Commonwealth of Pennsylvania
Department of Health

Identifying Information for a Pediatric Extended Care Center

Name of Entity: _____

D/B/A: _____

Street Address: _____

_____
(City) *(County)* *(State)* *(Zip Code)*

Mailing Address: _____

_____
(City) *(County)* *(State)* *(Zip Code)*

Telephone No. _____ Fax No. _____

Email Address: _____

Contact Person: _____

Total Licensed Capacity:

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 $500.

Mail the completed and signed original application materials and check or money order to:

Pennsylvania Department of Health
Division of Home Health
555 Walnut Street, 7th Floor, Suite 701
Harrisburg, PA 17101

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

pennsylvania
DEPARTMENT OF HEALTH

Affirmation

I understand that the license will be issued to me on the condition that I will conduct the above named facility in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Department of Health, Title VI of the Civil Rights Act of 1964; and the Pennsylvania Human Relations Act, and I hereby declare that the information given in this application is true to the best of my knowledge and belief.

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

Please type or print legibly

Provider/License Number: _____

Password Agreement

I, _____ **(Name)** hereby certify that effective _____ **(date became administrator)**, I am the Administrator/Director/Chief Executive Officer for_____**(Facility Name)** and that I am responsible for submitting a Plan of Correction in response to deficiencies cited by the Pennsylvania Department of Health on CMS Form 2567.

1. I acknowledge receipt of the facility identification number and my individual password (which will be provided after receipt of this agreement) from the Pennsylvania Department of Health.

2. I agree to maintain the confidentiality of both the facility identification number and my password.

3. I recognize and acknowledge that the use of my password to electronically submit a Plan of Correction, in response to deficiencies cited on a CMS Form 2567, identifies me as the signer of the Plan of Correction.

4. I further recognize and acknowledge that the use of my password, in conjunction with the submission of a Plan of Correction, authorizes the Pennsylvania Department of Health to conclusively accept that electronic Plan of Correction as my authorized submission.

I have had the opportunity to review this Agreement and hereby agree to the above statements.

_____
Email address

_____
Signature of Administrator/CEO/Director

_____
Signature of Witness

_____
Date

Return to: Division of Home Health 555
Walnut Street, 7th Floor, Suite 701
Harrisburg, PA 17101

Or

Fax to: 717.787.3188

Commonwealth of Pennsylvania
Department of Health
Division of Home Health

Civil Rights Survey

Agency Name: _____

Note: The word "discrimination" shall be understood to mean "discrimination on the basis of race, color, national origin, religious creed, ancestry, sex, age, or handicap" as used in the Pennsylvania Human Relations Act of 1955, as amended.

1. Is a non-discrimination policy which states services are provided, referrals are made, and employment actions are made without regard to race, sex, color, national origin, ancestry, religious creed, handicap, or age posted conspicuously in the agency?
   - ☐ Yes – If yes, provide a copy and indicate where posting are located.
   - ☐ No – If no, state what corrective steps will be taken to assure a non-discrimination policy is developed and posted.

   _____

   Note: When any change in policy, a signed and dated copy of the revised policy shall be submitted to the State Survey Agency within 30 days of the effective change.

2. Does the agency include the non-discrimination policy in brochures, media notices, and posters?
   - ☐ Yes – If yes, identify publications and media communications means used.
   - ☐ No – If no, state what corrective steps will be taken.

   _____

3. Describe methods and materials used to orient patients and staff to civil rights compliance requirements.

   _____

4. Are patients/consumers and staff informed that complaints of discrimination may be filed with the Office of Equal Opportunity, Pennsylvania Department of Health, and/or the Pennsylvania Human Relations Commission?
   - ☐ Yes – If yes, explain the contents of the information and how it is disseminated.
   - ☐ No – If no, state what corrective steps will be taken.

   _____

5. Describe methods used to assure communication with non-English speaking, limited English proficient and speech impaired persons who you may provide service to (even if you do not currently serve these consumers).

   _____

6. Describe methods used to assure communication with the hearing and visually impaired person who you may provide services to (even if you do not currently serve these consumers).

_____

7. Does the non-discrimination policy statement include that reasonable accommodation is to be provided for handicapped employees?
   - ☐ Yes – If yes, explain its content and how it is disseminated.
   - ☐ No – If no, specify reasons or corrective actions to be taken.

_____

8. Within the past 12 months, have there been any complaints of discrimination filed against this agency?
   - ☐ Yes
   - ☐ No

   If yes, for each complaint registered, please show date of the complaint; the sex and race/national origin of the complainant; major allegations made in the complaint; agency with which the complaint was registered; and the finding of either cause or no cause by the investigating agency.

_____

Chart 2 – Employment

Attach file for Employment with its content entered in the following format:

Job Title	Black		Hispanic		White		American Indian		Asian		Alaskan Native		Pacific Islander	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
DIVISION OF HOME HEALTH

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

These instructions are designed to clarify certain questions on the licensure form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION IS CURRENT.

Item A – Under identifying information, specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

Please answer all questions as of the current date. If the Yes block for any item is checked, list requested additional information under Remarks on Page 2, referencing the item. If additional space is needed, use an attached sheet.

Item C – List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination, amounting to an ownership interest of five percent (5%) or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any indirect ownership interest I the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: If A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operations direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority expressed or reserved, to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to a new ownership or control.

Item F – If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Changes in Provider Status. Change in provider status is defined as any change in management control. Examples of such changes would include: A change in medical or nursing director, a new administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any changes of ownership.

If the Yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item G – If the answer is Yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item H – If the answer is Yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include the name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item I – A chain affiliate is any freestanding health care facility that is either owned, controlled or operated under lease or contract by an organization consisting of two or more freestanding health care facilities organized within or across State lines which is under the ownership, or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider based facilities, such as hospital-based home health care agencies, are not considered to be chain affiliates.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
DIVISION OF HOME HEALTH

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

A. Identifying Information

Name of Entity	D/B/A	Telephone No.

Street Address	City, County, State	Zip Code

B. Answer the following questions by checking " Yes" or " No." If any of the questions are answered "yes", list names and address of individuals or corporations under Remarks on Page 2. Identify each item number to be continued.

1. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5% or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

   Yes ____ No _____

2. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

   Yes ____ No _____

C. List names, address for individual, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under "Remarks."

Name	Address	EIN

D. Type of Entity: ___ Sole Proprietorship __ Partnership __ Corporation __ Unincorporated Associations __ Other

1. If the disclosing entity is a corporation, list names, address of the Directors and EINs for the corporation under "Remarks."

E. Check appropriate box for each of the following questions:

1. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors) If "yes", list names, addresses of individuals and provider number

   ___Yes ___No

Name	Address	Provider Number

F. Has there been a change in ownership within the last year? ___Yes ___No

If yes, give date _____

Do you anticipate any change of ownership or control within the year? ___Yes ___No

If yes, when? _____

G. Is this facility operated by a management company, or leased in whole or part by another organization? ___Yes ___No

If yes, give date of change in operations _____

H. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? ___Yes ___No

I. Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) ___Yes ___No

Name EIN

Address

If the answer to the above question is No, was the facility ever affiliated with a chain? (If yes, list name, address of corporation and EIN) ___Yes ___No

Name EIN

Address

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, 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.

Name of Authorized Representative (Typed) Title

Signature Date

Remarks

COMMWEALTH of PENNSYLVANIA
DEPARTMENT OF HEALTH
LICENSE BOND FORM FOR PEDIATRIC EXTENDED CARE CENTER

Know all men by these presents, that we, licensee _____(**Name of operator of Pediatric Extended Care Center**) of _____ (**Address, City, State, ZIP)** hereinafter referred to as the *principal*, and _____(**Bonding Co. –Surety**), a corporation organized and existing under the laws of the State of _____ and authorized to do business in the Commonwealth of Pennsylvania, as *surety*, are held and firmly bound unto Commonwealth of Pennsylvania – Department of Health hereinafter referred to as the *obligee*, in the sum of **$50,000** lawful money of the United States of America, to the payment of which sum, well and truly to be made, we bind ourselves, our heirs, executors, administrators, successors and assignees, jointly and severally, firmly by these presents.

The condition of this obligation is such, that whereas, the principal has made application to the obligee for the purpose of a license to operate a **Pediatric Extended Care Center** in the Commonwealth of Pennsylvania.

WHEREAS, the said principal has applied for or is about to apply for a license to carry on the business of a Pediatric Extended Care Center. This bond shall be conditioned upon the faithful performance by the operator of the Pediatric Extended Care Center to remain in compliance with and carry out his business under the Prescribed Pediatric Extended Care Centers Act, 35 P.S. § 449.61 *et seq.,* and the rules and regulations promulgated pursuant to this subpart.

NOW, THEREFORE, if the principal shall faithfully comply with all laws, ordinances, rules and regulations which have been or may hereinafter be in force concerning said license, and shall save and keep harmless the obligee from all loss or damage which it may sustain or for which it may become liable on account of the issuance of said license to the principal, then this obligation shall be void; otherwise, to remain in full force and effect.

This bond is effective _____ and remains in effect as long as the license is valid. The surety may at any time terminate its liability by giving thirty (30) days written notice of the obligee, and the surety shall not be liable for any default after such thirty day notice period, except for defaults occurring prior thereto.

IT IS UNDERSTOOD AND AGREED, THAT if this bond terminates with the expiration of said license, it may be continued in force from year to year by continuation certificate if such certificate be found acceptable to said obligee; provided, however, that regardless of the number of years this bond shall continue in form, the surety's liability shall in no event exceed the penal sum of this bond.

Signed, Sealed and Dated this _____ day of _____, 20_____.

Principal: _____

By: _____ By: _____

Name:_____ Name:_____

Title: _____ Title: _____

Facility License Number (if facility is currently licensed): _____

Bonding Company:
Federal Employer Identification Number (EIN): Bond Number: _____
_____

Surety: _____

By: _____ By: _____

Name: _____ Name: _____

_____ _____
Qualified Pennsylvania Resident Agency (if required) Title (Attach Attorney In Fact if required)

Department of Health on _____ (Date) by _____ (Department)

This bond form is approved as to form and legality by:

Department of Health on _____ (Date) by _____ (Office of Legal Counsel)

Office of Attorney General _____ Office of General Counsel _____

COMMWEALTH of PENNSYLVANIA
DEPARTMENT OF HEALTH

Instructions for Bond Form – Operator of Pediatric Extended Care Center

If the Principal is a partnership, **please** state all partners at the beginning of the Bond, and all partners shall the Bond. If principal is a corporation, the president or vice-president **must** sign for the corporation. Their signatures shall be attested to by the Secretary, Asst. Secretary, Treasurer or Asst. Treasurer. If the Principal is a limited liability company and is manager managed, then the operating agreement will outline which managers are required to sign. If the Principal is a limited liability company that is member managed, then the operating agreement will outline which members are required to sign.

The Corporate Surety, if signing by an Attorney In Fact, shall have attached to the Bond a Power of Attorney bearing a certification date **the same as**, or subsequent, to the **date of the Bond.** Out of state corporate sureties signed outside of the Commonwealth of Pennsylvania, shall have said Bond countersigned by a Qualified Pennsylvania Resident Agent.

** BOND MUST BE ON FILE WITH THE DEPARTMENT OF HEALTH BEFORE LICENSE IS VALID**

Name of Operator of Pediatric Extended Care Center: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Amount: $50,000

***Bond shall be sent to:**

Department of Health
Division of Home Health
555 Walnut Street, 7th Floor, Suite 701
Harrisburg, PA 17101