Oregon Health Authority

Hospice License Application

TYPE OF ACTION

* Fee payment required (See fee schedule) **Requires Public Health Division pre-approval	
New hospice*: ☐	License renewal* : ☐ License #: _____ Average daily census: _____
Related information:	CMS Certification Number (CCN) #: _____ Is hospice accredited? ☐ Yes ☐ No
	Accrediting agency _____ Effective date _____ Is hospice deemed? ☐ Yes ☐ No

Change request	Eff. date of change	Change request	Eff. date of change
☐ Name ☐ Address		☐ Service area**	
☐ Ownership*		☐ Administrator	
☐ Add/remove Multiple Location Office (MLO)**		☐ Other (specify):	

HOSPICE INFORMATION

Hospice legal name:		
Hospice DBA name (if applicable):		
Hospice physical address, city, state & ZIP:		
Phone:	Fax:	County:
Hospice mailing address (if different from above):		
Name of administrator:		Phone:
Administrator email:	Hospice email:	
Ownership type: Corporation ☐ Partnership ☐ Sole proprietor ☐ Other ☐ Specify: _____		
Tax status: Profit ☐ Non-profit ☐ Tax ID #:		
Name of owner(s):		
Address, city, state & ZIP of owner(s) – attach additional pages if necessary.		
Phone:	FAX:	County:

Emergency contact name:	Phone:
Describe the geographic service area for this hospice:	

SERVICES AND STAFFING

- Indicate number of individuals for each category as applicable in columns 3, 4, and 5

Core services	Staffing	Number of employees	Number of staff under contract or arrangement	Number of volunteers
Physician services				
Nursing services	*Registered Nurses (RNs)*			
	Licensed Practical Nurses (LPNs)			
Medical Social Service (MSS)	*Masters prepared Social Worker (MSW)*			
	Qualified Bachelors prepared Social Worker(s)			
Counseling services - bereavement	*Qualified bereavement professional*			
Counseling services - dietary	*Qualified registered dietician or nutritionist*			
Counseling services - spiritual	*Clergy, pastoral counselors, or other(s)*			
Other required services	Staffing	Number of employees	Number of staff under contract or arrangement	Number of volunteers
Physical Therapy (PT)	Licensed Physical Therapists (LPTs)			
	Licensed Physical Therapist Assistants (LPTAs)			
Occupational Therapy (OT)	Licensed Occupations Therapists (OTs)			
	Licensed Occupational. Therapist Assistants (COTAs)			
Speech Therapy (ST)	Licensed Speech Pathologist (SLPs)			
Hospice Aide services	Qualified Hospice Aide(s)			
Homemaker services	Qualified Homemaker(s)			

MULTIPLE LOCATION OFFICE (MLO) OPERATIONS

- List required information for each MLO; List additional locations on a separate page; Indicate 'A' if adding, 'R' if removing, or 'N' if no change

Enter A, R, or N	Address	Phone	Distance from primary hospice
choose one			
choose one			

I declare, under penalties of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct and complete. I will notify the Health Care Regulation and Quality Improvement Section, in writing, of any changes in this information as required.

Administrator's signature _____ ***Name (please print)*** _____

Title (please print) _____ ***Date (mm/dd/yyyy)*** _____

HCRQI office use only

Initial licensure: ☐ Eff. date: _____ Initials: Date:

Renewal licensure/change: ☐ ☐ Approved ☐ Denied ☐ Withdrawn Initials: Date:

CASH OFFICE:	QC Initial - **617**	QC Renewal - **618**	Index - **50202**	PCA - **51042**

The Hospice Oregon Administrative Rules, forms, and other related information may be found on the HCRQI website at: www.healthoregon.org/hcrqi

ALL APPLICATION FEES ARE NON-REFUNDABLE

FEE SCHEDULE	HOSPICE
New	$1,140.00
Annual renewal	$1,140.00
Change of ownership	$1,140.00

Make check payable to Oregon Health Authority and mail to:
Health Care Regulation and Quality Improvement
PO Box 14260
Portland, OR 97293-0260

NEW HOSPICE APPLYING FOR INITIAL LICENSURE MUST COMPLETE REMAINDER OF PAGE AND SUBMIT WITH APPLICATION PACKET

Initial (new hospice) Licensure Application Checklist

☐ Complete the Hospice License Application form.

☐ Include a check or money order for $1,140.00 payable to the "Oregon Health Authority".

☐ Include a résumé for your administrator: Please ensure that your administrator's résumé meets the following requirements:

- Must be current.
- Must include employer names and locations, dates of employment including month and year, title of positions held, and duties performed.
- Must show evidence that the administrator is a hospice employee who possesses the education and experience required by the hospice governing body as required by CFR 418.100.
- A job description which reflects the governing body approved education and experience qualifications must accompany the résumé.

☐ Develop agency specific policies and procedures, forms, curriculums to address and ensure compliance with the Hospice OARs, Division 35. Include a sampling of those policies and procedures that demonstrate compliance with the following requirements:

- CFR 418.52 Patient's Rights
- CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services
- CFR 418.100 Organization and Administration of Services

☐ Send all documents above to: HCRQI, PO Box 14260, Portland, OR 97293 to attention of the Hospice Program. Please do not send in partial applications or incomplete documentation.

Health Care Regulation and Quality Improvement
Phone: 971-673-0540 Fax: 971-673-0556

PRINT FORM