GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION

APPLICATION INSTRUCTIONS AND FORMS FOR A LICENSE TO OPERATE A HOME CARE AGENCY IN THE DISTRICT OF COLUMBIA

The information below consists of instructions for completing the application package. Please follow them carefully.

COMPLETING THE LICENSING APPLICATION

Section A. *Residence Name/ Demographic*

Enter the legal name (individual or corporation) of the residence exactly as it should appear on the license. Also, enter the name of the contact for the application process. All applicants or persons with oversight and/or day-to-day responsibilities must be at least 21 years of age.

Section A1. *Addresses of the HCA*

Enter the street and mailing addresses of the HCA, to include city, state, zip code, telephone number and email address.

Section B. *Type of Application*

Identify the type of application by checking the appropriate brackets on the application.

Section C. *Services Provided*

Identify all of the service (s) that applies by checking the bracket (s).

Section D. *Application/Owner Information*

Enter information on business operations of the HCA. Provide all applicable data

Section E. *Director's information*

Provide the Director's resume and a copy of all professional licenses and certifications.
DCMR Title 22 Chapter 39 requires that:

- 3904.1- The governing body shall appoint a Director who shall be responsible for managing and directing the agency's operations, serving as liaison between the governing body and staff, employing qualified personnel, and ensuring that staff members are adequately and appropriately trained.

- 3904.2 The Director shall be a person who:

    1. Is a licensed physician;
    2. Is a licensed registered nurse; or
    3. Has training and experience in health services administration, including at least one (1) year of supervisory or administrative experience in home health care or related health programs.

Section F. *Affidavits*

Submit a signed and notarized application.

Additional Application Forms*

Additional required forms to complete this licensure process include the following:

- A Certificate of Occupancy
- A Certificate of Need
- A completed, signed, dated and notarized Application
- Cleans Hands Act Certificate
- Current Health Certificate for the Director
- Proof of Criminal Background Check for the Director
- Verification of Insurance
- Reference Letters (3) for the Director
- Corporation Form(s), if applicable
- Original Copy of the Certificate of Good Standing

***Please see and use the HCA Checklist that has been included as a tool to assist you with the completion of the application package process.**

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Home Care Agencies (HCAs) License Application

Please type or print in ink.

A. AGENCY INFORMATION

Name of Agency	**Telephone No.**	**Fax No.**
Agency Street Address	**City**	**Zip Code**
Mailing Address (If Different from Street Address)	**City**	**Zip Code**

Contact Person for this Application:

Address	**City/State/Zip**	**Telephone No.**	**E-Mail Address**

B. TYPE OF APPLICATION

[ ] Initial Application **[ ] Renewal Application** **[ ] Change of Ownership**

Number of Patients _____

C. SERVICES PROVIDED: (Please check all that apply)

[ ] Occupational Therapy
[ ] Personal Care Aide Services
[ ] Home Health Aide Services
[ ] Intravenous Therapy
[ ] Medical Social Services
[ ] Other (specify) _____

[ ] Chore Services
[ ] Physical Therapy
[ ] Homemaker Services
[ ] Skilled Nursing
[ ] Speech Language Pathology

D. APPLICANT/OWNER INFORMATION

Applicant is a (n)
[ ] Individual
[ ] Limited Partnership
[ ] General Partnership
[ ] Corporation
[ ] Other (Specify) _____.

If the applicant is a limited partnership corporation, list the names, document number, and federal identification number registered with the District of Columbia, Division of Corporations within the Department of Consumer and Regulatory Affairs.

Name of Limited Partnership/Corporation

Address

Document Number **Federal Employer Identification Number**

If a limited partnership/corporation, please attach a current copy of your Certificate of Good Standing issued by the Division of Corporations within the Department of Consumer and Regulatory Affairs.

Is the Corporation _____ for Profit? _____ Not for Profit?

Are the property and building(s) _____ owned by the applicant? _____ Leased or rented? If leased or rented, who is the property owner(s)?

Name **Address** **City/State/Zip** **Telephone No.**

Is the agency to be managed by someone other than the applicant? ____ Yes _____ No, if yes, Provide the name of the management company/individual:

Name **Address** **City/State/Zip** **Telephone No.**

Complete the following information on each corporate office, director, individual owner, and partner. Attach additional pages if necessary.

If the applicant/owner is a corporation, complete items 1 thru 7 as applicable.

1.

Corporate President	**Mailing Address/City/State/Zip**	**Telephone No.**

2.

Corporate Vice-President	**Mailing Address/City/State/Zip**	**Telephone No.**

3.

Corporate Secretary	**Mailing Address/City/State/Zip**	**Telephone No.**

4.

Corporate Treasurer	**Mailing Address/City/State/Zip**	**Telephone No.**

5.

Director	**Mailing Address/City/State/Zip**	**Telephone No.**

6.

Director	**Mailing Address/City/State/Zip**	**Telephone No.**

7.

Director	**Mailing Address/City/State/Zip**	**Telephone No.**

If the applicant(s)/owner(s) is an/are individual(s), complete items 8 thru 11 as applicable.

8.

Individual Owner	**Mailing Address/City/State/Zip**	**Telephone No.**

9.

Individual Owner	**Mailing Address/City/State/Zip**	**Telephone No.**

10.

Individual Owner	**Mailing Address/City/State/Zip**	**Telephone No.**

11.

Individual Owner	**Mailing Address/City/State/Zip**	**Telephone No.**

If the applicant/owner is a general or limited partnership, or other type of ownership, complete items 12 thru 14 as applicable.

12.

Partner Other (specify)	DOB	Telephone No.	
Mailing Address	**City**	**State**	**Zip**

13.

Partner Other (specify)	DOB	Telephone No.	
Mailing Address	**City**	**State**	**Zip**

14.

Partner Other (specify)	DOB	Telephone No.	
Mailing Address	**City**	**State**	**Zip**

E. DIRECTOR'S INFORMATION

First Name	Middle Initial	Last Name

What date did the above person begin employment with the facility as the director?

_____

Is the Director a licensed physician? _____ **YES** _____ **NO**

Is the Director a licensed registered nurse? _____ **YES** _____ **NO**

Does the Director have training and experience in health services administration, including at least one (1) year of supervisory or administrative experience in home health care or related health programs? _____ **YES** _____ **NO**

Please attach a copy of the Director's resume that includes the Director's professional work history and educational background.

Will the director be serving as director of more than this HCA? **_____ YES** **_____ NO**

IF yes, provide the name of the other facilities:

Name of Facility _____ **License Number** _____

Name of Facility _____ **License Number** _____

F. AFFIDAVIT NOTE: This application must be signed and notarized

I hereby swear that the statements in this application and its attachments are true and correct, and understand that providing false or misleading information may result in a fine, denial, suspension, or revocation of this license.

_____
(Signature of Applicant)

_____
(Title)

Sworn to (or affirmed) and subscribed before me this _____ day of _____, _____

By _____
(Name of Applicant)

_____
(Signature of Notary Public)

_____
(Notary Public Seal)

Personally Known or Produced Identification _____

Type of Identification Produced _____