Mississippi Department of Health

Application for Licensure of Hospice

Licensure Year: July 1, 2018 - June 30, 2019

1. Name of Agency ____

2. Address____
   Number and Street City or Town Zip Code

   ____
   Post Office Box Number City or Town Zip Code

3. County ____________________ Telephone (______) ______________________

4. Name and Address of responsible party. (The one individual designated in writing to be responsible for conducting the business of the Hospice with the licensing agency.)

   ____

   ____

   Email for Contact Person ____

5. Name of Hospice Administrator ____

6. Name of Medical Director ____

7. Type of Hospice: ______ Freestanding ______ Home ______ Hospital
   ______ Inpatient ______ Nursing Home
   ______ Pediatric Home Care (Must have the capacity and intent to provide unique services to patients under eighteen (18) years of age.)

8. If Inpatient and providing Inpatient Care give the number of beds. ___________
   Note: Inpatient services can only be added as an additional service to an established Home or Pediatric Care Hospice.

9. Type of Ownership. (Check only one).
   ____ Non-Profit Corporation ____ State Government ____ Individual Proprietor
   ____ Profit Corporation ____ Local Government ____ Other (Specify)

A. Full name of Owner ____

B. List name(s), address(es) and office(s) of governing body member(s):

____
____
____
____

C. List name(s) and address(es) of any person(s) or entity(ies) owning at least 5% of the entity: Include percentage owned. (Attach additional sheet, if necessary):

____
____
____
____

10. Geographic Area Served. (Specify counties.)

____
____
____
____
____

11. Locations of Alternative Office Sites, if any: (Complete address and phone number)

____
____
____

12. Hospice Services Provided.

A. List all CORE services, and the person responsible for each service.

____
____
____
____

B. Hospice Staff.

Specify number of employees by full-time staff, part-time staff, under arrangement or volunteer.

	Full-time	Part-time	Under Arrangement	Volunteer
Administrator(s)				
Assistant Administrator(s)				
Medical Director(s)				
Registered Nurses				
Licensed Practical Nurses				
Aides, Orderlies, Attendants				
Registered Records Administrator(s)				
Accredited Records Technician(s)				
Other Medical Record Personnel				
Pharmacist(s)				
Registered Dietitian(s)				
Occupational Therapist(s)				
OT Aide(s)				
Physical Therapist(s)				
Physical Therapy Aide(s)				
Audiologist(s)				
Speech Pathologist(s)				
Respiratory Therapist(s)				
Medical Social Worker(s)				
Counselor				
Clergy				
Other Personnel				
Total				

13. Is Hospice operated by lease and/or management agreement? ______________________
If yes, attach a copy(ies) of the agreement(s).

14. If a corporation, attach copies of the Corporate Charter and Articles of Incorporation (unless a copy has previously been submitted to this office).

15. Date of adoption of governing body bylaws: ________________________________
(Attach copy, if application is for initial licensure).

16. Licensure fee. In accordance with House Bill #289 of the Regular Legislative Session of 2016, attach a check or money order in the amount of **$1150.00** for the main location, **$1150.00** for each alternative office site (branch location) of the hospice, and an additional **$20.70** per bed for inpatient units made payable to the Mississippi State Department of Health.

I (we) do hereby certify on behalf of ____, after diligent research, inquiry and study, that the information and material contained in this foregoing application of a license is true, accurate and correct, to the best of my (our) knowledge and belief. It is understood that the Mississippi State Department of Health will rely on this information and material in making its decision as to the issuance of a license, and if it finds that the application contains distorted facts or misrepresentation or does not reveal truth and accuracy, the Mississippi State Department of Health may reject the application. It is further understood that if a license is issued based upon the evidence contain in this application, such license may be canceled or revoked, if the Mississippi State Department of Health determines its findings were based on evidence, not true, factual, accurate and correct.

______________________________	______________________________
Signature	Signature
______________________________	______________________________
Title	Title
______________________________	______________________________
Date	Date

MAIL TO: **MISSISSIPPI STATE DEPARTMENT OF HEALTH**
DIVISION OF HEALTH FACILITIES LICENSURE AND CERTIFICATION
POST OFFICE BOX 1700
JACKSON, MISSISSIPPI 39215-1700