# In-Home Services License Application Packet

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## In order to process your request:

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health
PO Box 1099
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

In-Home Service Credentialing
PO Box 47877
Olympia, WA 98504-7877

## Contact us:

360-236-4700

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# Application Instructions Checklist

When your application for In-Home Services Agency License is received by the Department of Health (DOH), it will be reviewed and you will be notified in writing of any outstanding documentation needed to complete the process.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

Indicate type of application—new, change of ownership, amended or renewal.

- **New**—First time requesting an In-Home Service Agency license.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of a licensed In-Home Service Agency.
- **Amended**—To request the addition of a Service Category (e.g. Home Care, Hospice, Hospice Care Center, Home Health); add or eliminate Service(s), change Accreditation information, add or eliminate a Service Area(s), change Administrator, Clinical Director or Direct Supervisor information, add Other Office Locations.
- **Renewal**—To renew an existing In-Home Services License.

☐ **Check One:** Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ **Application Fee:** You can check the online **fee page** for current fees.

☐ **1. Demographic Information:**
**Uniform Business Identifier Number (UBI #):** Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

**Federal ID Number (FEIN #):** Enter your Federal ID Number, if the business has been issued one.

**Legal Owner/Operator Name:** Enter the owner's name as it appears on the UBI/Master Business License.

**Mailing Address:** Enter the owner's complete mailing address.

**Phone and Fax:** Enter the owner's phone and fax numbers.

**Email and Web Address:** Enter the owner's email and facility Web addresses, if applicable.

**Facility/Agency Name:** Enter the doing business as name. Name used on advertising, signs, and web sites.

**Physical Address:** Enter the facility's physical street location including city, state, zip code, and county.

**Phone and Fax Numbers:** Enter the agency's phone and fax number.

**Mailing Address:** Enter the agency's mailing address, if different than physical address.

☐ **2. Facility Specific Information:**

**A. Service Categories: Please check all in-home service categories that apply.**

**Service Categories of Home Care, Home Health, and Hospice:** Enter the number of Full Time Equivalents (FTEs). To calculate FTEs, an example would be, take your agency's total labor hours for one year and divide that number by 2080.

**Service Categories of Hospice Care Center:** Enter the number of licensed beds authorized by the Certificate of Need and Construction Review Services.

**B. Services Provided:**

**Home Care Services:** Please check all that apply.

**Home Health Services:** Please check all that apply. You must choose at least two home health services before you may provide home care services.

**Hospice Services:** Please check all that apply.

**Hospice Care Center Services:** Please check all that apply.

**C. Medicare Designation/Certification:**
Please check if agency is Medicare certified to provide Home Health or Hospice services. If check Yes, enter the corresponding six character provider number(s). In Washington this provider number always begins with 50. If you do not know your six character provider number, please contact your Medicare Fiscal Intermediary.

**AAA and/or DDD Contracts:**
Check yes or no. If yes, please enter the contract dates, last monitoring survey and the agency who conducted the monitoring survey.

**Accreditation Information:**
Agency 1 and 2: If your agency is accredited, please enter the name of the accreditation agency, the accreditation effective date, expiration date, and check the box for accreditation as a Home Health or Hospice agency.

**D. Service Areas:**
Check the service counties and service categories in which you deliver care to patients or clients. If you only deliver care in part of a county, attach a separate sheet describing the service area within the county. For Medicare, check both state counties you provide services in as well as those counties that were authorized by Certificate of Need for Medicare.

☐ **3. Key Individuals:**

**A. Administrator:**
Enter the administrators name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

**Direct Supervisor (Home Care Category):** Enter the supervisor's name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

**Clinical Director (Home Health and/or Hospice Category):** Enter the director's name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

**B. Legal Owner Information:**
List the names, titles, addresses, and phone numbers of the corporate officers, LLC members, partners, individuals owning 10% or more of the agency. Attach additional sheet, if necessary.

☐ **4. Other Office Locations:**

**Other Office Locations:**
Enter the name, street address, mailing address, phone number, fax number, email address, and on-site manager or supervisor name. Check the service categories provided from this location. If there are more than two locations, please attach additional sheets as needed. If this is an approved Medicare Branch Office, check the box.

☐ **5. Change of Ownership Information:**
For the current and prospective legal owners, enter the name, phone number, current license number, agency name, agency address, email address, and effective date of ownership change. Current and prospective legal owners must attest to the change in ownership by signing their names on the space provided and indicate the date signed.

☐ **Signature:**

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.

## Additional Information:

For more information on serving state funded DSHS clients, please contact your local Area Agency on Aging (AAA) at 1800-422-3263 or the Division of Developmental Disabilities (DDD) at 1800-562-3022.

DSHS can explain the requirements for contracting with them. Contracts are not available to newly licensed home health agencies.

Contact the AAA or DDD before completing the Department of Health application packet if you wish to also provide services to DSHS clients.

The Area Agency on Aging can be found at **http://www.aasa.dshs.wa.gov/**.

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Washington State Department of Health

# License Requirements

## In order to process your request you must provide the following:

- ☐ Return completed application, along with the application fee.
- ☐ Professional and Liability Insurance: Attach proof of the current professional and liability insurance as per **WAC 246-335-025**.
- ☐ Disclosure Statement : Attach a copy of the Disclosure Statement for the on-site Administrator/Director, Director of Clinical Services (Home Health or Hospice), or Supervisor of Direct Care Services (Home Care). Agencies must keep on file a current Disclosure Statement for the Administrator, Director of Clinical Services or Supervisor of Direct Care Services as stated in **WAC 246-335-025 (1)(c)** and **WAC 246-335-030 (3)**. Current copies must be dated within 3 months of the initial application date.
- ☐ Criminal History Background Check (CBC): Attach a copy of the current CBC of the on-site Administrator, Director of Clinical Services (Home Health or Hospice), or Supervisor of Direct Care Services (Home Care). Agencies must keep on file a current CBC for the Administrator, Director of Clinical Services or Supervisor of Direct Care Services as stated in **WAC 246-335-025 (1)(c)** and **WAC 246-335-030 (3)**. Current copies must be dated within 3 months of the initial application date.
- ☐ Copy of any and all current government issued business license(s) for each office location which may include state, county or city licenses.
- ☐ A description of how the agency will provide management and supervision of services throughout the service area(s).

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Washington State Department of Health

Date Stamp Here

**Revenue: 0597632360**

# In-Home Services Agency License Application

**This is for:** ☐ New ☐ Change of Ownership ☐ Amended ☐ Renewal

## Check One

| | | |
|---|---|---|
| ☐ Association | ☐ Limited Partnership | ☐ Public Hospital District |
| ☐ Corporation | ☐ Municipality (City) | ☐ Sole Proprietor |
| ☐ Federal Government Agency | ☐ Municipality (County) | ☐ State Government Agency |
| ☐ For-Profit | ☐ Non-Profit Corporation | ☐ Tribal Government Agency |
| ☐ Limited Liability Company | ☐ Partnership | ☐ Trust |
| ☐ Limited Liability Partnership | | |

## 1. Demographic Information

| | | | |
|---|---|---|---|
| UBI # | | Federal Tax ID (FEIN) # | |
| Legal Owner/Operator Name | | | |
| Mailing Address | | | |
| City | State | Zip Code | County |
| Phone (enter 10 digit #) | | Fax (enter 10 digit #) | |
| Email Address | | Web Address: | |
| Facility / Agency Name (Doing business as name. Name used on advertising, signs, and web sites) | | | |
| Physical Address | | | |
| City | State | Zip Code | County |
| Facility Phone (enter 10 digit #) | | Facility Fax (enter 10 digit #) | |
| Mailing Address (If different than physical address) | | | |
| City | State | Zip Code | County |

**For Office Use Only**

License #_____ Issue Date _____

## 2. Facility Specific Information

### A. Check all service categories provided:

| Service Category | # of FTE's | Service Category | # of Beds |
|---|---|---|---|
| ☐ Home Care | _____ | ☐ Hospice Care Center | _____ |
| ☐ Home Health | _____ | | |
| ☐ Hospice | _____ | | |

### B. Check all services provided:

**Home Care Services**

☐ Personal Care ☐ Respite Care ☐ Transportation
☐ Homemaker/Chore

**Home Health Services - Choose a least two services provided**

☐ Skilled Nursing ☐ Respiratory Therapy ☐ Bereavement Counseling
☐ Home Health Aide ☐ Medical Social Services ☐ Physical Therapy
☐ Durable Medical Equipment ☐ Occupational Therapy ☐ I.V. Services
☐ Speech Therapy ☐ Nutritional Counseling ☐ Applied Behavior Analysis

In addition to those services listed above, you may select any of the following:

☐ Personal Care ☐ Respite Care ☐ Transportation
☐ Homemaker/Chore

**Hospice Services**

☐ Skilled Nursing ☐ Durable Medical Equipment ☐ Respite Care
☐ Home Health Aide ☐ I.V. Services ☐ Volunteer
☐ Physical Therapy ☐ Nutritional Counseling ☐ Spiritual Counseling
☐ Occupational Therapy ☐ Bereavement Counseling ☐ Pallative Care
☐ Speech Therapy ☐ Personal Care ☐ Symptom & Pain Mgmt.
☐ Respiratory Therapy ☐ Homemaker/Chore ☐ Pharmacy Services
☐ Medical Social Services

**Hospice Care Center Services**

☐ Continuous Care ☐ Routine Home Care ☐ General In-Patient Care
☐ In-Patient Respite Care

### C. Medicare, Medicaid, and Accreditation information:

Is agency currently Medicare certified? ☐ Yes ☐ No

Home Health Medicare Provider # _____ Hospice Medicare Provider #_____

Does the agency have a DSHS Medicaid contract? ☐ Yes ☐ No Secure Fax (enter 10 digit #) _____

If yes, complete all the below AAA and/or DDD contracts that apply:

| | Contract Dates | Last Monitoring Survey | By Whom |
|---|---|---|---|
| ☐ DSHS Personal Care Program | _____to_____ | _____ | _____ |
| ☐ DSHS Chore Services | _____to_____ | _____ | _____ |
| ☐ DSHS Respite Program | _____to_____ | _____ | _____ |
| ☐ DSHS / DDD | _____to_____ | _____ | _____ |
| ☐ Other | _____to_____ | _____ | _____ |

Name of Accreditation Agency #1

_____

Effective Date_____

Expiration Date_____

☐ Home Health ☐ Hospice

Name of Accreditation Agency #2

_____

Effective Date_____

Expiration Date_____

☐ Home Health ☐ Hospice

## D. Requested Service Areas

| County | Home Care | State Home Health | State Hospice | State Hospice Care Center | Medicare Home Health | Medicare Hospice | Medicare Hospice Care Center |
|---|---|---|---|---|---|---|---|
| ☐ Adams | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Asotin | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Benton | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Chelan | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Clallam | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Clark | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Columbia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Cowlitz | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Douglas | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Ferry | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Franklin | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Garfield | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Grant | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Grays Harbor | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Island | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Jefferson | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ King | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Kitsap | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Kittitas | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Klickitat | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Lewis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Lincoln | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Mason | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Okanogan | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Pacific | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Pend Oreille | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Pierce | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ SanJuan | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Skagit | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Skamania | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Snohomish | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Spokane | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Stevens | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Thurston | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Wahkiakum | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Walla Walla | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Whatcom | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Whitman | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Yakima | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## 3. Key Individuals

**A. Complete all that apply:**

| | | |
|---|---|---|
| **Administrator Name** | | |
| Phone (enter 10 digit #) | Fax (enter 10 digit #) | |
| Email Address | | Hire Date |
| **Direct Supervisor Name** (Home Care) | | |
| Phone (enter 10 digit #) | Fax (enter 10 digit #) | |
| Email Address | | Hire Date |
| **Clinical Director Name** (Home Health, Hospice) | | |
| Phone (enter 10 digit #) | Fax (enter 10 digit #) | |
| Email Address | | Hire Date |

**B. Legal Owner Information–attach additional sheets as needed**

List the names, titles, addresses, and phone numbers of the corporate officers, LLC members, partners, individuals owning 10% or more of the agency.

| | | | |
|---|---|---|---|
| Name | | Title | |
| Mailing Address | | | |
| City | State | Zip Code | Phone (enter 10 digit #) |
| Name | | Title | |
| Mailing Address | | | |
| City | State | Zip Code | Phone (enter 10 digit #) |
| Name | | Title | |
| Mailing Address | | | |
| City | State | Zip Code | Phone (enter 10 digit #) |

## 4. Other Office Locations - Attach additional completed pages if you need more space.

Office Name ☐ Approved Medicare Branch Office

Physical Address

Mailing Address (if different from physical)

| City | Zip Code | County |
|---|---|---|
| Phone (enter 10 digit #) | Fax (enter 10 digit #) | |

Email Address

On-Site Manager or Supervisor

In-Home services categories provided from this location

☐ Home Health ☐ Home Care ☐ Hospice ☐ Hospice Care Center

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Office Name ☐ Approved Medicare Branch Office

Physical Address

Mailing Address (if different from physical)

| City | Zip Code | County |
|---|---|---|
| Phone (enter 10 digit #) | Fax (enter 10 digit #) | |

Email Address

On-Site Manager or Supervisor

In-Home services categories provided from this location

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Office Name ☐ Approved Medicare Branch Office

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Mailing Address (if different from physical)

| City | Zip Code | County |
|---|---|---|
| Phone (enter 10 digit #) | Fax (enter 10 digit #) | |

Email Address

On-Site Manager or Supervisor

In-Home services categories provided from this location

☐ Home Health ☐ Home Care ☐ Hospice ☐ Hospice Care Center

## 5. Change of Ownership Information

Name of Current Legal Owner:

| Name of Current Facility/Agency: | Current Facility/Agency License Number: |
|---|---|
| Effective Date of Ownership Change: | Current Owner Phone (enter 10 digit #): |
| Current Facility/Agency Physical Address: | |
| Name of Prospective Legal Owner: | Prospective Owner Phone (enter 10 digit #): |
| Name of Prospective Facility/Agency: | Prospective Owner Email Address: |
| Prospective Facility/Agency Physical Address: | |

| Signature of current legal owner | Date | Signature of prospective legal owner | Date |
|---|---|---|---|
| Print name of current legal owner | Date | Print name of prospective legal owner | Date |

## Signature

I certify that I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

| Signature of owner/authorized representative | Date |
|---|---|
| Print Name | Print Title |

Washington State Department of Health

# Disclosure Statement

I, _____ have never been:

1. **Convicted of a crime against children or other persons.**
   Aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, third degree assault; first, second, or third degree assault of a child; first, second, or third degree rape; first, second, or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promotion prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution; felony indecent exposure; criminal abandonment; or any of these crimes as they be rename in the future.
2. **Convicted of crimes relating to financial exploitation if the victim was a vulnerable adult.**
   A conviction for first, second, or third degree extortion; first, second, or third degree theft; first or second degree robbery; forgery; or any of these crimes that may be renamed in the future. A vulnerable adult is an adult who lacks the functional, mental, or physical ability to care for themselves
3. **Convicted of crimes related to drugs;**
   A conviction of a crime to manufacture, deliver, or possession with intent to manufacture or deliver a controlled substance.
4. **Found in any dependency action under RCW 13.34.040 to have sexually assaulted or exploited any minor or to have physically abused any minor;**
5. **Found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor;**
6. **Found in any disciplinary board final decision to have sexually or physically abuse or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult;**
   Any final decision issued by a disciplining authority under RCW 18.130 or the secretary of the department of health for the following businesses or professions: chiropractic, dentistry, dental hygiene, massage, midwifery, naturopathy, osteopathic medicine and surgery, physical therapy, physicians, practical nursing, registered nursing, and psychology.
7. **Found by a court in a protection proceeding under RCW. 74.34, to have abused or financially exploited a vulnerable adult.**
   The illegal or improper use of a vulnerable adult or that adult's resources for another person's profit or advantage.

Employee Signature _____ Date: _____

Witness Signature _____ Date: _____

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# RCW/WAC and Online Web Site Links

## RCW/WAC Links

In-Home Services Laws..... RCW 70.127

In-Home Services Rules..... WAC 246-335

## On-Line

In-Home Services Program ..... Web Page