Mississippi State Department of Health

Application for Licensure of Home Health Agency
Licensure Year: July 1, 2018 - June 30, 2019

1. Name of Agency _____

2. Address _____
Number and Street City or Town Zip Code

_____
Mailing Address (if different from physical address)

3. County _____ Telephone (____) _____

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

_____

_____

_____
Email Address of the responsible party

5. Name of Chief Administrative Officer _____

6. If parent agency, list names, addresses, and phone numbers of each branch office or sub-unit(s).
A. Branch(es): _____

_____

_____

B. Sub-Unit(s): _____

_____

7. If sub-unit, list name, address, and telephone number of parent agency:

_____

8. Type of Home Health Agency. (Check only one).

[ ] Private Non-Profit [ ] Governmental [ ] Hospital-Based [ ] Proprietary

9. Type of Ownership. (Check only one).

[ ] Non-Profit Corporation
[ ] For-Profit Corporation
[ ] Individual Proprietor
[ ] Other (Specify) _____

[ ] State Government
[ ] Local Government

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. Service provided. Place a "1" in the space beside each service provided by **AGENCY STAFF.** Place a "2" in the space beside each service provided **UNDER ARRANGEMENT.** Also indicate start date of each service.

	SERVICES	DATE
a.	_____Skilled Nursing	_____
b.	_____Home Health Aide	_____
c.	_____Physical Therapy	_____
d.	_____Occupational Therapy	_____
e.	_____Speech Therapy	_____
f.	_____Medical Social Services	_____
g.	_____Appliance & Equipment Service	_____
h.	_____Respiratory Therapy	_____
i.	_____Other (Specify below)	_____

12. Home Health Agency Employees. Specify number of employees by full-time staff, part-time staff and under arrangement.

	Full-time	Part-time	Under Arrangement
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)			
Other Health and Tech. Staff			
Other Personnel			
Total			

13. Is Agency 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 **$1,150.00**, 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**
HEALTH FACILITIES LICENSURE AND CERTIFICATION
POST OFFICE BOX 1700
JACKSON, MISSISSIPPI 39215-1700