STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND CERTIFICATION
-

Medical Facilities Unit – Acute Care

Home Health Care Services Agency

SECTION 1: Agency Information			
Agency Name:			
Doing Business As:			
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: ( )		Fax No. (Indicate none if none: ( )	
Administrator's Email Address:			

SECTION 2: Fees	
APPLICATION FOR HOME HEALTH CARE SERVICES AGENCY	
License Type: ☐ Initial Application (fee $300) Non-refundable ☐ Renewal Application (fee $600) Non-refundable License Renewal Period (dates): _____ to	 $ _____ $ _____
Make checks or money orders payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. **Total Checks/Money Orders enclosed =**	**$ _____**

For questions regarding this program and/or application, please contact the following:
Department of Health and Human Services
Licensing and Certification
Medical Facilities – Acute Care Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-9252 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: dlrs.medfacilities@maine.gov

Office Use Only:
Check# _____ MO # _____ Amount $_____ Initials: _____ License# _____

SECTION 3: Ownership Information (Use additional sheets, if necessary)

Type of Entity:

☐ Sole Proprietorship (complete section A)

☐ Partnership (complete section B)

☐ Other: _____

☐ Corporation (complete section C)

☐ Not-for-Profit (complete section D)

A. Sole Proprietorship

Owner Name:			
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: ( )	ID# (Owner SSN or EIN#):		

B. Partnership

List the names and addresses of partners or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5% or more in the disclosing entity. Indirect ownership interest is ownership interest in an entity that has an ownership in any entity higher in a pyramid than the disclosing entity.

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____

C. Corporation

List the names, address and titles of the Officers and Directors.

Officer Name	Title	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Director Name	Title	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Not-for-Profit

List the name and address of the President of the Board of Directors or the appropriate Municipal Government Representative.

Name Address

_______________________________________ ____

_______________________________________ ____

SECTION 4: Facility Information (Use additional sheets, if necessary)

Name of Person in Charge:	Title:
Home Address:	

City:	State:	Zip:	County:

Home Telephone No.: ( )	Office Telephone No.: ( )

Home Health Care Service Operation Date:

Date that this program has been open since: __________

Date that this program is scheduled to open: __________

Geographic Area (Please list Counties)Served:____

ψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ____

List all locations used by the agency and indicate if they are a branch or drop site:

Primary location owned or leased? Owned ___ Leased ___

Name of Owner of Building Address
Telephone Number

1. ____ ____
____ ____

2. ____ ____
____ ____

3. ____ ____
____ ____

Services Provided: Please select all that apply and indicate when each service was started.

- ☐ Skilled Nursing ________
- ☐ Speech Pathology ________
- ☐ Physical Therapy Services ________
- ☐ Occupational Therapy Services ________
- ☐ Medical Social Work ________
- ☐ Home Health Aide ________
- ☐ Certified Nursing Assistant ________
- ☐ Other: ______________________ ________

Full-Time Equivalent Staff: All employees of the Home Health Care Service Provider, including administrative, business, clerical and direct service providers, must be included in the calculation of this figure. A full-time equivalent employee is one or more individuals who is/are employed on the basis of at least 37 ½ hours per week for the home health agency. Both individuals directly employed and those contracted by the agency shall be counted in the calculation of the agency's full-time equivalency figure.

How many full-time equivalent staff are employed by the agency? _________________

Name of Director of Nursing: ____

Accreditation: Please select all Accreditation Organizations that this Home Health Agency is accredited by.

☐ Joint Commission ☐ CHAPS ☐ Other: _____

☐ Federal Deemed Status Dates: _____

Directions to the Agency: Please be specific; draw/provide a map if possible.

_____

_____

_____

_____

_____

SECTION 5: Submission

Submit your completed application with the following:

- A check or money order made payable to "Treasurer, State of Maine"
- A copy of any and all leases, if the building(s) used is leased.
- Letter(s) from the appropriate Municipal Official(s) that demonstrates compliance with all Local Ordinances relative to zoning and building code regulations. Applicable for Initial applicants or if you have moved since your last renewal.

In addition, first time applicants must also submit:

- Financial Feasibility Plan, to include, two (2) year projection of operating and non-operating expenses; evidence of the availability of financing to include cash flow, salaries, etc.
- Marketing Plan, to include, a description of the market area, size of the market and estimated growth, estimate of potential clients and competitors.

SECTION 6: Declaration

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge. I have read and understand the notice of successor liability included with this application.

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, _____, being duly authorized to assume responsibility for the conduct of the agency herein described, do hereby apply for a license to operate the agency and do agree to assume responsibility that the facility will comply with all current regulations of the Department of Health and Human Services, as authorized by Title 22, MRSA Chapter 1681, Sections 8621-8631.

_____	_____	_____
Print name of Administrator	**Signature of Administrator**	**Date**

Notice of Successor Liability

As required by 22 M.R.S.A. § 1714-A(4), the Division hereby provides written notice of successor liability regarding debts owed the Department.

Successor Liability

When a nursing home, boarding home, hospital or other provider of health care services is transferred, the transferee is liable for debts owed to the Department by the former provider unless by the time of sale:

> *(1) All debts owed by the former provider to the Department have been paid, except as stated in subparagraph (2);*
>
> *(2) If the indebtedness is the subject of an administrative appeal, an escrow account has been created and funded in an amount sufficient to cover the debt as claimed by the Department; or*
>
> *(3) An interim cost report has:*
>
> > *(a) Been filed and an escrow account has been created and funded in an amount sufficient to cover any overpayment identified in the report; or*
> >
> > *(b) Not been filed and an escrow account has been created and funded in an amount sufficient to cover 5% of Medicaid reimbursement or cost reimbursement for the last fiscal year or $50,000, whichever is less.*

Any transferee may request that the Department identify the amount of any debt owed by a nursing home, boarding home, hospital or other provider of health care services. When the Department receives such a request, it shall identify the debt within 30 days. Failure to identify the amount of a debt when a request is made in writing at least 30 days prior to the transfer precludes the Department from recovering that debt from the transferee.

If a transferee becomes liable for a debt, the transferee shall succeed to any defenses to the debt that could have been exercised by the former provider.

Liability of a transferee does not limit the liability of the former provider to the department for any debts whether or not they are identified at the time of sale. In addition, a transferee has a cause of action against a former provider to the extent that debts of the former provider are paid by the transferee, unless the transferee has waived the right to sue the former provider for those debts.

Questions about this notice or a request to identify the amount of any debt owed by a nursing home, boarding home, hospital or other provider of health care services should be directed to the following person:

Jonah Howard, Manager
MaineCare & Social Service Recovery
SHS#11
DHHS Financial Service Center
Augusta ME 04333-0011