State of Illinois
Illinois Department of Public Health

APPLICATION FOR LICENSE TO OPERATE HOSPICE

Pursuant to the Hospice Program Licensing Act (210 ILCS 60/1) et seq. formerly known as ch. 111 1/2, pars. 6101 et seq.) and the rules and regulations of the Illinois Department of Public Health entitled "Hospice Programs" (77 Ill. Adm. Code 280)

○ Renewal ○ Change of Ownership

○ Initial

License # _____ Medicare # _____

License Expiration Date _____

Agency Name and Mailing Address

Name _____

Address _____

City _____ State _____ Zip Code _____

Facility physical location (if different from above)

Address _____

City _____ State _____ Zip Code _____

Business Hours _____ A.M. to _____ P.M.

Days of the Week _____

E-mail Address _____

Name of Contact Person _____

Agency Phone _____

Agency Fax _____

County _____

Contact Phone _____

Type of Hospice

○ Comprehensive ○ Volunteer

Volunteer, check services provided:

☐ Nursing ☐ Pastoral Counsel
☐ Social Services ☐ Dietary Counsel
☐ Bereavement Counsel

Multiple Hospice Locations. A location or site from which the hospice program provides non-residential nursing, social, pastoral/counseling, bereavement or dietary services within a portion of the total geographic service area served by the hospice program. It is part of the hospice and located close enough to share administration, supervision and services in a manner that makes it unnecessary to require an independent license. *Inpatient care is provided in a hospital, skilled nursing facility or a hospice residence.*

Does your hospice maintain multiple hospice locations? ☐ Yes ☐ No

If yes, list address and phone number. Attach an additional sheet if more space is needed.

Address _____ City _____

State _____ Zip Code _____ Phone _____

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Type of Hospice Affiliation:

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

Type of Control:

- ☐ Voluntary Non-Profit Non-Church
- ☐ Voluntary Non-Profit Church
- ☐ Government Agency
- ☐ Proprietary
- ☐ Other (Specify)

Other _____

If type of control is "Proprietary" (corporation, sole proprietor, partnership or association), complete this section and complete and submit Attachment A(Statement of Ownership). If licensee/applicant is a corporation or limited partnership, list name and address of Illinois registered agent.

Name of Organization _____

President _____ Secretary _____

Illinois registered agent or person(s) legally authorized to receive service of process for entity:

Registered Agent Name: _____

Address: _____ City _____ State _____ Zip _____

Phone Number _____

**LICENSEE IS RESPONSIBLE
FOR ADVISING IDPH
OF *ANY* CHANGES IN THIS INFORMATION**

IMPORTANT NOTICE: This agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 83--457. Disclosure of this information is mandatory.

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Professional Staffing List

Include license or registration number when applicable and check if employee is full-time or part-time. Volunteers functioning in professional capacity must be included in this list. Include those employed by direct individual contract and identify by an asterisk (*). Indicate the Social Security number for home health aides in the column headed "License/ Registration Number." Attach additional sheets if more space is needed.

Name	Title	License / Reg #	Full Time	Part Time (# of Hours)	P - Paid V - Volunteer
	Administrator				
	Medical Director				

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

Facility Name _____

Address _____

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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) _____

Source of Income for Fiscal Year Ending _____ month/day/year _____ Estimated if new hospice

Source of Income:	**Percentage** %	**Income**
Medicare		
Part A		
Part B		
Medicaid		
Other Third Party Payors (Health Insurance, Champus, VA Worker's Comp, etc.)		
Fees from Patients		
Other (Grants, Contributions, Bequests, Fund Raising, etc.)		
TOTAL		
	100%	$

List counties or portions of counties hospice is approved to serve (geographic service area). If approved for a portion of a county, identify with an asterisk (*) before county name.

Hospice census report for fiscal year ending (month,day, year) ONLY FOR RENEWAL APPLICATION _____

New Admissions during year _____ Average patient count during year _____

Patients Terminated _____ If hospice provides inpatient services, indicate Y/N _____

Deceased _____ Discharged _____ Total number of acute care days _____

Highest patient count during year _____ Total number of respite days _____

Lowest patient count during year _____

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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 & Counseling*	☐ 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	

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

Contract - Hospice services provided indirectly through a contractual agreement.

Attach additional sheets if more space is needed

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 hospital licensed under the Hospital Licensing Act or a skilled nursing facility licensed under the Nursing Home Care Reform Act of 1979.

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The following are included as part of this application:

- ☐ Annual Hospice Service Plan (Initial & Renewal)
- ☐ Financial Audit for Current Fiscal Year (Renewal)
- ☐ Hospice Current Annual Budget (Initial & Renewal)
- ☐ License Fee

The license fee is as follows and must be submitted with the application:

Comprehensive Hospice - Initial & Renewal fee of $500 **Volunteer Hospice - Initial & Renewal fee of $250**

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge, and that I will comply with all rules and regulations governing the licensing of hospices in Illinois

Authorized Signature of Applicant	**Title**
Name of Administrator	**Date**
Signature of Individual Verifying Authorized Signature (if corporation or association, the second signature must be another corporate officer.)	**Title**
Name of Second Signature	**Date**

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ATTACHMENT A

STATEMENT OF OWNERSHIP

Name of Hospice _____

List name, telephone number, and occupation of every person who has entered into contract to manage, operate or who owns or controls, directly or indirectly, any of the shares of stock of, or any other financial interest in, the hospice:

Name / Address

Phone # Occupation % of Interest

Name / Address

Phone # Occupation % of Interest

Name / Address

Phone # Occupation % of Interest

Name / Address

Phone # Occupation % of Interest

Name / Address

Phone # Occupation % of Interest

Name / Address

Phone # Occupation % of Interest

Name / Address

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Name / Address

Phone # Occupation % of Interest

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APPLICATION ADDENDUM

This addendum must be completed as part of the following program/facility applications:

Ambulatory Surgical Treatment Center

Home Health Agency

Hospice Program

Hospital

Section 10-65(c) of the Illinois Administrative Procedure Act, 5 ILCS 100/10-65(c), was amended by P.A. 87-823, and requires individual licensees to certify whether they are delinquent in payment of child support.

APPLICANT IS AN INDIVIDUAL (SOLE PROPRIETOR) ◯ Yes ◯ No

The following questions must be answered only if the applicant is an individual (sole proprietor):

I hereby certify, under penalty of perjury, that I ◯ am ◯ am not more than 30 days delinquent in complying with a child support order.

Signature **Date**

FAILURE TO SO CERTIFY MAY RESULT IN A DENIAL OF THE LICENSE; MAKING A FALSE STATEMENT MAY SUBJECT THE LICENSEE TO CONTEMPT OF COURT (5 ILCS 100/10-65(c)

The completed application, appropriate attachments, and required license fee, made payable to Illinois Department of Public Health (check or money order - no cash), should be sent to:

Illinois Department of Public Health
525 West Jefferson Street
4th Floor
Springfield, IL 62761

The license fee is non-refundable. Filing an application is not a guarantee that a license will be issued.

If you have questions regarding this application, please write or call:

Illinois Department of Public Health
525 West Jefferson Street
4th Floor
Springfield, IL 62761

Telephone 217-782-7412
Fax 217-782-0382
TTY number (for hearing impaired) 800-547-0466