pennsylvania
DEPARTMENT OF HEALTH

Initial Application for Hospice Agency License

Identifying Information

Name of Entity: _____

D/B/A: _____

Mailing Address: _____
Street *City* *Zip Code*

Site Address: _____
Street *City* *Zip Code*

County: _____

Telephone: _____ Fax: _____
Include area code

Number of Direct Inpatient Beds: _____

Email Address: _____

Contact Person: _____

Days and Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours							

List of Geographic Service Areas by County

☐ Please indicate if the agency will have a 24-hour on-call system.

NOTE: An on-site inspection by surveyors will occur during the business hours submitted.

Payment

A Check or Money Order Payable to "Commonwealth of Pennsylvania" for the amount of the fee must accompany this application. **Currency is not acceptable.** The regular fee per license is $250.

Return the completed and signed original application with a mail check or money order to:

Pennsylvania Department of Health
Division of Home Health
132 Kline Plaza, Suite A
Harrisburg, PA 17104

IMPORTANT: Please retain a copy of your entire packet for your records.

Agreement

Application is made to operate a Hospice Agency in accordance with Chapter 8 of the Health Care Facility Act (35 P.S. §448.101 et. seq.). Application includes Initial Application Form with payment, Civil Rights Survey, Information requested of Health Care Providers applying for a license, Documentation Required for Initial Hospice License, and Password Agreement form.

I agree that all of the identifying information on this form and information furnished on the aforementioned attached documents and all other materials submitted are complete and true. I understand that incomplete or inaccurate information **IS REASON FOR DENYING THE ISSUANCE OF A LICENSE**. I further agree to conduct said facility in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Department of Health.

Affirmation

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

Authorized Representative's Signature*	Date
Print Name of Authorized Representative's	Date

**Authorized Representative – the individual within the Applicant organization with the legal authority to give assurances, make commitments, enter into contracts, and execute documents on behalf of the Applicant, including this Application. The signature of the Authorized Representative certifies that commitments made on this Application will be honored and ensures that the Applicant agrees to conform to applicable law and regulations.*