State of Illinois
Illinois Department of Public Health

Hospice Residence Initial Licensure Application

DIRECTIONS: Applicants who wish to obtain a hospice license for a **Hospice Residence** must complete this additional application along with the regular hospice application. Submit both forms together with the **$500 fee for review of the application for a hospice residence license**. Only 15 hospice residence licenses will be granted statewide. For further information, read **Section 280.4000 Inpatient Care Facilities** of the Hospice Rules and Regulations.

Department Use Only License # _____

Name of Hospice _____

Address _____

City _____ State _____ Zip Code _____

Administrator/Contact Person _____ Title _____

Phone number _____ Fax Number _____

Number of Proposed Hospice Beds (Maximum of 20) _____

Location of Proposed Hospice Residence _____

Address _____

City _____ State _____ Zip Code _____

County: _____ Population: _____

Is the property: ◯ Owned ◯ Leased

If the property is owned by the applicant, complete the following:

Ownership Type (Please check one)

◯ Voluntary Non-Profit Non-Church ◯ Voluntary Non-Profit Church ◯ Governmental Agency

◯ Proprietary ◯ Other (specify)

If Proprietary or Other (Corporation, Sole Proprietor, Partnership or Association) complete this section and submit Attachment "A1". If license applicant is a Corporation or Partnership, list name and address of Illinois Registered Agent.

Name of Organization _____

President: _____ City: _____

Illinois Registered Agent or person legally authorized to receive service of process for entity:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone number _____ Fax Number _____

Hospice Residence Initial Licensure Application

If it is leased, provide the following information on the actual owner

Name: _____

Address _____

City _____ State _____ Zip Code _____

The following must be included at the time of application:

☐ Documentation of a Needs Assessment and Cost Analysis completed by the Hospice to demonstrate the need for the hospice residence and an analysis of the costs involved in the establishment, licensing and maintenance of such a facility. The documentation submitted shall demonstrate the criteria used and results of the assessments.

☐ Documentation of the Hospice's Governing Body meeting minutes describing the Board official motion to proceed with the application; commitment by the organization to expend the necessary funds for application and completion of the project; and assignment of responsibility for moving forward with the application and implementation of the project.

☐ Application for licensure and fee of $500

☐ Proposed staffing for hospice residence by discipline, shift and date for two-week period.

☐ Written food sanitation policy according to 280.4040

☐ Written medication policy according to 280.4030.

NEW HOSPICE RESIDENCE

New hospice residences shall submit drawings for the proposed facility for review by the Department, which shall be in compliance with the requirements of the National Fire Protection Association (NFPA) Standard No. 101 (2012), "Life Safety Code" Chapter 32 new "Board and Care Homes, Impractical Evacuation Capabilities." The Department will request the drawings after provisional license has been issued.

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under the Hospice Program Licensing Act (210 ILCS 60). Disclosure of this information is **REQUIRED.** Failure to provide any information will result in this form not being processed. This form has been approved by Forms Management Center.

Hospice Residence Initial Licensure Application

ATTACHMENT (A1)

STATEMENT OF OWNERSHIP

Name of Hospice _____

Address _____

City _____ State _____ Zip Code _____

List name, address, telephone number, and occupation of each person who has entered into contract to manage, operate or who owns or controls (directly or indirectly) shares of stock, or any other financial interest of 5 percent or more of the hospice.

Copy next page and continue list, if needed.

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Hospice Residence Initial Licensure Application

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Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

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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 question 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.

Signed _____

Date: _____

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