APPLICATION FOR PEDIATRIC EXTENDED CARE FACILITY LICENSE
IDENTIFYING INFORMATION

Name of Entity _____

D/B/A: _____

Site Address : _____

City, County, State : _____

Telephone: ( )_____ Fax : ( )_____Email Address:_____

Administrator: _____ SSN:_____

Total License Capacity: _____

PAYMENT

THE FEE FOR A REGULAR LICENSE IS $500.00

A CHECK OR MONEY ORDER PAYABLE TO THE COMMONWEALTH OF PENNSYLVANIA FOR THE AMOUNT OF THE FEE MUST ACCOMPANY THIS APPLICATION. CURRENCY IS NOT ACCEPTABLE.

COMPLETION OF FORMS

Prior to the issuance of a license, applicants must complete and return the following: Application for Pediatric Extended Care Facility License; Department of Health Disclosure of Ownership and Control Interest Statement; and, Civil Rights Survey.

AGREEMENT

Application is made to operate a Pediatric Extended Care facility in accordance with Act 54 of 1999, the Prescribed Pediatric Extended Care Centers Act. This application includes Facility Identifying Information; Department of Health Facility Disclosure of Ownership and Control Statement; and, Civil Rights Survey.

I agree that all of the identifying information on this form and information furnished on the aforementioned attached documents and all other material submitted is complete and true. I further agree to operate said facility in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Pennsylvania Department of Health.

AFFIRMATION

The undersigned hereby affirms that the foregoing information is true and correct to the best of said person's knowledge, information and belief; said affirmation being made subject to the penalties prescribed by 18 Pa. C.S.A. §4904 (unsworn falsifications to authorities).

_____

Name of Authorized Representative (Printed) Title

_____

Signature Date

Mail the completed application, along with a check or money order, to the Pennsylvania Department of Health, Division of Home Health, 132 Kline Plaza, Suite A, Harrisburg, PA 17104.