



Washington State Department of

Health

Revenue Section

P.O. Box 1099

Olympia, WA 98507-1099

360.236.2917

<http://www.doh.wa.gov/hsqa/fsl/HHHACS>

In-Home Services License Application Packet

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Important Information:

In order to process your request:

Return completed application and the following information,

Fee payable to the Department of Health (Consult [fee schedule](#) for fee)

Professional and Liability Insurance – Attach proof of the current professional and liability insurance as per Chapter 246-335 WAC

Disclosure Statement – Attach a copy of the Disclosure Statement for the on-site Administrator/Director, Director of Clinical Services (Home Health or Hospice), or Supervisor of Direct Care Services (Home Care). Agencies must keep on file a current Disclosure Statement for the Administrator, Director of Clinical Services or Supervisor of Direct Care Services as stated in Chapter 246-335-021 (1)(c) and 246-335-030 (3) WAC. Current copies must be dated within 3 months of the initial application date.

Criminal History Background Check (CBC) – Attach a copy of the current CBC of the on-site Administrator, Director of Clinical Services (Home Health or Hospice), or Supervisor of Direct Care Services (Home Care). Agencies must keep on file a current CBC for the Administrator, Director of Clinical Services or Supervisor of Direct Care Services as stated in Chapter 246-335-025 (1)(c) WAC and Chapter 246-335-030 (3) WAC. Current copies must be dated within 3 months of the initial application date.

Mail this information to:

Department of Health

Revenue Section

PO Box 1099

Olympia, WA 98504-1099



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In-Home Services Application Checklist and Instructions

Please indicate type of application – new, change of ownership, amended or renewal

New – First time requesting an In-Home Services license. Consult fee schedule for fee amount required.

Change of Ownership – When name of legal owner/operator changes resulting from the sale of licensed agency. Consult fee schedule for fee amount required.

Amended – To request the addition of a Service Category (e.g. Home Care, Hospice, Hospice Care Center, Home Health); add or eliminate Service(s), change Accreditation information, add or eliminate a Service Area(s), change Administrator, Clinical Director or Direct Supervisor information, add Other Office Locations .

Renewal – To request the continuation of an existing In-Home Services License. Consult fee schedule for fee amount required.

Check One:

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

Section #1: Demographic Information:

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. City, county, and state government departments also have UBI#'s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/Master Business License.

Mailing Address: Enter the owner's complete mailing address.

Phone and Fax Numbers: Enter the owner's phone and fax number.

Email and Web Address: Enter the owner's email and agency Web addresses, if applicable.

Facility/Agency Name: Enter the agency's name as advertised on signs, brochures or Web site.

Physical Address: Enter the agency's physical street location including city, state, zip and county.

Phone and Fax Numbers: Enter the agency's phone and fax number.

Mailing Address: Enter the agency's mailing address, if different than physical address.

In-Home Services Agency License Application Checklist and Instructions (continued)

Section #2: Facility Specific Information:

A. Service Categories:

Please check all in-home service categories that apply.

Service Category: Enter the number of FTEs and beds by service category. Consult the fee schedule for the method to calculate the FTE number. Enter the number of beds authorized by the Certificate of Need and Construction Review Services.

B. Services Provided

Home Health Services: Please check all that apply.

Hospice Services: Please check all that apply.

Home Care Services: Please check all that apply.

Hospice Care Center Services: Please check all that apply.

Medicare Designation/Certification: Please check if agency is Medicare certified to provide Home Health or Hospice services. If check Yes , enter the corresponding provider number(s).

C. Accreditation Information

Agency 1 and 2: If your agency is accredited, please enter the name of the accreditation agency, the accreditation effective date, expiration date, and check the box for accreditation as a Home Health or Hospice agency.

D. Service Areas:

Check the service counties and service categories in which you deliver care to patients or clients. If you only deliver care in part of a county, attach a separate sheet describing the service area within the county. For Medicare, only check those counties that were authorized by Certificate of Need.

Section #3: Key Individuals:

Administrator: Enter the administrators name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

Clinical Director: Enter the directors name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

Direct Supervisor: Enter the supervisors name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

In-Home Services Agency License Application Checklist and Instructions (continued)

Section #4: Additional Information:

A. Other Office Locations:

Enter the name, street address, mailing address, phone number, fax number, email address, and on-site manager or supervisor name. Check the service categories provided from this location. If there are more than two locations, please attach additional sheets as needed. If this is a Medicare Branch Office, check the box.

B. AAA and/or DDD Contracts:

Check yes or no. If yes, please enter the contract dates, last monitoring survey and the agency who conducted the monitoring survey.

C. Legal Owner Information:

List the names, titles, addresses, and phone numbers of the corporate officers, LLC members, partners, individuals owning 10% or more of the agency. Attach additional sheet, if necessary.

D. Change of Ownership Information:

List the previous legal owner name, previous name of facility/agency, previous IHS license #, effective date of ownership change and physical address.

Signature:

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.



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Date Stamp Here

Revenue: 0597632360

In-Home Services Agency License Application

This is for: New Change of Ownership Amended Renewal

Check One

- | | | |
|--|---|---|
| <input type="checkbox"/> Association | <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Sole Proprietor |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Municipality (City) | <input type="checkbox"/> State Government Agency |
| <input type="checkbox"/> Federal Government Agency | <input type="checkbox"/> Municipality (County) | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership | |

1. Demographic Information

UBI #	Federal Tax ID (FEIN) #
-------	-------------------------

Legal Owner/Operator Name

Mailing Address

City	State	Zip	County
------	-------	-----	--------

Phone# ()	Fax# ()
------------	----------

Email Address	Web Address:
---------------	--------------

Facility/Agency Name (Business name as advertised on signs or Web site)

Physical Address

City	State	Zip	County
------	-------	-----	--------

Facility Phone# ()	Fax# ()
---------------------	----------

Mailing Address (If different than physical address)

City	State	Zip	County
------	-------	-----	--------

For Office Use Only

Credential # _____

2. Facility/Agency Information (check all that apply)

A. Check all service categories provided:

- Home Health Home Care
 Hospice Hospice Care Center

Service Category	FTEs	License Category	Beds
Home Health	_____	Hospice Care Center	_____
Hospice	_____		
Home Care	_____		

B. Check all services provided:

Home Health Services

- | | |
|--|---|
| <input type="checkbox"/> Skilled Nursing | <input type="checkbox"/> I.V. Services |
| <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Nutritional Counseling |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Bereavement Counseling |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Personal Care |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Homemaker/Chore |
| <input type="checkbox"/> Respiratory Therapy | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Medical Social Services | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Durable Medical Equipment | |

Hospice Services

- | | | |
|--|--|---|
| <input type="checkbox"/> Skilled Nursing | <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> I.V. Services | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Nutritional Counseling | <input type="checkbox"/> Spiritual Counseling |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Bereavement Counseling | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Personal Care | <input type="checkbox"/> Symptom & Pain Mgmt. |
| <input type="checkbox"/> Respiratory Therapy | <input type="checkbox"/> Homemaker/Chore | <input type="checkbox"/> Pharmacy Services |
| <input type="checkbox"/> Medical Social Services | | |

Home Care Services

- Personal Care
 Homemaker/Chore
 Respite Care
 Transportation

Hospice Care Center Services

- Continuous Care
 Routine Home Care
 General In-Patient Care
 In-Patient Respite Care

Is agency currently Medicare certified? Yes No

Home Health Provider # _____ Hospice Provider # _____

C. Check all service categories provided:

Accreditation Agency 1 _____	Accreditation Agency 2 _____
Effective Date _____	Effective Date _____
Expiration Date _____	Expiration Date _____

- Home Health Hospice Home Health Hospice

2. Facility/Agency Information (continued)

D. Requested Service Areas

County	Home Care	State Home Health	State Hospice	State Hospice Care Center	Medicare Home Health	Medicare Hospice	Medicare Hospice Care Center
Adams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asotin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chelan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clallam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Columbia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cowlitz	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Douglas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ferry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Franklin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Garfield	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grays Harbor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Island	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jefferson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
King	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kitsap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kittitas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Klickitat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lewis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lincoln	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Okanogan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacific	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pend Oreille	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pierce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SanJuan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skagit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skamania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snohomish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spokane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stevens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thurston	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wahkiakum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walla Walla	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whatcom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whitman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yakima	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Key Individuals

Administrator Name

Phone #

Fax #

Email Address

Hire Date

Direct Supervisor Name (Home Care)

Phone #

Fax #

Email Address

Hire Date

Clinical Director Name (Home Health, Hospice)

Phone #

Fax #

Email Address

Hire Date

4. Additional Information

A. Other Office Locations

Office Name

Medicare Branch Office? Yes No

Street Address

Mailing Address

City

Zip

County

Phone #

Fax #

Email Address

On-Site Manager or Supervisor

In-Home services categories provided from this location

Home Health Home Care Hospice Hospice Care Center

Office Name

Medicare Branch Office? Yes No

Street Address

Mailing Address

City

Zip

County

Phone #

Fax #

Email Address

On-Site Manager or Supervisor

In-Home services categories provided from this location

Home Health Home Care Hospice Hospice Care Center

B. Does agency have any of the following AAA and/or DDD contracts Yes No

If Yes, complete all that apply.

	Contract Dates	Last Monitoring Survey	By Whom
<input type="checkbox"/> DSHS Personal Care Program	_____ to _____	_____	_____
<input type="checkbox"/> DSHS Chore Services	_____ to _____	_____	_____
<input type="checkbox"/> DSHS Respite Program	_____ to _____	_____	_____
<input type="checkbox"/> DSHS / DDD	_____ to _____	_____	_____
<input type="checkbox"/> Other	_____ to _____	_____	_____

4. Additional Information (continued)**C. Legal Owner Information—attach additional sheets as needed**

List the names, titles, addresses, and phone numbers of the corporate officers, LLC members, partners, individuals owning 10% or more of the agency

Name	Address	Phone #	Title

D. Change of Ownership Information

Previous Name of Legal Owner

Previous Name of Facility/Agency

Previous IHS License #

Effective Date of Ownership Change

Physical Address

Signature

I certify that I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

Signature of owner/authorized representative

Date

Print Name

Print Title