

The licensure application must be completed in its entirety and submitted with all required fees. Incomplete submissions will be rejected.

GENERAL INFORMATION

An application for a hospice care program license may be made by an individual owner or administrative officer on behalf of a corporation or by its managing agents on whom rests responsibility for maintaining approved standards for the program.

The application shall be verified before an officer of the State authorized to administer oaths, by the individual, or by a member of the firm or association or an officer of the corporation making this application.

REQUIRED ATTACHMENTS

The following must be included with each application:

- Check or money order made payable to West Virginia Department of Health and Human Resources (WVDHHR) for a non-refundable license fee. Applicable fees are as follows:
 - a. Initial license fee - \$100.00
 - b. Change of Ownership fee - \$100.00
 - c. Renewal fee
 - i. Average yearly caseload of fewer than 10 patients - \$50.00
 - ii. Average yearly caseload of 10 or more patients - \$100.00
 - d. These licensing fees also apply to branch offices
- A copy of a valid Certificate of Need or a letter of exemption from the West Virginia Health Care Authority must be included for initial applicants.



Office of Health Facility
Licensure & Certification

HOSPICE CARE PROGRAM
LICENSURE APPLICATION

COMPLETE THIS APPLICATION AND RETURN TO:

Office of Health Facility Licensure & Certification
Attention: Medicare Program
408 Leon Sullivan Way
Charleston, WV 25301-1713
(304) 558-0050

LOG NUMBER _____
DATE _____

OFFICIAL USE ONLY

NOTE: This application can only be accepted if all required fields are completed and requested documentation is attached.

PROGRAM INFORMATION

Type of Application: Initial Change of Ownership Renewal

Operating Name: _____

Legal Name: _____

Physical Address: _____

Street Address

City

State

ZIP Code

Mailing Address: _____

Street Address

City

State

ZIP Code

Phone: () _____

Fax: () _____

E-mail Address: _____

Website URL: _____

BUSINESS INFORMATION

FEIN: _____

License Number: _____

Name of Lessor (or N/A): _____

Is there any direct or indirect financial interest of applicant with Lessor? Yes No N/A

If yes, please explain: _____

PROGRAM PERSONNEL

Name of Program Director: _____

Last

First

M.I.

Title of Program Director: _____ E-mail: _____

Name of Medical Director: _____



GOVERNING BODY MEMBER

Full Name: _____
Last First M.I.

Address: _____
Street Address

City State ZIP Code

Occupation: _____ **Position:** _____

APPLICANT

Date of Application: _____ **Title or Position:** _____
MM/DD/YYYY

If other than individual or administrative officer:

Name: _____

Address: _____
Street Address

City State ZIP Code

SIGNATURE

STATE OF WEST VIRGINIA

County of _____

_____, being by me duly sworn on his/her oath, deposes and says that he/she has read the foregoing application and knows the contents thereof: that the statements concerning the above named Center/Agency, therein contained, are correct and true of his/her own knowledge.

Signature of Applicant: _____

Subscribed and sworn to before me this _____ day of _____, 20_____.

Signature Notary Public

My Commission Expires: _____



GOVERNING BODY MEMBER

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address

City *State* *ZIP Code*

Occupation: _____ **Position:** _____

GOVERNING BODY MEMBER

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address

City *State* *ZIP Code*

Occupation: _____ **Position:** _____

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Full Name: _____
Last *First* *M.I.*

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Street Address

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Occupation: _____ **Position:** _____

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Full Name: _____
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City *State* *ZIP Code*

Occupation: _____ **Position:** _____

GOVERNING BODY MEMBER

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address

City *State* *ZIP Code*

Occupation: _____ **Position:** _____