State of Alaska

Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application

DUE DATE: 90 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE (AS 47.32.060)

Pursuant to the AS 47.32 Licensing Statute and the regulations of the Department of Health Health Facilities Licensing requirements (7 AAC 10 and 7 AAC 12).

This application can be used for initial licensure applications and biennial license renewals. Please check the appropriate box below to indicate the purpose of this application.

Type of License Applying for (select one)**:** ☐ Initial Provisional Licensing ☐ Biennial Renewal License

General Instructions:

1. Application should be complete, clear and legible. After this application is completed, it should be printed, signed in permanent ink and submitted to the State of Alaska, Health Facilities Licensing & Certification team. Contact info is located below.

2. If more space is needed, additional pages can be attached as necessary. This also applies to any information that does not fit within the given space and should indicate "see attached page #" or something similar.

3. This application must be executed and verified by the individual owner or by two officers in the case of a corporation, association or governmental unit or agency.

4. There are licensure fees associated with this application. Please see 7 AAC 12.615 for more information regarding the fees due for your facility. If there are any questions about these fees, please contact 907-334-2483.

5. A separate application is required for facility branches operated on separate premises if that facility operates under a separate license number. Separate applications are required for each individual facility that is licensed separately, even though ownership is the same.

1. FACILITY DEMOGRAPHIC

State Licensing Number: _____

Legal Name: _____

Doing Business as: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Primary Fax Number: _____ Secondary Fax Number: _____

Generic Email (*info@abcfacility.com*): _____

Other Locations Under Same Licensure:

Other locations under same licensure include facilities that are located in services area as the parent facility and shares administration, supervisors, and/or services with the parent facility on a daily basis.

Please provide the name and location of any secondary locations under the same established licensure:

Name: _____ Location: _____

Name: _____ Location: _____

Name: _____ Location: _____

2. ADMINISTRATION

Please provide the information below for all positions as they apply to your facility type.

a. **Administrator** (*for initial applications, attach resume as **Exhibit I***):

Name: _____ Title: _____

Direct Phone: _____ Fax: _____

Email: _____

b. **Medical Director / Director of Clinical Services (***for initial applications, attach resume as **Exhibit II***):

Name: _____ Title: _____

Direct Phone: _____ Fax: _____

Email: _____

c. **Supervising Nurse / Director of Nursing:**

Name: _____ Title: _____

Direct Phone: _____ Fax: _____

Email: _____

3. ACCREDITATION (if applicable)

Is the facility be fully approved by and accreditation organization? Yes*: ☐ No: ☐

If ***yes***, please provide the following information:

Accrediting Organization: _____

Date of last Accrediting Body Survey: _____ Type of Survey: _____

Date Accreditation Expires: _____ Frequency of Accreditation Cycle: _____

**Facilities with accreditation through a nationally recognized organization may be eligible to waive their biannual State licensing survey for the current/upcoming licensing period. To apply, and for more information, please see the State Licensing Survey Waiver Application attached at the end of this application.*

4. OWNERSHIP & CONTROL

Governmental: ☐ State ☐ Borough ☐ City/Community

Non for Profit: ☐ Church Operated or Affiliated ☐ Corporation

Proprietary: ☐ Individual ☐ Partnership ☐ Corporation

Other (please explain): _____

a. **Individual or Partnership Owned (list all persons who own the facility)**

Number	Name	Address
1.		
2.		
3.		
4.		

b. **Names under which person(s) in (a.) do business (other than the facility indicated on this application)**

Number	Name	Business
1.		
2.		
3.		
4.		

c. **Corporate Ownership**

Name of Corporation: _____

State where Parent Firm or Organization is Incorporated or Registered: _____

List title, name, and address of each corporate officer: _____

Number	Title	Name	Address
1.			
2.			
3.			
4.			

d. **List names and addresses of each shareholder holding more than 5% of shares OR ownership**

Number	Name	State of Residence	Percent of Shares
1.			
2.			
3.			
4.			

e. **If the property or building this facility is operating in is on a lease or rental agreement, please specify ownership.**

f. **Trust or Endowment Operated**

Trustee Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

g. **Have any of the individuals listed on under this section been convicted of a felony or two or more misdemeanors involving moral turpitude in the last 5 years?**

If *yes*, attach a list of names and explanations as **Exhibit III:** Yes: ☐ No: ☐

5. CRIMINAL BACKGROUND CHECKS

Does the facility have a system in place for performing criminal background checks in accordance with **AS 47.05** and **7 AAC 10.900 - 990** through the Alaska Background Check Program (BCP)?

Yes: ☐ No: ☐

6. INSURANCE

Does this facility have current Malpractice Insurance? Yes*: ☐ No: ☐

Company:_____

Address:_____

Expiration Date:_____

7. SUBUNITS & BRANCHES

Branch office is located in the same service area as the parent agency and shares administration, supervision, and service with the parent agency on a daily basis; a branch office **is not required to be separately licensed**.

Subunit is located outside the service area where the parent agency is located, and does not share administration, supervision, and services with the parent agency on a daily basis; a subunit must be separately licensed under this chapter. **A separate application must be submitted for each subunit**.

Does the agency have any subunits or branch offices? Yes: ☐ No: ☐

Provide the name and location of any subunits or branch offices of the hospice agency:

Name	Location	Subunit (Yes or No)	Branch (Yes or No)

8. TYPE OF HOSPICE AFFLIATION

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

☐ Other: _____

9. AUTHORITY & SUPERVISION

If the hospice has established lines of authority or supervision, provide an organization chart that provides the line of authority or supervision.

If yes, attach chart and explanation as **Exhibit VI**.

10. ADMINSTRATIVE (Full-Service Hospice Only - as of completion date of this application)

Does the agency have a governing body? ☐ Yes ☐ No

Does the agency have a quality assurance & risk management program? ☐ Yes ☐ No

Does the agency have a program director? ☐ Yes ☐ No

Does the agency maintain client records per **7 AAC 12.339(a)-(e)**? ☐ Yes ☐ No

Does the agency have an orientation & staff development program for all staff?	☐ Yes	☐ No
Does the agency maintain records of licensure of all professional employees?	☐ Yes	☐ No
Does the agency have a registered nurse who coordinates therapeutic services?	☐ Yes	☐ No
Does the agency have an interdisciplinary team?	☐ Yes	☐ No

Provide a list of disciplines:

11. CLIENT CENSUS INFORMATION (if this is an initial application, skip this section)

Provide number of clients (unduplicated admissions) served during the last full calendar year (from January 1 through December 31):_____

Number of clients served in all age categories below for the last full calendar year (as indicated above):

	Under 5	5-17	18-44	45-64	65-74	Over 75	Total
Males							
Females							
Total							

During the time period indicated above, provide the following information:

Admitted _____ Discharged _____ Clients Terminated _____

Deceased _____ Respite Days _____ Acute Care Days _____

Highest Client Count _____ Lowest Client Count _____ Average Client Count _____

12. PERSONNEL/STAFFING

Provide full time equivalents (FTEs), part time equivalents (PTEs) & paid volunteers (PVs) for the following staffing areas.

*Vacancies: The total number of FTE's & PTE's MUST include any vacant positions. A vacancy does not reduce the total number of positions.

If you indicate vacancies, please provide a yes or no response to the "actively recruiting" and "qualified person acting" column.

Positions	FTE	PTE	PV	Vacancies*	Actively Recruiting (Yes or No)	Qualified Person Acting (Yes or No)
Administration						
Medical Director						
Physician or PAC						
R.N.						
LPN						
Nurse Practitioner						
Physician Assistant						
Home Health Aide						
Personal Care Attendant						
Dietitian						
Occupational Therapist						
Physical Therapist						
Speech Pathologist						
Audiologist						
Medical Social Worker						
Health Care Professional						
Non-Health Care Professional						
Total					N/a	N/a

13. VOLUNTEERS

This section refers to volunteers providing care or services not requiring licensure and not listed in Section 12 – Personnel/Staff above.

Number of Volunteers: _____

Total combined volunteer hours of care & services provided per week (approximate hour):_____

14. ADMINSTRATOR'S AFFLICATIONS

Does the administrator have other affiliations with a licensed home health, hospice, hospital, or nursing home?

☐ Yes (If yes, provide information below) ☐ No

Facility Name:	Address:

15. SOURCES OF INCOME

Provide the information as requested below for source(s) of income:

Sources	Percentage	Income
Medicare Part A		
Medicare Part B		
Medicaid		
Third Party Payers (Health Insurance, VA, Workers Comp, ect.)		
Fees from Patients		
Other (Grants, Contributions, Bequests, Fund Raising, ect)		
Total	100%	

16. SERVICES (attach additional sheet if more space is needed

Service Category	Services Provided		Name of Outside Contractor
Physician Services*	☐ Direct	☐ Contract	_____
Nursing Services*	☐ Direct	☐ Contract	_____
Social Services*	☐ Direct	☐ Contract	_____
Pastoral Counseling*	☐ Direct	☐ Contract	_____
Bereavement Counseling*	☐ Direct	☐ Contract	_____
Dietary Counseling*	☐ Direct	☐ Contract	_____

Short-Term Inpatient (respite)**	☐ Direct	☐ Contract	_____
Shor-Term Inpatient (acute)**	☐ Direct	☐ Contract	_____
Aide Service	☐ 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	_____
Personal Care	☐ Direct	☐ Contract	_____
IV Infusion	☐ Direct	☐ Contract	_____

*Services required to quality as Full-Service Hospice

** Short-Term inpatient care can only be provided in a licensed hospital or skilled nursing facility.

Contracts must be available for review by the Department staff at the time of licensure survey.

17. GEOGRAPHICAL AREA SERVED

Please describe the geographical area served by the agency. Provide specific areas or regions. The Department will not accept descriptions such as “Southeast Alaska” or “South Central Alaska”:

18. COMPLIANCE AGREEMENT

A. Volunteer Hospice Agency Only

7 AAC 12.317. Scope of service: volunteer hospice agency.

(a) Subject to (b) of this section, a volunteer hospiceagency shall provide each of, and only, the following services:

(1) direct service volunteers;

(2) spiritual and emotional support services to the client, the client's family, and caregivers if these services aredesired during the time the client is receiving hospice care;

(3) supervision, orientation, and training to direct service volunteers and other hospice staff;

(4) bereavement counseling services to assist the client's family and caregivers in coping with grief experiencedafter the client's death; and

(5) volunteer services in accordance with **7 AAC 12.336**.

(b) A volunteer hospice agency may provide short-term respite care to the client's family for the relief of the client's daily care.

(c) A volunteer hospice agency shall investigate, analyze, and respond to client grievances related to client care.

(d) A volunteer hospice agency shall ensure that each client has a plan of care approved by the attending physician or advanced nurse practitioner, and by the program manager.

(e) A volunteer hospice agency shall develop and implement written policies and procedures consistent with this chapter that govern each service provided by the agency, including policies relating to confidentiality, training, and admissions. The policies and procedures must accurately describe the agency's goals, the methods by which the goals are achieved, and the mechanisms by which basic hospice care services are delivered. The agency must review its policies and procedures at least annually. The program director shall document each review by dating and signing an attestation. The agency shall revise its policies and procedures if determined necessary by the agency or by the department to ensure that each policy and procedure iscurrent and adequate for purposes of carrying out the agency's functions and maintaining consistency with this chapter.

(f) Volunteer services in a volunteer hospice agency must be directed by a coordinator of volunteer services who shall.

(1) implement a direct service volunteer program;

(2) coordinate the orientation, education, support, and supervision of direct service volunteers; and

(3) coordinate the use of direct service volunteers with other hospice staff and community resources.

DOES THE VOLUNTEER HOSPICE AGENCY MEET ALL THE ABOVE SCOPE OF SERVICE REQUIREMENTS?

☐ Yes ☐ No*

***If not please provide an explanation on a separate sheet as Exhibit V**

B. Full-Service Hospice Only

7 AAC 12.316. Scope of service: full-service hospice agency.

(a) A full-service hospice agency shall provide
- (1) physician or advanced nurse practitioner services to provide directed medical care that meets the client'smedical needs for palliative care and management of terminal illness;
- (2) nursing care and services provided by or under the supervision of a registered nurse;
- (3) social work services provided in accordance with
- (4) spiritual and emotional counseling services in accordance with **7 AAC 12.337** to the client, the client's family,and caregivers if these services are desired during the time the client is receiving hospice care;
- (5) bereavement counseling services in accordance with **7 AAC 12.337** to the client's family and caregivers afterthe client's death;
- (6) volunteer services in accordance with **7 AAC 12.336;**
- (7) dietary counseling services in accordance with **7 AAC 12.337;**
- (8) pharmaceutical hospice services in accordance with **7 AAC 12.343;**
- (9) services related to the referral and transfer of clients for laboratory services that are provided by an organization other than the hospice; the referral and transfer services must be provided in accordance with a written plan that delineates available services and the procedures for referring and transferring clients;
- (10) services related to the transfer of specimens for laboratory services that are provided by an organization other than the hospice; the transfer services must be provided in accordance with a written plan that delineates available services and the procedures for transferring specimens; and
- (11) short-term respite care to the client's family for the relief of the client's daily care.

(b) In addition to meeting the requirements of (a) of this section, the hospice agency shall evaluate each client's
- (1) access to emergency medical services, including ambulance service;
- (2) access to service, equipment, and supplies;
- (3) safety and emergency preparedness within the client's place of residence.

(c) The hospice agency shall make nursing services, physician or advanced nurse practitioner services, and drugs and biologicals available on a 24-hour basis to the extent necessary to meet the client's needs for palliative care and management of terminal illness and related conditions.

(d) The hospice agency shall arrange for short-term inpatient care if home care is not feasible for pain control, symptom management, and respite purposes. The agency shall ensure that any short-term inpatient care is provided in a licensed facility that is most appropriate to meet the client's needs.

(e) The hospice agency shall offer hospice care in the least costly setting that can assure the quality of care and eachtype and amount of service that is necessary to meet the client's needs.

(f) The hospice agency shall have a risk management program that includes procedures to investigate, analyze, and respond to client grievances related to client care.

(g) The hospice agency shall develop and implement written policies and procedures consistent with this chapter that govern each service provided by the agency, including policies relating to confidentiality, training, and admissions. The policies and procedures must accurately describe the agency's goals, the methods by which the goals are achieved, and the mechanismsby which basic hospice care services are delivered. The agency shall review its policies and procedures at least annually. The program director shall document each review by dating and signing an attestation. The agency shall revise its policies and procedures if determined necessary by the agency or by the department to ensure that each policy and procedure is current and adequate for purposes of carrying out the agency's functions and maintaining consistency with this chapter.

DOES THE FULL-SERVICE HOSPICE AGENCY MEET ALL THE ABOVE SCOPE OF SERVICE REQUIREMENTS?

☐ Yes ☐ No*

***If not, please provide an explanation on a separate sheet as Exhibit VI**

State of Alaska

Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application

This form must be completed to finalize the transaction.

Licensing renewal fee amounts can be reviewed under **7 AAC 12.615.** For more information or for assistance calculating the fees for your facility, please contact HFLC at 907-334-2483 or by email at dhcs.hflc@alaska.gov

We accept payments by **check** and **credit card**.

To make a credit card payment by phone: **Call 907-334-2400, opt. 3**. You will be asked to provide the full facility name, state licensing number, and exact payment amount.

State Licensing Number: _____

Facility Type: Select One **Payment Type:** Select One

Facility Name: _____

Facility Contact: _____ **Phone:** _____

Payment Amount (includes licensing and bed / branch fees if applicable): $ _____

Date of Credit Card Payment (indicated the date you made a payment by phone): _____

Payment by Check: **Check #**: _____ **Check Date**: _____

Make Checks Payable to: State of Alaska – HFLC

HFLC Mailing/Physical Address:
State of Alaska
Health Facilities Licensing & Certification
4601 Business Park Blvd. Bldg. K
Anchorage, AK 99503

For State of Alaska Accounting Use ONLY

DEPT: 06 **FUND**: 1004 **UNIT**: 4011 **APPR**: 062330704 **REVENUE**: 5101

Activity: ☐ 4HF0 - License/Renewal Fee ☐ 4HF1 - Revisit ☐ 4HF2 - Modification ☐ 4HF3 - Fine

Payment Received on: _____ Check # / CC Auth#: _____

Payment Received & Coded by: _____

Notes/Comments: _____

19. ATTESTATION

The applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that the contents of this application and the information provided with it are true, accurate, and complete.

In addition, the applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that he or she has reviewed the regulatory requirements contained in **7 AAC 10.900 - 990** (Barrier Crimes, Criminal History Checks, and Centralized Registry), **7 AAC 10.9500 - 9535** (General Variance), **7 AAC 10.9600 - 9620** (Inspections and Investigations), the applicable requirements of **7 AAC 12.310 - 349** (Hospice Agencies) and the applicable requirements of **7 AAC 12.600 - 990** (General Provisions).

The undersigned give assurance that the facility is in compliance to the best of his/her knowledge, and he/she is prepared for an on-site inspection to validate compliance.

Printed Administrator or Designee Name:_____ Date:_____

Signature of Administrator or Designee:_____

Submit this application and all required attachments via mail, hand delivered, faxed or email:

Health Facilities Licensing & Certification
4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503

Phone: (907) 334-2483 **Fax**: (907) 334-2682

Email: dhcs.hflc@alaska.gov

State of Alaska

Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application

State Licensure Survey Waiver Application

Facilities with accreditation through a nationally recognized organization may be eligible to waive their biannual State licensing survey for the current/upcoming licensing period. To learn more about the survey waiver an eligibility, please referto **7 ACC 12.925** and **AS 47.32.030(a)(9)(A-C).** To apply, please provide the following information.

Facility Type: Select One AK License Number: _____

Facility Name: _____

Satellite Locations: Yes*: ☐ No: ☐ (*if yes, inspection reports for those sites are also required)

Physical Address: _____

Mailing Address: _____

Primary Phone: _____ Primary Fax: _____

Email for facility distribution list: _____

Administrator: _____ Administrator's Phone: _____

Administrator's E-Mail: _____

Secondary Contact _____ Title: _____

Secondary's Phone _____ Secondary's E-Mail: _____

Name of Accrediting Organization (AO): _____

Date of last inspection: _____ Frequency of accreditation cycles: _____

Were any deficiencies identified during last inspection? *Yes: ☐ No: ☐

*If yes, have the deficiencies been corrected? Yes: ☐ No: ☐

For surveys conducted in the past 2-3 months, in which the facility has not received the report or have an approved plan of correction – when do you expect to receive these documents? _____

Name of Person Completing Form: _____ Date: _____

*****A copy of your last inspection report and plan of correction MUST be submitted with the application or the waiver will be denied*****

FOR DIVISION USE ONLY

Date Application Received: _____ All attachments included: Yes: ☐ No: ☐

Application Reviewed by: _____ Date Reviewed: _____

Application is: Approved: ☐ Denied*: ☐

Reason for Denial: _____

Signature: _____ Date: _____