pennsylvania
DEPARTMENT OF HEALTH

Hand delivery of the application is not accepted.

Applications must be mailed in.

Dear Applicant:

The following series of documents contain the materials for a Home Care Agency/Home Care Registry initial license application.

Please note that all questions must be answered, and all requested supporting documentation must be provided. Please label all the exhibits. Do not staple any pages or place in a binder for submission.

Please retain a copy of your application, as it will not be returned to you.

If your application has been forwarded for review, you will receive a confirmation email along with the time frame for review. Do not contact the Division for the status of your application.

If you fail to submit all of the required information, you will receive an email specifying necessary revisions. If the revisions are not submitted **within 30 days**, your application will be withdrawn from consideration.

If the application is withdrawn from consideration, you will receive an email stating the reasons for this decision. If you wish to reapply, you will have to mail a complete application, with the required corrections, and the application fee.

If your application is in accordance with Pennsylvania Home Care Agency rules and regulations, the Division of Home Health will issue you a license via email.

Sincerely,

Division of Home Health

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Initial Home Care Agency/Registry Licensure Application Checklist

This checklist must be included/submitted with the initial application. The purpose of this checklist is to ensure that you complete and submit **ALL** required documents. Your signature on the application is an acknowledgement that you have reviewed the regulations and requirements listed below, for obtaining a home care license.

Checklist:

- ☐ **Read the Chapter 51 regulations for health care facilities, found at the following link:** https://www.health.pa.gov/topics/Documents/Facilities%20and%20Licensing/Chapter51.pdf
- ☐ **Read the Chapter 611 regulations for home care agencies/registries at the link below, and print a copy to keep at your agency:** https://www.health.pa.gov/topics/Documents/Facilities%20and%20Licensing/Chapter611.pdf
- ☐ **Read the Health Care Facilities Act, found at the following link:** https://www.health.pa.gov/topics/Documents/Facilities%20and%20Licensing/FacilitiesAct.pdf
- ☐ **Completed/Signed the Identifying Information of Home Care Agency/Registry**
- ☐ **A check/money order, made payable to "Commonwealth of PA" for $100.00**
- ☐ **Completed/Signed Password Agreement form** *(only one person can be listed as the contact person)*
- ☐ **Completed Civil Rights Survey**
  - ☐ A copy of your agency's non-discrimination policy
- ☐ **Completed Home Care Agency/Registry Licensure Survey**
  - ☐ A copy of direct owner criminal background check dated within a year prior to application submission and based on residency --- refer to regulations.
  - ☐ A copy of direct owner child line clearances *(if applicable)*
  - ☐ Exhibit L, as described in #12 of the form, to include the Consumer Notice of Direct Care Worker Status form *(an example of the Consumer Notice of Direct Care Worker status form is included in this initial application)*
  - ☐ Required policies included *(Be sure to label the exhibits accordingly).*
- ☐ **Completed Information Requested of Healthcare Providers Applying for a License to Operate a Healthcare Facility form**
  - ☐ 10 questions physically answered. All parts of each question **must** be answered. Extra pages may be attached if more space is needed.
  - ☐ Copy of direct owner's resume and/or administrator's resume *(if the administrator is not the direct owner)*
  - ☐ Copy of Department of State business registration confirmation and fictitious name registration (screen shots will not be accepted).
  - ☐ Copy of Proof of EIN (SS4 approval form)

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- ☐ **Review your entire application. Remove information that is not specifically requested in the application materials. Do not submit stapled pages.**
- ☐ **Before submitting a completed application, be sure to make a complete copy for your safe keeping.** *(The Division will not provide you with a copy of your application).*

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Identifying Information for Home Care Agency/Registry License

Please check the **one** that applies:

- ☐ Home Care Agency
- ☐ Home Care Registry
- ☐ Home Care Agency & Home Care Registry

Name of Entity: _____

Doing Business As/Fictitious Name: _____

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

Physical Site Address: _____
(No PO Boxes) *Street* *City* *Zip Code*

County: _____

Telephone: _____ Fax: _____

Email Address *(must be an active email address)*: _____

Contact Person: _____

Days and Hours of Operation: *Physically present in office*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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

List of Geographic Service Area by **County**:
f not adjoining to the county agency is physically located in, include plan for supervision and staffing for that area on a separate sheet of paper.

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

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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 $100.

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

Pennsylvania Department of Health
Division of Home Health
2525 N. 7th Street,
Harrisburg, PA 17110

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

Agreement

Application is made to operate a Home Care Agency/Home Care Registry 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, and Initial Home Care Agency / Registry Licensure Survey.

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 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.*

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Provider/License Number: _____
Initial Applicants: This section is for Dept. use Only

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 main 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 the 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/Director/CEO

_____
Signature of Witness

_____
Date

Already Licensed Facilities ---
Return to: ra-dhhomehealth@pa.gov
With the required supporting documentation

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Civil Rights Survey

Extra pages may be attached if more space is needed. Please label accordingly, and place directly behind the Civil Rights Survey form.

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?

   ☐ **Provide a copy** and indicate where postings are located.

   _____

   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 services to (even if you do not currently serve these consumers).

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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).

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7. Does the non-discrimination policy statement include that reasonable accommodation is to be provided for handicapped employees?
   - ☐ Yes – If yes, explain the contents of the information 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.

Employment

Be sure to include yourself and/or all owners, along with anyone hired.

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

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Home Care Agency/Registry Licensure Survey

Extra pages may be attached if more space is needed. Please label accordingly, and place directly behind the Licensure Survey form.

1. List the number of direct care workers employed and/or rostered, or intend to hire within the first year, by the agency.

   _____

2. Describe or attach your agency or registries essential requirements for hiring and/or rostering of direct care workers. If attached, please label as Exhibit A. *Refer to Regulation: 611.51(a)(b)*

3. Criminal background checks are required for all employed or rostered direct care workers, office staff and the direct owner(s). Describe your agency or registry's policy for requiring background checks and prohibiting individuals with a prohibited conviction or Department of Aging ineligibility determination from being hired or rostered. If attached, label as Exhibit B. Also attach a copy of the background check results for the direct owner(s). *Refer to Regulation: 611.52(a-i)*

4. Describe your agency policy regarding how and when employees are required to obtain Childline Clearances. Please include a copy of the process in place that ensures all staff employed and/or rostered, including office staff and direct owner(s) receive child abuse clearances. If attached, label as Exhibit C. *Refer to Regulation: 611.53(a)(b)(c)*

    a. If services are provided to consumers less than 18 years of age, have all staff, including office staff and direct owner(s) had child abuse clearances completed or initiated? Attach a copy of the ChildLine verification for the direct owner(s).

5. Do you hire or roster individuals on a provisional basis pending the outcome of a criminal background check and ChildLine verification? If yes, describe your policy. If attached, label as Exhibit D. *Refer to Regulation: 611.54(a)(1-7)(b)*

6. Describe or attach an outline of your agency or registry's training program and/or competency exam process, including the process for competency review. If attached, label as Exhibit E. *Refer to Regulation: 611.55(a-e)*

a. If direct care workers are not directly trained or tested for competency by the agency or registry, describe or attach a copy of the process used to verify the individual has successfully completed a training program approved by the Department. If attached, label as Exhibit F.

7. All individuals employed and/or rostered who have direct consumer contact are required to be screened for active tuberculosis prior to consumer contact and annually thereafter. Describe or attach your policy that addresses this process. If attached, label as Exhibit G. *Refer to Regulation: 611.56(a)(b)*

8. Describe or attach your policy that addresses the consumer's right to be involved in the service planning process and to receive services with reasonable accommodations of individual needs and preferences. If attached, label as Exhibit H. *Refer to Regulation: 611.57(a)(1)*

9. Describe or attach your policy that address termination of consumer services. If attached, label as Exhibit I. *Refer to Regulation: 611.57(a)(2)*

10. All individuals affiliated with the home care agency and/or registry is prohibited from assuming power of attorney or guardianship over a consumer utilizing your services. Describe or attach your policy that address this. If attached, label as Exhibit J. *Refer to Regulation: 611.57(b)*

11. Agencies and registries are prohibited from allowing a consumer to endorse a check over to the home care agency or registry. Describe or attach your policy that addresses this. If attached, label as Exhibit K. *Refer to Regulation: 611.57(b)*

12. Attach a sample or copy of the information packet which will be provided to the consumer prior to the commencement of services. Attach as Exhibit L. *Refer to Regulation: 611.57 (c)(1-7).*

THE PACKET MUST INCLUDE THE FOLLOWING:

a. A form or other document that will show a list of services to be provided to the consumer, the hours when they will be provided, and the identity of the direct care worker that will provide the services.
b. Cost of the services to be provided on an hourly or weekly basis.
c. Department of Health contact information for inquiries about licensure requirements and agency/registry compliance.
d. Department of Health hotline and local AAA Ombudsman telephone numbers.
e. Hiring/Competency requirements of direct care workers.
f. Disclosure addressing employee or independent contactor status of direct care worker *(example included in this application)* providing services to the consumer, and the resultant tax and insurance obligations and other responsibilities of the consumer.

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Consumer Notice of Direct Care Worker Status

This form is to be completed by every consumer utilizing the services of a Home Care Agency or Home Care Registry

I, _____ understand that:
(Print Name)

_____
Initials

The direct care worker who will be providing services in my home is an employee of "Agency Name" . "Agency Name" is responsible for withholding and reporting State and Federal Income tax, Federal Unemployment tax, Social Security taxes and Medicare taxes on behalf of the direct care worker. "Agency Name" is also responsible for paying workers compensation insurance to cover the direct care worker in the event of an injury on the job.

_____
Initials

The direct care worker who will be providing services in my home is not an employee of "Registry Name" , and therefore, may be considered my employee. Since the direct care worker may be my employee, I may be responsible for withholding and reporting State and Federal Income tax, Federal Unemployment tax, Social Security taxes and Medicare taxes on behalf of the direct care worker. I also understand that the direct care worker is not covered by Worker's Compensation Insurance.

_____
Initials

I have been informed that "Name of Agency or Registry"
_____ maintains _____ does not maintain
general and professional liability insurance covering the direct care worker. If "Name of Agency or Registry" does not maintain general and professional liability insurance, and the direct care worker is not covered under workers compensation, I have been advised to check my homeowner's or renter's insurance to determine if it covers any injury or accident involving the direct care worker while working in my home.

_____
Signature of Consumer or Consumer's Representative Date

_____
Signature of Representative of Agency or Registry Date

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

INFORMATION REQUESTED OF HEALTH CARE PROVIDERS APPLYING FOR A LICENSE TO OPERATE A HEALTH CARE FACILITY

You must physically answer the following 10 questions, along with including the requested supporting documentation. Should you need further clarification, directions are located at the end of this document.

BUSINESS STRUCTURE

1. A description of the business structure of the health care provider ("Applicant") applying for a license to operate a health care facility, as defined in the Health Care Facilities Act, Act of July 19, 1979, P.L. 130, as amended, 35 P.S. §§448.101 - 448.904b.

OWNERSHIP AND/OR CONTROLLING INTEREST

2. (a) Identify the persons and entities with 5% or greater direct or indirect ownership or controlling interest in the Applicant (see attached definitions).

(b) Provide the information requested in questions 1, 4, 5 and 8 with respect to all persons and entities identified in (a).

DOCUMENTATION

3. (a) A copy of the Applicant's articles of incorporation, certificate of registration, certificate of incorporation, charter, certificate of organization, or other articles, statements or documents establishing the legal existence of the business entity that will hold the license. This submission shall include applicable Pennsylvania Department of State filings and approvals. For foreign entities, provide a copy of the applicable Pennsylvania Department of State filings and approvals to conduct business in Pennsylvania.

(b) A copy of the applicant's by-laws, operating agreement, partnership agreement, or other rules adopted for the regulation or management of the business entity applying for licensure, regardless of the name used to describe those rules.

IDENTIFICATION OF INDIVIDUALS WITH MANAGEMENT AND OPERATIONAL AUTHORITY

4. (a) A list of the names, addresses and health care experience of the individuals who are responsible for the overall business direction of the Applicant

(b) A list of the names, addresses and health care experience of the individual[s] to be appointed by the Applicant to act on its behalf in the overall management and operation of the health care facility regardless of form of ownership.

(c) The names, addresses and health care experience of the individual[s] who will have responsibility for day-to-day operations and who will provide immediate direction and control over the manner of delivery of health care services to individuals served by the health care facility.

LOCATION OF APPLICANT

5. Address of the Applicant's headquarters. If the Applicant has out-of-state headquarters, the Applicant also shall supply the address where the Applicant may be served with legal documents within Pennsylvania.

HEALTH CARE SERVICES TO BE PROVIDED BY APPLICANT

6. (a) A description of the health care services the Applicant intends to offer through the health care facility.

(b) If the application for licensure is the result of a change of ownership, the health care provider should provide a description of

i. any actual or anticipated change from the health care services currently offered,
ii. any actual or anticipated change in the present staff, or in the composition of the staff, and
iii. a description of any anticipated innovations in the manner of delivery of health care services.

BACKGROUND OF APPLICANT

7. The Applicant's previous experience in operating health care facilities inside or outside Pennsylvania, including:

(a) the type of health care facilities currently or previously owned, managed or operated by Applicant

(b) the names and addresses of facilities currently or previously owned, managed or operated by Applicant and persons and entities identified in 2(a)

(c) a description of any adverse action taken by any state or federal agency against any of the facilities identified in 7(b), and any documentation regarding the action taken and its resolution.

8. Have any of the facilities identified in 7(b) or any of the individuals identified in 4(a), (b) or (c):

(a) Been subject to criminal or civil fraud charges; or

(b) Ordered to pay a civil monetary penalty (other than those listed in response to 7(c); or

(c) Convicted of Medicare or Medicaid fraud and abuse?

If yes, please provide documentation regarding the action taken and its resolution.

9. Are there any ongoing fraud and abuse investigations at any facility identified in 7(b)?

INTENTIONS WITH RESPECT TO CHARITY CARE

10. A description of the Applicant's intentions with respect to the level of charity and uncompensated care to be provided.

Special Instructions:

Under the Commonwealth of Pennsylvania's Right-to-Know Law, ("RTKL"), 65 P.S. §§ 67.101-67.3104, any information submitted in response to this form may be considered a public record, which will be provided by the Department in response to request for copies of such records.

Records that constitute or reveal a trade secret or confidential proprietary information are exempt from disclosure under the RTKL. 65 P.S. § 67.708(b)(11).

"Trade secret" is defined as "information, including a formula, drawing, patter, compilation, including a customer list, program, device, method, technique, or process that (1) derives independent economic value, actual, or potential, from not being generally known to and not being readily ascertainable by proper means by other persons who can obtain economic value from its disclosure and/or use; and (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy. The term includes data processing software obtained by an agency under a licensing agreement prohibiting disclosure."

"Confidential Proprietary Information" is defined as "commercial or financial information received by an agency: (1) which is privileged and confidential; and (2) the disclosure of which would cause substantial harm to the competitive position of the person that submitted the information."

If you believe that any of the information that is bring provided in response to this form meets the definition of either "trade secret" or "confidential proprietary information," you must so assert at the time of submission. The written response to each question must state whether any of the answers given are or contain either "trade secrets" or "confidential proprietary information." The written response must also state the basis on which you are asserting that the information provided constitutes either "trade secrets" or "confidential proprietary information" and should not be re-disclosed. This is necessary as the Department's response to a RTKL requester must include the basis on which the information is considered to be a "trade secret" or the reason the information is considered "confidential proprietary information." Without the basis for your assertion, the Department is unable to assert this exception to disclosure under the RTKL on your behalf.

Further, you must indicate on **each page** of additional documentation submitted that the page contains "trade secret" or "confidential proprietary information" which should not be released. If only some of the information on a page is "trade secret" or "confidential proprietary information," please identify the **confidential** text. A blanket statement that all information being submitted falls within one of these two categories is **not** acceptable.

Failure to raise a claim of "trade secret" or "confidential proprietary information" will result in a waiver of any future claim(s) that this information should not be provided by the Department of a third party requestor because it falls within one of these classifications.

DIRECTIONS AND DEFINITIONS FOR PROVIDING THE
INFORMATION REQUESTED OF HEALTH CARE PROVIDERS APPLYING FOR
A LICENSE TO OPERATE A HEALTH CARE FACILITY

BUSINESS STRUCTURE

1. Please provide as much information as necessary to provide a complete description of the business structure of the Applicant. While you may choose to provide an organizational chart outlining chain of command or lines of decision-making authority for the Applicant, that is not the primary purpose of this question. The purpose of this question is to obtain a detailed explanation of the business entity that is seeking a license to operate a health care facility. The business entity may be a business corporation, professional corporation, nonprofit corporation, limited liability company, general partnership, limited partnership, limited liability partnership, restricted professional company, unincorporated association, professional association, sole proprietorship, trust, estate, joint stock company, insurance company, the Commonwealth or political subdivision or instrumentality (including a municipal corporation or authority) or other government entity. The description of the business structure of the entity applying for a license should include information about those entities or persons that have an ownership interest in the Applicant. The explanation of the business structure should include information about a parent corporation, a holding company, or the corporate or individual members of a limited liability company.

OWNERSHIP AND/OR CONTROLLING INTEREST

2. Please see the definitions to determine the direct/indirect ownership/control of the Applicant. Please include "parent" corporations, sole members or any entities that have a relationship with the Applicant that results in ownership or control as defined below.

DOCUMENTATION

3 (a) Please provide the documentation that demonstrates the legal existence of business entity that is seeking a license to operate a health care facility. The technical form of that documentation may vary. If the Applicant is a corporation, the documentation will be the Articles of Incorporation. If the Applicant is a limited liability company, the documentation will be a Certificate of Authority. If the Applicant is a Partnership, the documentation will be the Partnership Agreement. If the business entity that will operate the health care facility is a sole proprietorship, there will be no documentation to supply. A foreign corporation shall supply a copy of the corporation's application for a Certificate of Authority to do business in Pennsylvania.

(b) Please provide the documentation necessary to describe the rules for the regulation, management and operation of the Applicant as a business entity. The form of that documentation may vary. If the Applicant is a corporation, the documentation may be titled "by-laws." If the Applicant is a limited liability company, the operating agreement will include the rules for operation of the company. If the Applicant is a partnership, the partnership agreement will include the operating rules for the partnership. If the business entity that will operate the health care facility is a sole proprietorship, there is no requirement for documentation setting forth the rules for running the business.

IDENTIFICATION OF INDIVIDUALS WITH MANAGEMENT AND OPERATION AUTHORITY

4. (a) The names included in the response to this question should include any and all persons who have overall responsibility for business direction of the Applicant. The title of these persons may vary depending upon the form of business entity that will operate the health care facility. In a corporation, these persons often are referred to as "directors." In a limited liability company, these persons often are referred to as "members."

(b) The names included in the response to this question should include any and all persons appointed by the health care provider to act on its behalf in the overall management and operation of the health care facility. The title assigned to these persons may vary depending upon the form of the business entity that will operate the health care facility. In a corporation, these persons often are referred to as "officers." In a limited liability company, the members may fill the roles described in (a) and (b), or the members may appoint an individual to manage the company, and may be referred to as "manager." This person or persons also may be referred to as the "general partners," "managing partners," "chief executive officer," or "chief operating officer."

(c) The name provided in the response to this question should be, for example, the individual who is licensed as a nursing home administrator, or the individual named as the administrator, director of nursing, medical director, or executive director for the health care facility.

It is possible that the same persons will have responsibility for the business direction of the health care facility, for the overall management and operation of the facility, and for direction and control over the manner of delivery of health care services. In the event of repetition of names in response to (a), (b), and (c) above, simply supply all names in response to this question 4 and list the responsibilities of each.

LOCATION OF APPLICANT

5. An applicant with an out-of-state address must supply an in-state address to which the Department or one of its divisions may deliver correspondence including notice of an adverse action or other legal documentation.

HEALTH CARE SERVICES TO BE PROVIDED BY APPLICANT

6. Self-explanatory.

BACKGROUND OF APPLICANT

7. The term "adverse action" refers to an adverse licensure or certification action by a state or federal agency, including civil monetary penalties.

8, 9. Self-explanatory.

10. A response to this question is solicited merely as a means of collecting information. An answer indicating an unwillingness to provide charity care will not affect the Department's decision with regard to the application for licensure.

IF YOU NEED ASSISTANCE FILLING OUT THIS FORM, PLEASE HIRE A CONSULTANT OR AN ATTORNEY.

DEFINITIONS

“Direct Ownership” means an interest through the possession of stock, equity in capital or any interest in the profits of the Applicant.

“Indirect Ownership” means an interest in an entity that has direct or indirect ownership interest in the Applicant. The amount of indirect ownership in the Applicant that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the Applicant.

“Control” means the ability to control operational direction or management of the Applicant 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 (e.g. joint venture agreement, unincorporated business status) of the Applicant; the ability or authority to nominate or name members of the Board of Directors or Trustees of the Applicant; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management rules of the Applicant; the right to control any or all of the assets or other property of the Applicant 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 Applicant, or to arrange for the sale or transfer of the Applicant to new ownership or control.