

**HOSPICE  
CHANGE OF OWNERSHIP APPLICATION  
FOR MEDICARE AND MEDICAID or STATE LICENSE ONLY**

To: Applicant

From: Kelly Hemmelgarn BSN, RN  
Program Director  
Division of Acute Care

Dear Applicant:

In accordance with your request, we are enclosing the necessary forms for a change ownership (chow) for a Hospice. Please complete the forms and return them to this office along with a copy of **Bill-Of Sale, Transfer of Assets Agreement, or comparable document. document from the Internal Revenue Services that list the name of corporation and EIN number and document from the Secretary of State's office that list name of corporation or d/b/a name if applicable .**

If you are buying an existing certified entity, the previous owner's provider agreement(s) will be automatically assigned to you provided that your application is approved.

Please note that in assuming the previous owners' provider agreements; you will also be assuming responsibility and liability for implementing and/or abiding by the terms of the previous owner's plan for correcting any deficiencies.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on grounds of race, color or national origin in any program receiving federal financial assistance. Although your entity may have already given assurance in connection with other federal programs, the Department nevertheless requires facilities to submit to their State agency a copy of the email submitted by the OCR to the facility when they have successfully submitted all of their clearance materials. (NOTE: do not submit the HHS 690, Assurance of Compliance, or the OCR checklist with policies to the Department.) **Any question concerning the Civil Rights Application should be directed to the Office of Civil Rights.**

To qualify for payment, your facility must be in compliance with the requirements for participation, the requirements for reimbursement (including financial solvency), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, the latter three of which determination is made by the Office of Civil Rights in Chicago.

**In order to expedite your application make sure the application is accurate and complete. If the application is not completed accurately and/or documentation is missing it hinders and delays the processing of the application.**

**Ensure that all forms in this application packet, including duplicate forms, have original signatures. The processing of the application for change of ownership cannot be process until this Division has received all of the required completed forms and documentation.**

**Review all rules and regulations before submitting your application to the Indiana State Department of Health.**

**List of Enclosed Forms to be Completed and Returned with CHOW Application:**

- ◆ Application for License Approval To Operate A Hospice Program (State Form 43813). *Submit all documentation requested on the application.*
- ◆ Hospice Request for Certification In The Medicare Program (Form CMS-417). *General instructions and definitions included.*
- ◆ Home Health Agencies/Hospice Agencies Geographic Area Served. *Submit one original*
- ◆ Three (3) copies of the Health Insurance Benefits Agreement (Form CMS-1561). *Submit all three (3) originals – not applicable for state license only.*

NOTE: On the second line of the Health Insurance Benefits Agreement (Form HCFA-1561) after the term, Social Security Act, enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). Ordinarily, this is the same as the business name used on all official IRS correspondence concerning payroll withholding taxes, such as W-3 or 941 forms. For example, the ABC Corporation, owner of the Community General Hospital, would enter on the agreement: "ABC Corporation d/b/a Community General Hospital". A partnership of several persons might complete the agreement to read: "Robert Johnson, Louis Miller, and Paul Allen, partners, Easy Care Home Health Services". A sole proprietorship would complete the agreement to read: "John Smith d/b/a Mercy Hospital". The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners of the enterprise to enter into this agreement. If the Health Insurance Benefits Agreement is signed by someone other than an officer, director or partner of the enterprise, then one of the officers, directors or partners of the enterprise as listed on the Medicare Provider/Supplier General Application (Form CMS-855A) must give that individual written permission to sign. Please submit a copy of this letter of authorization.

- ◆ A copy of the email sent to your facility, by the Office of Civil Rights, when you have successfully submitted all of your clearance materials. Contact the Office of Civil Rights for questions regarding the Civil Rights Application.

**NOTE:**

***Centers of Medicare and Medicaid Services (CMS) implemented New HCFA-855 application procedures, effective November 1, 2001. The new version of the HCFA-855, is now known as the CMS-855A, which will replace the HCFA-855 and HCFA-855C currently used. Indiana State Department of Health (ISDH) will no longer maintain, distribute and/or process the HCFA-855A application. Contact your fiscal intermediary for the distribution and questions regarding the completion and submission of the CMS-855A application. Any questions concerning the Medicare Provider/Supplier Enrollment Application (CMS-855A) should be directed to your fiscal intermediary/carrier.***

**Documentation/Information to be submitted with CHOW Application:**

- ◆ A copy of the “Articles of Incorporation” or “Certificate Of Assumed Business Name” signed by the Indiana Secretary of State for doing business in Indiana
- ◆ A copy of a SS-4 form or comparable document from the Internal Revenue Services (IRS) that reflects the corporation name and EIN number
- ◆ \$100.00 Licensure Fee
- ◆ Copies of current valid Indiana licenses and limited criminal history checks on staff if there has been a staff change. In addition submit a letter reflecting the staff names and effective date the staff change.
- ◆ A copy of Bill of Sale, Transfer of Assets Agreement or comparable document. The document **must** contain the elements listed below.
  - ❖ The name of the buyer and seller
  - ❖ The complete date of transaction (effective date of agreement)
  - ❖ The signature of buyer and seller

**Submit your completed application to the address below:**

**Indiana State Department of Health  
Cashier's Office 2<sup>ND</sup> Floor  
2 N Meridian Street  
Indianapolis, IN 46207-7236**

**Enclosed for reference is a copy of Web Site Addresses for Rules/Regulations and/or other documentation listed below that can be access and downloaded from the internet:**

- ◆ Federal Regulations for requested Provider/Supplier application (42 CFR Part 418) *Hospice Conditions of Participation*
- ◆ Article 25. Hospice Programs (IC 16-25) *Indiana State Statute*

If you need assistance in completing items in this application packet, please contact the Program Coordinator at 317/233-7302.



Eric J. Holcomb  
Governor  
Kristina Box, MD, FACOG  
State Health Commissioner

Dear Provider:

Due to recent requests from the Regional office, and in an effort to become more efficient when processing your Change of Ownership (CHOW) applications, the department will require the following information to be submitted in conjunction with each CHOW.

### **Change of Ownership (CHOW) Requirements**

**Cover letter** – Each CHOW application must contain an acceptable cover letter. If a CHOW occurs with multiple facilities involved with the same buyer, a separate cover letter and documentation is required for each facility. The cover letter should address only one (1) facility.

Please ensure that the cover letter is submitted in conjunction with the submission of the CHOW application. The cover letter should include the following:

- A brief description of the type of transaction that took place
- Projected or actual effective date of the transaction
- Names of the parties involved in the Change of Ownership (CHOW)
- Statement regarding the CMS 855-whether an 855 has been filed, approved, or will be filed

Example:

*This notice is to confirm that, effective 01/01/2018, a Change of Ownership took place between the buyer, ABC Corporation, EIN Number, 12-345678 and the seller WXY Corporation, d/b/a AAA Homecare, EIN Number 98-765432.*

Facility Address: Please list the complete dba name and address of the seller.  
Seller's CCN Number or License Number, if applicable:

**Other:**

Example: *The buyer/seller's CMS 855 application will be /has been filed with the provider's fiscal intermediary. We will notify the department once an approval notice has been received.*

### **Changes that took place as a result of the CHOW:**

Name Change – did the name of the agency/clinic change as a result of the CHOW?

Staff changes (if applicable): New Administrator, Clinical Supervisor, etc.?

Days/ Hours of operation changed (if applicable)

Mailing Address changed or added (if applicable):

Other changes (please describe)

## **IMPORTANT!!!**

Prior to submission of the cover letter and the application, the buyer must submit to the department the following notices. (*Notices should be submitted at least thirty days in advance of the transaction taking place*):

- *A Notice or Intent to Sell letter from the Seller –the notice must be on the Seller's letterhead and must be signed by the seller or the seller's authorized representative*
- *A Notice or Intent to Purchase from the Buyer – the notice must be on the Buyer's letterhead and must be signed by the buyer or an authorized agent.*

Please contact the Program Coordinator at 317-233-7302 if you have questions regarding this notice.



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

EFFECTIVE IMMEDIATELY

**From:** Indiana State Department of Health, Division of Acute Care, Home Health, Hospice, & RHC, if applicable

**To:** All Initial Providers and providers seeking a Change of Ownership

**Date:** November 04, 2016

**Re: New Changes for Completion & Submission of the Office of Civil Rights (OCR) Application & Clearance**

Effective September 1, 2016, Centers for Medicare & Medicaid Services published S & C Memo 16-37 to revise the OCR Clearance process for new providers and Change of Ownership (CHOW).

A brief summary of the changes are shown below:

- The new process requires that providers successfully submit electronically an attestation of compliance with the civil rights requirements to the OCR before the State survey agency (SA) and the Regional office (RO) may process requests for initial surveys or CHOWs.
- Confirmation from OCR of successful submission of the attestation will meet the requirements for OCR clearance and eliminates the need for CMS ROs to issue provisional provider agreements.
- OCR will begin receiving electronic attestations on September 1, 2016.

This memo changes the method that facilities will use to submit OCR clearance materials. The whole process is now electronic, including the submission of the HHS 690 form.

Facilities are required to submit to their State agency a copy of the email submitted by the OCR to the facility when they have successfully submitted all of their clearance materials. **Note: do not submit the HHS 690, Assurance of Compliance, or the OCR checklist with policies.**

You must; however, submit the CMS 1561, **Health Insurance Benefits agreement** along with the OCR verification to your state agency.

This summary amends any prior information and instructions regarding the submission of OCR documents.

If you have questions regarding this policy, please contact the Office of Civil Rights, or visit their website at [www.ocrportal.hhs.gov/ocr/aoc/instructions.jfs](http://www.ocrportal.hhs.gov/ocr/aoc/instructions.jfs).

Please review the following page for additional information and resources.



2 North Meridian Street • Indianapolis, IN 46204  
317.233.1325  
[www.statehealth.in.gov](http://www.statehealth.in.gov)

To promote and provide  
essential public health services.

## Civil Rights Clearance for Medicare Provider Applicants

### Civil Rights Clearance for Medicare Provider Applicants

If you are a health care provider seeking Initial Medicare Part A certification and/or undergoing a change of ownership (CHOW), you will need a civil rights clearance from the Office for Civil Rights (OCR) to be certified as a Medicare Part A provider by the Centers for Medicare and Medicaid Services (CMS). To seek a civil rights clearance from OCR, follow the instructions below:

Medicare Part A providers are required to sign an attestation of their compliance with all applicable civil rights laws enforced by OCR (including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 1557 of the Affordable Care Act). This attestation is referred to as an Assurance of Compliance. New applicants for Medicare funding and current providers undergoing a change of ownership are responsible for submitting this attestation electronically to OCR.

To submit this attestation, go to the [Assurance of Compliance Portal](#). Please follow all of the instructions and provide the required information. Please note that the former process in which CMS granted providers conditional approvals while OCR processed the provider's civil rights clearance application are no longer granted or an accepted temporary clearance. After September 1, 2016, OCR will accept only Assurance of Compliance forms and only via the [Assurance of Compliance Portal](#) for clearance purposes.

CMS has legal authority under Title XVIII of the Social Security Act to require health care providers to meet the legal requirements of the civil rights nondiscrimination statutes and regulations enforced by OCR in order to participate in the Medicare Part A program. These statutes and regulations ensure that eligible persons have equal access to quality health care regardless of their race, color, national origin, disability, or age. The specific statutes include: Title VI of the Civil Rights Act of 1964 (which prohibits discrimination on the basis of race, color and national origin); Section 504 of the Rehabilitation Act of 1973 (which prohibits discrimination on the basis of disability); the Age Discrimination Act of 1975 (which prohibits discrimination on the basis of age); and Section 1557 of the Affordable Care Act (which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities).

[Click here for more detailed technical assistance, more information on civil rights, and the same civil rights sample policies and procedures.](#)

For questions about submitting a civil rights clearance, [contact OCR](#).



**APPLICATION FOR LICENSE  
APPROVAL TO OPERATE A HOSPICE PROGRAM**

State Form 43813 (R5/5-05)  
Indiana State Department of Health-Division of Acute Care  
(Pursuant to IC 16-25-3)  
Form Approved By State Board Of Accounts-2005

**Division of Acute Care Use Only**

Date Received \_\_\_\_\_

Date Approved \_\_\_\_\_

- All questions on this application must be answered completely in printed or typed script. Supporting documentation must be attached. An incomplete or illegible application will be returned without being processed.
- License and/or approval renewal must be obtained annually.
- This application and the license, and/or approval which may be issued as a result, are neither assignable nor transferable.
- Previous receipt of a certification is not a guarantee that a license and/or approval will be issued.
- A non-refundable application fee in the amount of \$100.00 must accompany this application. No license and/or approval shall be issued without receipt of this fee.

Please Type or Print Legibly

**SECTION I - TYPE OF APPLICATION**

Application (check appropriate item)

- Change of Ownership (Anticipated date of Sale/Purchase/Lease) \_\_\_\_\_  New Facility  
Submit a dated and signed copy of the bill of sale, lease or other document of transfer
- Medicare  Medicare and Medicaid  State License Only

**SECTION II - IDENTIFYING INFORMATION**

**A. Practice Location (facility/dba)**

*If the d/b/a is different from the direct owner submit Articles of Incorporation from the Office of the Secretary of State listing the d/b/a. The d/b/a should be registered with the Office of the Secretary of State and appear on the Articles of Incorporation submitted to ISDH with the application.*

Name of Facility			
Street Address		P.O. Box	
City	County	Zip Code +4	
Telephone Number ( ) ( )	Fax Number ( ) ( )	Facility's office hours (i.e. 8:00 a.m. – 4:00 p.m. Monday - Friday)	

**B. Mailing Address (if different from practice location)**

Street Address		P.O. Box	
City	State	Zip Code +4	

**C. Licensee/Ownership Information (owner)**

*The owner/entity as registered with the Office of Secretary of State and appears on the Articles of Incorporation form submitted to ISDH. Submit Articles of Incorporation from the Office of Secretary of State along with a W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.*

Licensee/Owner/Entity of the facility d/b/a (The entity's name as registered with the secretary of state and that appears on the form/certificate)

Street Address		P.O. Box	
City	State	Zip Code+4	
Telephone Number ( ) ( )	Fax Number ( ) ( )	EIN Number (submit documentation to validate)	Fiscal Year End Date (mm/dd)

**D. Site Offices** (applicable for change of ownership – do not complete if initial application)

Does the facility have other sites?  Yes  No

If yes, please provide the name, address, and telephone number of each site location. (use additional sheet if necessary)

Name	Address (street address/city/zip)	Telephone Number

**E. Type of Hospice**

Is this facility a provider based facility? (owned by a separately licensed entity)  Yes  No

If yes, provide Medicare number

If yes, include a copy of the license with the application

License number of licensed entity \_\_\_\_\_ Date issued \_\_\_\_\_ Date expires \_\_\_\_\_

Please mark appropriate box for the type of hospice you are providing.

- Home Health Agency       Hospital       Intermediate Care Facility
- Skilled Nursing Facility       Freestanding Hospice

**SECTION III – STAFFING**

**A. Home Health Aides**

Does the applicant employ, contract, or use home health aides in providing services to its patients?  Yes  No

If yes, please provide a list of all home health aides presently employed, contracted, or used by the applicant, along with a copy of the current criminal history check and documentation of the applicant's inquiry of the State Nurse Aide Registry for each aide.

**B. Volunteers**

Does the applicant use volunteers in providing services to its patients?  Yes  No

If yes, please provide a list of all volunteers used by applicant, along with a copy of the documentation of the current criminal history check for all volunteers with patient contact and documentation of applicant's inquiry of the State Nurse Aide Registry for each such volunteer who acts as a home health aide.

<b>C. Medical Director (physician)</b>		
Name (enter full name)		Indiana license number
<p>1. Submit a current copy of the Medical Director's (Physician) Indiana license and current criminal history check.</p> <p>2. Has the Medical Director (Physician) ever been convicted of any criminal offense relating to, or in any way associated with, the provision of health services?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, attach a separate sheet of paper, that explains the facts of each case, completely and concisely and how it was resolved.)</i></p> <p>3. Has the Medical Director's (Physician) license ever lapsed, been suspended, or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>(If yes, attach on a separate sheet of paper that explains the place, date, and agency initiating the action, action taken, and the reason.)</i></p>		
<b>D. Administrator</b>		
Name (enter full name) <i>Submit a copy of the administrator's resume and current criminal history check.</i>		
<b>E. Patient/Family Care Coordinator</b>		
Name (enter full name)		Indiana license number (if applicable)
Education (Name of School)	Degree	Year Graduated
List of post-secondary and hospice experience		
<hr/> <hr/> <hr/>		
<p>1. Submit a current copy of any applicable Indiana license, resume with complete employment history and current limited criminal history check.</p> <p>2. Has the coordinator ever been convicted of any criminal offense relating to, or in any way associated with, the provision of health care services?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, attach a separate sheet of paper, that explains the facts of each case, completely and concisely and how it was resolved.)</i></p> <p>3. Has the coordinator's license (if applicable) ever lapsed, been suspended, or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p><i>(If yes, attach a separate sheet of paper that explains the place, date, agency initiating the action, action taken, and the reason.)</i></p>		

**SECTION IV – DISCLOSURE OF APPLICANT ENTITY**

**A. Directors/Officers/ Partners/Managing Agents/Managing Employees**

List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, president, vice president, secretary, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

Officer or Partner Name	Title	Business Address <i>(street address/city/state/zip)</i>	Telephone Number

**B. Type of Ownership (applicable for change of ownership – do not complete if initial application)**

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Asset Purchase Agreement | <input type="checkbox"/> Assignment of Interest      | <input type="checkbox"/> Lease       |
| <input type="checkbox"/> Merger                   | <input type="checkbox"/> New Partnership             | <input type="checkbox"/> Sale        |
| <input type="checkbox"/> Termination of Lease     | <input type="checkbox"/> Transfer of Asset Agreement | <input type="checkbox"/> Other _____ |

*Submit a bill of sale or comparable document, which includes corporation/owner(s) name(s) and buyer/seller signature(s) and effective date of transaction with the application.*

**C. Type of Entity**

<u>For Profit</u>	<u>NonProfit</u>	<u>Government</u>
<input type="checkbox"/> Individual	<input type="checkbox"/> Church Related	<input type="checkbox"/> State
<input type="checkbox"/> * Partnership	<input type="checkbox"/> Individual	<input type="checkbox"/> County
<input type="checkbox"/> ** Corporation	<input type="checkbox"/> * Partnership	<input type="checkbox"/> City
<input type="checkbox"/> *** Limited Liability Company	<input type="checkbox"/> ** Corporation	<input type="checkbox"/> City/County
<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> *** Limited Liability Company	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Federal
_____	_____	<input type="checkbox"/> Other (specify) _____
_____	_____	_____
_____	_____	_____

\*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

\*\*If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate of Authority to do Business in the State of Indiana" signed by the Indiana Secretary of State.

\*\*\*If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

**C. Licensure/Operating History**

Have the owners or managers of the facility operated any facility within Indiana, or any other state that had a record of denial of licensure or operation with less than a full license (i.e. probationary, provisional, denial of annual license renewal, etc)?  Yes  No

*(If "Yes", attach a separate sheet of paper that identifies the name of each facility, and explains the facts completely and concisely)*

1. If any applications have been denied or withdrawn, so state with a full explanation. *(use additional sheet if necessary)*
2. If any license has been granted, state the date granted and expiration date. *(use additional sheet if necessary)*

**SECTION V – GOVERNING BODY**

List the name and addresses of the Governing Body Officers

Name	Business Address of Officer (street address/city/state/zip)

**SECTION VI - CERTIFICATION OF APPLICATION**

The undersigned hereby makes application for a license to operate a hospice in the State of Indiana and, in support of this application, represents and shows that the applicant is able to comply with the hospice licensure/approval Statute, IC 16-25-3 and accompanying regulations.

I swear or affirm under the penalty of perjury that all statements made in this application, and any attachments thereto, are correct and complete and that I will comply with all laws, rules and regulations governing the licensing of hospice programs in Indiana.

**Applicant's signature or signature of the applicant's authorized agent should appear below.**

**If signed by any individual (e.g., the administrator) other than indicated in section II.B. Of this application, an affidavit must be submitted with the application, affirming that said person has been given the power to bind the applicant/licensee.**

Name of Authorized Representative (Typed)	Title
Signature of Authorized Representative	Date

**SECTION VII – DOCUMENTATION THAT MUST BE SUBMITTED WITH THE LICENSE APPLICATION**

1. The non-refundable license fee (\$100.00).
2. Disclosure document (refer to page 7 of this application).
3. A copy of the Medical Director's (Physician) current Indiana physician's license (a **legible wallet size** that shows the expiration date), resume and current limited criminal history check.
4. A copy of the Administrator's current limited criminal history check.
5. A copy of the Patient/Family Care Coordinator's license (**legible wallet size** copy of current Indiana license(s) that shows the expiration date), resume and current limited criminal history check.
6. Completed limited criminal history checks from the Indiana State Police Central Repository must be submitted with the application for Medical Director, Administrator, and Patient Family Care Coordinator.
7. Articles of Incorporation and/or other documents from the Office of the Secretary of State must be submitted:
  - ◆ If a limited Partnership, submit a copy of the "Application for Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.
  - ◆ If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State.
  - ◆ If applicant is an out of state corporation (foreign corporation), submit a copy of the "Certificate of Authority" to do business in the State of Indiana" signed by the Indiana Secretary of State.
  - ◆ If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.
  - ◆ If the "doing business as" (dba) name is different from the corporation's (direct owner) name submit "Certificate of Assumed Business Name" or "Articles of Incorporation" that list the d/b/a name signed by the Indiana Secretary of State that list the d/b/a name.
8. Submit a W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.
9. Submit copies of all contracts on services provided by contract. The contracts must be identified by dividers, signed and dated.
10. A list of each and every home health aide employed, contracted, or utilized (this includes volunteers) by the applicant at the time of the application.
11. A list of each and every volunteer utilized by the applicant at the time of the application, including the date the individual volunteered services.
12. Documentation of the inquiry with the State Nurse Aide Registry regarding each home health aide listed included in the application. Documentation must include:
  - ◆ Name and title of individual conducting the Health Health Aide check;
  - ◆ Date of check;
  - ◆ Name and social security number of the home health aide;
  - ◆ Results of check ("Finding", "No Finding"; "Not listed"); and
  - ◆ If a finding exists, the nature of that finding, and whether it is being contested.

## SECTION VIII – DISCLOSURE STATEMENT

In order for the Department to grant an application for licensure or approval of a hospice program, the applicant must be able to demonstrate its ability to comply with the minimum standards established by IC 16-25-3, effective July 1, 1999. This ability to comply is demonstrated by the applicant through what is known as a "Disclosure Statement", which is submitted each year along with the initial or renewal application.

There is no required format for a Disclosure Statement; however, two (2) topics, services and supplies and patient rights, must be addressed. In addition, a toll free number for the facility must be provided should an individual have any questions or comments about a program.

Listed below are those minimum standards that must be included in the applicant's Disclosure Statement. Additional information may be included.

1. A description of all hospice services to include:
  - a. **Core Services:**
    - (1) Physician services;
    - (2) Nursing services;
    - (3) Medical social services; and
    - (4) Counseling Services.
  - b. **Other services, including but not limited to:**
    - (1) Physical therapy;
    - (2) Occupational therapy;
    - (3) Speech therapy;
    - (4) Home health aide;
    - (5) Homemaker;
    - (6) Medical supplies; and
    - (7) Short term inpatient care.
2. A description of supplies provided to clients, including how those supplies are made available or Delivered.
3. A statement of patient rights, to include:
  - a. Acknowledgement that hospice services and supplies shall be dispensed on a patient's individual needs.
  - b. Description of an internal dispute resolution process to include:
    - (1) How the dispute resolution process is initiated;
    - (2) The name of the ultimate decision-maker; and
    - (3) How the patient may appeal a decision rendered under this procedure
  - c. A statement that patient has the right to participate in the planning of his care
  - d. A statement that the patient has the right to refuse any component of the hospice's services or supplies.
  - e. The Indiana State Department of Health's hot line toll-free number: 1-800-227-6334.

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## INSTRUCTIONS FOR COMPLETING HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

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### STATEMENT CONCERNING INFORMATION COLLECTION REQUIREMENTS AND USES:

This form is required to obtain or retain Medicare benefits. It serves two purposes. First, it provides basic information about the Hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions are met.

Answer all questions as of the current date. Complete and return this form to your State Agency (found at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/state\\_agency\\_contacts.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/state_agency_contacts.pdf)), and retain a copy for your files.

Detailed instructions are given for questions other than those considered self-explanatory.

#### Item I:

- Request to establish eligibility in—current Hospice Benefits are available only through the Medicare program.
- Medicare certification number:  
Insert the facility's six digit Medicare Certification Number. Leave blank on initial requests for certification.
- State/County and State/Region Codes:  
Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.
- Related certification number:  
If Hospice is affiliated with any other type Medicare provider, insert the related facility's six digit Medicare Certification Number.

#### Item IV:

- If a service is provided directly by the facility place a "1" in the appropriate block.
- If a service is provided through an outside source (i.e., by contract/arrangement), place a "2" in the appropriate block.
- If a service is provided both directly and through arrangement, place a "3" in the appropriate box.

## HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

<b>I. Identifying Information</b>	Name of Hospice		Street Address									
	Request to Establish Eligibility In 1. <input type="checkbox"/> Medicare <span style="float: right;">PH1</span>		City, County and State			Zip Code						
	Medicare/Certification Number <span style="float: right;">PH2</span>	State/County <span style="float: right;">PH3</span>	State/Region <span style="float: right;">PH4</span>	Telephone Number (include area code) <span style="float: right;">PH5</span>	Related Certification Number <span style="float: right;">PH6</span>							
<b>II. Type of Hospice (Check One)</b>  PH7	1. <input type="checkbox"/> Hospital 2. <input type="checkbox"/> Skilled Nursing Facility 3. <input type="checkbox"/> Intermediate Care Facility 4. <input type="checkbox"/> Home Health Agency 5. <input type="checkbox"/> Freestanding Hospice		For Hospitals Only (Check One) A. <input type="checkbox"/> The Joint Commission Accredited B. <input type="checkbox"/> AOA Accredited C. <input type="checkbox"/> Both The Joint Commission and AOA Accredited D. <input type="checkbox"/> Non-Accredited			Fiscal Year Ending Date						
	<b>III. Type of Control (Check One)</b> PH8 <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"><b>Non-Profit:</b> 1. <input type="checkbox"/> Church 2. <input type="checkbox"/> Private 3. <input type="checkbox"/> Other</td> <td style="width: 33%; border: none;"><b>Proprietary:</b> 4. <input type="checkbox"/> Individual 5. <input type="checkbox"/> Partnership 6. <input type="checkbox"/> Corporation 7. <input type="checkbox"/> Other</td> <td style="width: 33%; border: none;"><b>Government:</b> 8. <input type="checkbox"/> State 9. <input type="checkbox"/> County 10. <input type="checkbox"/> City 11. <input type="checkbox"/> City-County</td> <td style="width: 33%; border: none;">12. <input type="checkbox"/> Combination Government and Nonprofit 13. <input type="checkbox"/> Other</td> </tr> </table>									<b>Non-Profit:</b> 1. <input type="checkbox"/> Church 2. <input type="checkbox"/> Private 3. <input type="checkbox"/> Other	<b>Proprietary:</b> 4. <input type="checkbox"/> Individual 5. <input type="checkbox"/> Partnership 6. <input type="checkbox"/> Corporation 7. <input type="checkbox"/> Other	<b>Government:</b> 8. <input type="checkbox"/> State 9. <input type="checkbox"/> County 10. <input type="checkbox"/> City 11. <input type="checkbox"/> City-County
<b>Non-Profit:</b> 1. <input type="checkbox"/> Church 2. <input type="checkbox"/> Private 3. <input type="checkbox"/> Other	<b>Proprietary:</b> 4. <input type="checkbox"/> Individual 5. <input type="checkbox"/> Partnership 6. <input type="checkbox"/> Corporation 7. <input type="checkbox"/> Other	<b>Government:</b> 8. <input type="checkbox"/> State 9. <input type="checkbox"/> County 10. <input type="checkbox"/> City 11. <input type="checkbox"/> City-County	12. <input type="checkbox"/> Combination Government and Nonprofit 13. <input type="checkbox"/> Other									
<b>IV. Services Provided:</b> By staff, place a "1" in the block(s) If under arrangement, place a "2" in the block(s) If by staff and arrangement, place a "3" in the block(s)  PH9	<b>Core:</b> 1. <input type="checkbox"/> Physician Services      2. <input type="checkbox"/> Nursing Services      3. <input type="checkbox"/> Medical Social Services      4. <input type="checkbox"/> Counseling Services											
	5. <input type="checkbox"/> Physical Therapy 6. <input type="checkbox"/> Occupational Therapy 7. <input type="checkbox"/> Speech-Language Pathology 8. <input type="checkbox"/> Hospice Aide 9. <input type="checkbox"/> Homemaker 10. <input type="checkbox"/> Medical Supplies 11. <input type="checkbox"/> Short Term Inpatient Care 12. <input type="checkbox"/> Other(Specify)		PH10 A. _____ Acute B. _____ Respite			Name and Address of Contractee		Medicare Certification/Supplier Number				
<b>V. Number of Employees/ Volunteers Full-time Equivalent</b> Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18)	Physicians <span style="float: right;">PH11</span>		Registered Professional Nurses <span style="float: right;">PH12</span>		Licensed Practical Nurses/ Licensed Vocational Nurses <span style="float: right;">PH13</span>		Medical Social Workers <span style="float: right;">PH14</span>		Total Number			
	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	PH19			
	Homemakers <span style="float: right;">PH15</span>		Hospice Aide <span style="float: right;">PH16</span>		Counselors <span style="float: right;">PH17</span>		Others <span style="float: right;">PH18</span>				Employees	Volunteers
	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	A.	B.		

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date
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IDENTIFY THE COUNTIES SERVED

C = CURRENT    N = NEW    R = REMOVE



**GEOGRAPHIC AREA SERVED**

**PLEASE MARK THE COUNTIES ACCORDINGLY**

**C = CURRENT      N = NEW      R = REMOVE**

Adams <input type="checkbox"/>	Franklin <input type="checkbox"/>	Lawrence <input type="checkbox"/>	Rush <input type="checkbox"/>
Allen <input type="checkbox"/>	Fulton <input type="checkbox"/>	Madison <input type="checkbox"/>	St. Joseph <input type="checkbox"/>
Bartholomew <input type="checkbox"/>	Gibson <input type="checkbox"/>	Marion <input type="checkbox"/>	Scott <input type="checkbox"/>
Benton <input type="checkbox"/>	Grant <input type="checkbox"/>	Marshall <input type="checkbox"/>	Shelby <input type="checkbox"/>
Blackford <input type="checkbox"/>	Greene <input type="checkbox"/>	Martin <input type="checkbox"/>	Spencer <input type="checkbox"/>
Boone <input type="checkbox"/>	Hamilton <input type="checkbox"/>	Miami <input type="checkbox"/>	Starke <input type="checkbox"/>
Brown <input type="checkbox"/>	Hancock <input type="checkbox"/>	Monroe <input type="checkbox"/>	Steuben <input type="checkbox"/>
Carroll <input type="checkbox"/>	Harrison <input type="checkbox"/>	Montgomery <input type="checkbox"/>	Sullivan <input type="checkbox"/>
Cass <input type="checkbox"/>	Hendricks <input type="checkbox"/>	Morgan <input type="checkbox"/>	Switzerland <input type="checkbox"/>
Clark <input type="checkbox"/>	Henry <input type="checkbox"/>	Newton <input type="checkbox"/>	Tippecanoe <input type="checkbox"/>
Clay <input type="checkbox"/>	Howard <input type="checkbox"/>	Noble <input type="checkbox"/>	Tipton <input type="checkbox"/>
Clinton <input type="checkbox"/>	Huntington <input type="checkbox"/>	Ohio <input type="checkbox"/>	Union <input type="checkbox"/>
Crawford <input type="checkbox"/>	Jackson <input type="checkbox"/>	Orange <input type="checkbox"/>	Vanderburgh <input type="checkbox"/>
Daviess <input type="checkbox"/>	Jasper <input type="checkbox"/>	Owen <input type="checkbox"/>	Vermillion <input type="checkbox"/>
Dearborn <input type="checkbox"/>	Jay <input type="checkbox"/>	Parke <input type="checkbox"/>	Vigo <input type="checkbox"/>
Decatur <input type="checkbox"/>	Jefferson <input type="checkbox"/>	Perry <input type="checkbox"/>	Wabash <input type="checkbox"/>
DeKalb <input type="checkbox"/>	Jennings <input type="checkbox"/>	Pike <input type="checkbox"/>	Warren <input type="checkbox"/>
Delaware <input type="checkbox"/>	Johnson <input type="checkbox"/>	Porter <input type="checkbox"/>	Warrick <input type="checkbox"/>
Dubois <input type="checkbox"/>	Knox <input type="checkbox"/>	Posey <input type="checkbox"/>	Washington <input type="checkbox"/>
Elkhart <input type="checkbox"/>	Kosciusko <input type="checkbox"/>	Pulaski <input type="checkbox"/>	Wayne <input type="checkbox"/>
Fayette <input type="checkbox"/>	LaGrange <input type="checkbox"/>	Putnam <input type="checkbox"/>	Wells <input type="checkbox"/>
Floyd <input type="checkbox"/>	Lake <input type="checkbox"/>	Randolph <input type="checkbox"/>	White <input type="checkbox"/>
Fountain <input type="checkbox"/>	LaPorte <input type="checkbox"/>	Ripley <input type="checkbox"/>	Whitley <input type="checkbox"/>

**HEALTH INSURANCE BENEFIT AGREEMENT**

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act,  
as Amended and Title 42 Code of Federal Regulations (CFR)  
Chapter IV, Part 489)

**AGREEMENT**

between

**THE SECRETARY OF HEALTH AND HUMAN SERVICES**  
and

\_\_\_\_\_   
doing business as (D/B/A) \_\_\_\_\_

In order to receive payment under title XVIII of the Social Security Act, \_\_\_\_\_

D/B/A \_\_\_\_\_ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

**ATTENTION:** Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_

**ACCEPTED FOR THE PROVIDER OF SERVICES BY:**

NAME (signature)

TITLE

DATE

**ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:**

NAME (signature)

TITLE

DATE

**ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:**

NAME (signature)

TITLE

DATE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0832. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.