NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
LICENSURE /CERTIFICATION /ACUTE/HOME CARE SECTION
SITE: 1205 UMSTEAD DRIVE
RALEIGH, NORTH CAROLINA 27603
MAILING: 2712 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-2712
PHONE (919) 855-4620

FOR OFFICIAL USE ONLY
LICENSE NO._____
PC_____DATE_____

INITIAL [ ] CHOW [ ] NAME CHANGE [ ] [ ]OTHER _____

2025
LICENSURE APPLICATION FOR HOME CARE, NURSING POOL, AND HOSPICE

A separate application is to be completed for each site from which home care (including home health), nursing pool, or hospice services are offered. Separate legal entities operated out of the same office must submit separate applications.

LEGAL IDENTITY OF APPLICANT: OWNER/CORPORATE IDENTITY

(Full legal name of corporation or partnership, individual, or other legal entity owning the enterprise or services.)

_____

AGENCY NAME/DOING BUSINESS AS

(D/B/A) - Name(s) under which the facility or services are advertised or presented to the public:

Primary: _____

AGENCY MAILING ADDRESS: If materials are to be mailed to another address list here:

P. O. Box_____

City _____State_____Zip_____

AGENCY SITE ADDRESS:

Street_____
City _____State_____Zip_____County_____
E-mail Address _____ Web Site _____
(If applicable) (If applicable)
Telephone (___) _____ Fax (___) _____
Administrator/Director: _____

Title: _____

LICENSURE CATEGORIES APPLIED FOR: *(CHECK ALL THAT APPLY)*

1. ____Home Care Agency (G.S. 131E-138)
2. ____Nursing Pool (G.S. 131E-154.3)
3. ____Hospice Services (G.S. 131E-200)

(The information provided in this application will be used by the Department for the Certificate of Need and for planning process.)

SCOPE OF SERVICES:

In the columns below, check each service offered through this site.

YES	HOME CARE
____	Nursing Services
____	Infusion Nursing Services
____	In-Home Aide Services
____	Medical Social Services
____	Physical Therapy
____	Occupational Therapy
____	Speech Therapy
____	Clinical Respiratory Services (including Pulmonary or Ventilation)
____	Home Medical Equipment (DME) Do you also have a medical equipment permit issued by the Board of Pharmacy? Yes ___ No ___
	Note: Not required for Home Care Licensure or Nursing Pool

YES	NURSING POOL
____	Licensed Nursing Personnel, Nurse Aides or Allied Health Personnel

YES	HOSPICE
____	Hospice Home Services (Licensed hospice care services only)
____	Hospice In-patient Beds (List only if you operate licensed beds in your own facility) Number of Beds_____
____	Hospice Residential Beds (List only if you operate licensed beds in your own facility) Number of Beds____
____	Do you have an agreement to operate Hospice licensed inpatient beds or hospice residential beds in another facility. If so, list facility_____
____	If you have contract for patients needing in-patient or residential accommodations, give the name of the contractor: _____ _____

YES	COMPANION, SITTER AND RESPITE CARE
____	Companion / Sitter / Respite

LICENSE APPLICATION PROCESS: An applicant must be able to complete all necessary requirements within one year (12 months) from receipt of the initial application and fee date to obtain a license. After initial licensure, the agency must have the license renewed every year.

ACCREDITATION INFORMATION

If home care licensure is being requested on the basis of deemed status as an accredited agency, **attach a <u>complete</u> copy of accrediting organization's inspection report (or findings) together with its decision, if surveyed within the last 12 months**. Licensure based upon deemed status cannot be completed without full disclosure.

ACCREDITING ORGANIZATION		EXP DATE
____	JCAHO (Joint Commission on Accreditation for Healthcare Organizations)	_____
____	CHAP (Nat'l League for Nursing)	_____
____	NCHC (Nat'l Home Caring Council)	_____
____	ACHC (Accreditation Commission for Home Care, Inc.)	_____
____	Other_____	_____

HOME CARE AGENCY APPLICANTS

1. If Medicare Certified Home Health, what is your provider number? _____

2. This agency is a Home Health Agency. Please check one.
   Parent_____ Branch _____ Sub-unit

HOSPICE APPLICANTS

1. If Medicare certified, what is your hospice provider number? _____

2. Has this site been issued a Certificate of Need to provide hospice services?
   Yes ____ No _____

NURSING POOL APPLICANTS ONLY

1. Nursing Pool applicants must attach a copy of the written administrative and personnel policies governing the provided services. **(Initial applications only)**

   All nursing pool applicants must attach a copy of the agency's current general and professional liability insurance policy (binder acceptable). The document must show that the applicant is insured against loss, damage, and expense related to a death or injury claim resulting from negligence or malpractice in the provision of health care by the nursing pool and its employees.

OWNERSHIP DISCLOSURE (Please fill in any blanks and make changes where necessary).

Mark the term which describes the legal character of the operating ownership then proceed to the indicated block.

_____For-Profit

1. Proprietor (Proceed to Block I)
2. General Partnership (Proceed to Block II)
3. Limited Partnership (Proceed to Block II)
4. For Profit Corporation (Proceed to Block III)

_____ Not-For-Profit

5. Not for Profit Corporation (Proceed to Block III)

6. Unit of Government (Proceed to Block IV)

BLOCK I. PROPRIETOR (unincorporated individual)

Proprietor's Name_____

Proprietor's Home Address and Telephone

Street _____

City/State/Zip _____

Telephone (_____)_____

BLOCK II. PARTNERSHIP

Partnership Name: _____
Is it a general partnership? ___ Yes ____ No
Is it a limited partnership? ____ Yes ___ No
Is the partnership registered with the NC Secretary of State, Corporation Division? ____ Yes ____ No
If "Yes", what is the exact wording of the partnership's registered name? _____
_____
Where is the partnership registered? State _____ County _____
Address and Telephone Number of the Partnership:
Street/Box: _____
City/State/Zip_____
Telephone (____) _____
Give the name and address of the principal partners

Name Title Percent Ownership
_____
_____
_____
_____

Attach additional sheets as needed

BLOCK III. CORPORATION

What is the exact wording of the Corporate Name on file with the Office of the NC Secretary of State? (Corporate Office)
_____
In what state was the corporation originally established? _____
Address and Telephone Number of the corporation:
Street/Box _____
City/State/Zip _____
Telephone (____) _____

List the names and addresses of **ALL** officers and/or any other persons with a controlling interest of 5% or more.

Name Title Percent of Stock
_____
_____
_____
_____

(Attach additional sheets as needed)

BLOCK IV. UNIT OF GOVERNMENT

Name of the governmental unit which has the ownership responsibility and liability for the services offered:

_____

Title of the official in charge of the governmental unit:

_____

Check which best describes the type of governmental unit:

____ City _____ County _____ State _____ Authority

Health Dept._____
DSS _____
Other (Please Specify): _____

MULTIPLE FACILITY AGENCY SYSTEMS

Yes___ No ____ Is this agency part of a multiple facility/agency system in North Carolina? (A multiple facility/agency system is defined as two or more entities under the same management or ownership).

If you checked yes on the above question, list the name (s) of the other entities licensed in North Carolina by the Division of Health Service Regulation.

Name Location License #

_____

_____

_____

_____

(Attach additional sheets as needed)

Is your agency owned in whole or in part or operated by a hospital? Yes ___ No _____
If yes, please specify name of entity_____
Is your agency managed by another entity? Yes _____ No _____
If yes, please specify name of entity _____

I certify that this application and all attachments as submitted are accurate and true representations of the services offered as reported herein.

Signature _____

Typed Name _____

Title _____

Date _____

The NC Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age, or disability in employment or the provision of services.

SERVICE CATEGORIES FOR HOME CARE PROVIDERS

In the columns below, identify each service provided by county through this site. Also, identify by check mark whether the service is provided to your clients by **contract** with another agency, by **in-house** staff or both.

County	Nursing		Infusion Nursing		In-Home Aide / Companion Sitter Respite		Medical Social Services		PT		ST		OT		Clinical Respiratory *	
	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT

IN-H - In-House Staff
CTRT - Service provided by contract
*** - Clinical Respiratory includes pulmonary and ventilation services**

PLEASE ATTACH A LIST OF ALL CONTRACTORS AND THE SERVICE(S) PROVIDED BY COUNTY UNDER THIS ARRANGEMENT. DO NOT LIST CONTRACTS YOU HAVE WITH OTHER AGENCIES TO PROVIDE SERVICES TO THEIR CLIENTS.

SERVICE CATEGORIES FOR HOSPICE HOME CARE, HOSPICE IN-PATIENT AND HOSPICE RESIDENTIAL PROGRAMS

In the columns below, identify each service provided by county through this site. Also, identify by check mark whether the service is provided to your clients by **contract** with another agency, by **in-house** staff or both.

County	Nursing		Social Work		Add'l Counsel		Bereavement		Volunteers		Inpatient Care	
	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT

County	PT		OT		ST		Home Health Aide		Nutritional Assessment & Dietary Counseling		Other Services	
	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT	IN-H	CTRT

In-H **In-House Staff**
Ctrt **Service provided by contract**
***** **Clinical respiratory includes pulmonary and ventilation services**

PLEASE ATTACH A LIST OF ALL CONTRACTORS AND THE SERVICE(S) PROVIDED BY COUNTY UNDER THIS ARRANGEMENT. DO NOT LIST CONTRACTS YOU HAVE WITH OTHER AGENCIES TO PROVIDE SERVICES TO THEIR CLIENTS.