



**State of Alaska**  
 Department of Health & Social Services  
**Hospice Agency**  
 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 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)

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> GOVERNMENTAL               | <input type="checkbox"/> State                         | <input type="checkbox"/> Borough          | <input type="checkbox"/> City        |
| <input type="checkbox"/> NOT FOR PROFIT CORPORATION | <input type="checkbox"/> Church Operated or Affiliated | <input type="checkbox"/> Other Non-Profit |                                      |
| <input type="checkbox"/> PROPRIETARY                | <input type="checkbox"/> Individual                    | <input type="checkbox"/> Partnership      | <input type="checkbox"/> 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 |
|-------|------|---------|
|       |      |         |
|       |      |         |
|       |      |         |
|       |      |         |
|       |      |         |



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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                                | <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 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.)**



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**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                  |
|----------------------|----------------------|--------------------------|--------------------------|
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |





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**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  | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> |
| FEMALE | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> |
| TOTAL  | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> | <input style="width: 60px; height: 25px;" type="text"/> |

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

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

**IX. TYPE OF HOSPICE AFFILIATION**

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



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**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      |                             |
|--|----------------------|----------------------|----------------------|----------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
|  |                      |                      |                      |                      | <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 |
| Pastor/Spiritual Counselor                             | <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 Coordinator                           | <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 |
| 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 |

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

Facility Name

Address



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**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.)           |             |        |
| <b>TOTAL</b>  | <b>100%</b> |        |

**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





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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 |                            |
| 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 |                            |
| Personal Care                  | <input type="checkbox"/> Direct | <input type="checkbox"/> Contract |                            |
| IV Infusion                    | <input type="checkbox"/> Direct | <input type="checkbox"/> 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**



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**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.**



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**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.**



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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).

**If this is an initial application, 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.]***