET ALL THE ABOVE SCOPE OF SERVICE REQUIREMENTS?

☐ Yes ☐ No

If not, please provide an explanation on a separate sheet.

B. Volunteer Hospice Agency Only

7 AAC 12.317. Scope of service: volunteer hospice agency. (a) Subject to (b) of this section, a volunteer hospice agency shall provide each of, and only, the following services:

(1) direct service volunteers;

(2) spiritual and emotional support services to the client, the client's family, and caregivers if these services are desired during the time the client is receiving hospice care;

(3) supervision, orientation, and training to direct service volunteers and other hospice staff;

(4) bereavement counseling services to assist the client's family and caregivers in coping with grief experienced after the client's death; and

(5) volunteer services in accordance with 7 AAC 12.336.

(b) A volunteer hospice agency may provide short-term respite care to the client's family for the relief of the client's daily care.

(c) A volunteer hospice agency shall investigate, analyze, and respond to client grievances related to client care.

(d) A volunteer hospice agency shall ensure that each client has a plan of care approved by the attending physician or advanced nurse practitioner, and by the program manager.

(e) A volunteer hospice agency shall develop and implement written policies and procedures consistent with this chapter that govern each service provided by the agency, including policies relating to confidentiality, training, and admissions. The policies and procedures must accurately describe the agency's goals, the methods by which the goals are achieved, and the mechanisms by which basic hospice care services are delivered. The agency must review its policies and procedures at least annually. The program director shall document each review by dating and signing an attestation. The agency shall revise its policies and procedures if determined necessary by the agency or by the department to ensure that each policy and procedure is current and adequate for purposes of carrying out the agency's functions and maintaining consistency with this chapter.

(f) Volunteer services in a volunteer hospice agency must be directed by a coordinator of volunteer services who shall

(1) implement a direct service volunteer program;

(2) coordinate the orientation, education, support, and supervision of direct service volunteers; and

(3) coordinate the use of direct service volunteers with other hospice staff and community resources.

DOES THE VOLUNTEER HOSPICE AGENCY MEET ALL THE ABOVE SCOPE OF SERVICE REQUIREMENTS?

☐ Yes ☐ No

If not, please provide an explanation on a separate sheet.

I. Licensure Fee Payment Submission Form

Remit this form along with payment – see 7 AAC 12.615 for specific fees due

Facility Type:		**Date:**
Branch Location (if applicable)		
Facility Name:		
Facility Location:		
Facility Contact:		
Contact Number:		
License Number:		
Licensure Fee:		
Provisional Licensure Fee:		
Bed Fee (if applicable):		
Note No. of beds: ( )		
Revisit Fee:		
Modification Fee:		
Total:		

Make checks payable to: State of Alaska - HFLC

Unit: 4011 **Fund:** 1004 **Dept:** 06 **Appropriation:** 062330704 **Revenue:** 5101
Activity (select one)**:** ☐ 4HF0 License Fee ☐ 4HF1 Revisit Fee ☐ 4HF2 Modification Fee

For State of Alaska accounting use only

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

IX. ATTESTATION

The applicant, or the person authorized to submit the 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 of 7 AAC 12.310 - 349 (Hospice Agencies) 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**

Administrator or Designee Name

Date

Signature of Administrator or Designee

Please submit this application to:

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

Phone: (907) 334-2483
Fax: (907) 334-2682
Email: dhcs.hflc@alaska.gov

[Note: To submit by E-mail, print the document, sign above, and scan to a PDF file. Attach the signed PDF document to an E-mail and send to the above E-mail address.]

Print Form