In-Home Services License Application Packet

Contents:

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

In-Home Services Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Application Instructions Checklist

When your application for an In-Home Services Agency License is received by the Department of Health (DOH), it will be reviewed and you will be notified in writing of any outstanding documentation or licensing fees needed to complete the process.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

☐ **Application Fee:** You can check the online fee page for current fees.

☐ On page one of the application, indicate type of application—new, change of ownership, amended or renewal.

- **New** - First time requesting an In-Home Services Agency license.
- **Change of Ownership** - When name of legal owner/operator changes resulting from the sale of a licensed In-Home Services Agency. Any transaction that results in a change of the unified business identifier or federal employer identification number.
- **Amended** -To request the addition of a Service Category (e.g. Home Care, Home Health, Hospice, Hospice Care Center); add or eliminate Service(s), add or change accreditation information, add or change DSHS contracting information, add or eliminate a Service Area(s), change Administrator, Clinical Director or Direct Supervisor information, add Other Office Locations.
- **Renewal** - To renew an existing In-Home Services License.

☐ **Check One:** Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ 1. Demographic Information:
Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/Master Business License.

Mailing Address: Enter the owner's complete mailing address.

Phone and Fax: Enter the owner's phone and fax numbers.

Email: Enter the owner's email, if applicable.

Facility/Agency Name: Enter the doing business as name. Name used on advertising, signs, and web sites.

Physical Address: Enter the facility's physical street location including city, state, zip code, and county.

Phone and Fax Numbers: Enter the agency's phone and fax number.

Mailing Address: Enter the agency's mailing address, if different than physical address.

Agency email and web address: Enter the agency's email and web address, if applicable.

☐ **2. Agency Specific Information:**

A. Service Categories: Please check all in-home service categories that apply.

Service Categories of Home Care, Home Health, and Hospice: Enter the number of Full Time Equivalents (FTEs). Complete the Full-Time Equivalent Worksheet to determine your FTE's. A minimum of one FTE per service area, per service category is required.

Service Category of Hospice Care Center: Enter the number of licensed beds authorized by Certificate of Need and Construction Review Services.

Services Provided:

Home Care Services: Please check all that apply.

Home Health Services: Please check all that apply. You must choose at least two home health services in order to have an approved home health service category. Home Health agencies may also provide non-medical services - check all that apply.

Hospice Services: Please check all that apply.

Hospice Care Center Services: Please check all that apply.

B. Medicare Designation/Certification:
Please check if agency is Medicare certified to provide Home Health or Hospice services. If yes, enter the corresponding six character provider number(s). In Washington this provider number always begins with 50. If you do not know your six character provider number, please contact your Medicare Fiscal Intermediary.

DSHS/AAA and/or DDD Contracts:
Check yes or no. If yes, attach a copy of the final executed contract.

Accreditation Information:
If your agency is accredited, please enter the name of the accreditation agency, the accreditation effective date, expiration date, and check the box for accreditation as a Home Health or Hospice agency.

C. Service Areas:
Check the service counties and service categories in which you propose to deliver care to patients or clients. The department must approve the requested counties before an agency may provide services in those counties. Approval of a county includes the expectation that agencies will strive to service all clients or patients within the county boundaries. For Medicare, check both the state counties you provide services in as well as those counties that were authorized by Certificate of Need for Medicare.

☐ **3. Key Individuals:**

A. Administrator:
Enter the administrators name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

Supervisor of Direct Care Services (Home Care Category): Enter the supervisor's name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

Director of Clinical Services (Home Health and Hospice Categories):
Enter the director's name, phone number, fax number, email address, and hire date. This must be the same person identified on the Disclosure Statement and Criminal History Background Check.

B. Legal Owner Information:
List the names, titles, addresses, and phone numbers of the corporate officers, LLC members, partners, individuals owning 10% or more of the agency. Attach additional sheet, if necessary.

☐ **4. Other Office Locations:**
Enter the name, street address, mailing address, phone number, fax number, email address, and on-site manager or supervisor name. Check the service categories provided from this location. If there are more than two locations, please attach additional sheets as needed. If this is an approved Medicare Branch Office, check the box.

☐ **5. Change of Ownership Information:**
For the current and prospective legal owners, enter the name, phone number, current license number, agency name, agency address, email address, and effective date of ownership change. Current and prospective legal owners must attest to the change in ownership by signing their names on the space provided and indicate the date signed.

☐ **Signature:**

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.

Additional Information:

For more information on serving state funded DSHS clients, please contact your local Area Agency on Aging (AAA) at 1800-422-3263 or the Division of Developmental Disabilities (DDD) at 1800-562-3022.

DSHS can explain the requirements for contracting with them. Contracts are not available to newly licensed home care agencies.

The Area Agency on Aging can be found at http://www.aasa.dshs.wa.gov/.

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Washington State Department of Health

License Requirements

In order to process your request you must provide the following:

- ☐ Return completed application, along with the application fee.
- ☐ A copy of your In-Home Services Orientation Class certificate of completion. For more information, please see the Department of Health website.
- ☐ Commercial General Liability Insurance: Attach proof of the current commercial general liability insurance as per WAC 246-335-320(2)(b).
- ☐ Disclosure Statement: Attach a copy of the Disclosure Statement for the on-site Administrator/Director, Director of Clinical Services (Home Health or Hospice), or Supervisor of Direct Care Services (Home Care) as stated in WAC 246-335-320 (2)(d) and WAC 246-335-325 (4). Current copies must be dated within 3 months of the initial application date.
- ☐ Criminal History Background Check (CBC): Attach a copy of the current CBC of the on-site Administrator, Director of Clinical Services (Home Health or Hospice), or Supervisor of Direct Care Services (Home Care) as stated in WAC 246-335-320 (2)(d) and WAC 246-335-325 (4). Current copies must be dated within 3 months of the initial application date.
- ☐ Copy of any and all current government issued business license(s) for each office location which may include state, county or city licenses.
- ☐ A completed full-time equivalent (FTE) worksheet.
- ☐ A description of how the agency will provide management and supervision of services throughout all requested service area(s).

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Washington State Department of Health

Date Stamp Here

Revenue: 0597632360

In-Home Services Agency License Application

This is for: ☐ New ☐ Change of Ownership ☐ Amended ☐ Renewal

Check One

☐ Association	☐ Limited Partnership	☐ Public Hospital District
☐ Corporation	☐ Municipality (City)	☐ Sole Proprietor
☐ Federal Government Agency	☐ Municipality (County)	☐ State Government Agency
☐ For-Profit	☐ Non-Profit Corporation	☐ Tribal Government Agency
☐ Limited Liability Company	☐ Partnership	☐ Trust
☐ Limited Liability Partnership		

1. Demographic Information

UBI #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Name			
Mailing Address			
City	State	Zip Code	County
Phone (enter 10 digit #)	Fax (enter 10 digit #)		Email Address
Agency Name (Doing business as name. Name used on advertising, signs, and web sites)			
Physical Address			
City	State	Zip Code	County
Agency Phone (enter 10 digit #)		Agency Fax (enter 10 digit #)	
Mailing Address (If different than physical address)			
City	State	Zip Code	County
Agency Email Address		Agency Web Address	

2. Agency Specific Information

A. Check one or more service categories below along with related services:

☐ **Home Care category** **# of FTE's** _____

Home Care Services:

☐ Personal Care ☐ Housework ☐ Essential Shopping ☐ Travel to Medical Services
☐ Meal Preparation ☐ Family Respite Care

Primary Account Administrator Name _____ Primary Account Administrator Email_____
(This is used for securely sending DSHS/BCCU background results.)

☐ **Home Health category** **# of FTE's** _____

Home Health Services (check at least two services):

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Respiratory Therapy
☐ Speech Therapy ☐ Home Health Aide ☐ I.V. Services ☐ Durable Medical Equipment
☐ Nutritional Counseling ☐ Medical Social Services ☐ Nutritional Counseling ☐ Applied Behavior Analysis

Home health agencies may also provide non-medical services - you may select any of the following:

☐ Personal Care ☐ Housework ☐ Essential Shopping ☐ Travel to Medical Services
☐ Meal Preparation ☐ Family Respite Care

☐ **Hospice category** **# of FTE's** _____

Hospice Services:

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Respiratory Therapy
☐ Speech Therapy ☐ Home Health Aide ☐ I.V. Services ☐ Durable Medical Equipment
☐ Nutritional Counseling ☐ Medical Social Services ☐ Bereavement Counseling ☐ Spiritual Counseling
☐ Respite Care ☐ Pharmacy Services ☐ Symptom & Pain Mgmt. ☐ Paliative Care
☐ Volunteer Services

Hospice agencies may also provide non-medical services - you may select any of the following:

☐ Personal Care ☐ Housework ☐ Essential Shopping ☐ Travel to Medical Services
☐ Meal Preparation ☐ Family Respite Care

☐ **Hospice Care Center category** **# of beds** _____

Hospice Care Center Services:

☐ Continuous Care ☐ General Inpatient Care ☐ Inpatient Respite Care ☐ Routine Home Care

B. Medicare, Medicaid, and Accreditation information:

Is this Home Health or Hospice agency currently Medicare certified? ☐ Yes ☐ No

Home Health Medicare Certification # 50-__ __ __ __ Hospice Medicare Certification # 50-__ __ __ __

Does the Home Care agency have a DSHS Medicaid contract? ☐ Yes ☐ No

If yes, attach a copy of the final executed DSHS contract.

Name of Accreditation Agency _____ ☐ Home Health ☐ Hospice

Effective Date_____ Expiration Date_____

☐ Deeming Accreditation ☐ Non-Deeming Accreditation

C. Requested Service Areas

County	Home Care	State Home Health	State Hospice	State Hospice Care Center	Medicare Home Health	Medicare Hospice	Medicare Hospice Care Center
Adams	☐	☐	☐	☐	☐	☐	☐
Asotin	☐	☐	☐	☐	☐	☐	☐
Benton	☐	☐	☐	☐	☐	☐	☐
Chelan	☐	☐	☐	☐	☐	☐	☐
Clallam	☐	☐	☐	☐	☐	☐	☐
Clark	☐	☐	☐	☐	☐	☐	☐
Columbia	☐	☐	☐	☐	☐	☐	☐
Cowlitz	☐	☐	☐	☐	☐	☐	☐
Douglas	☐	☐	☐	☐	☐	☐	☐
Ferry	☐	☐	☐	☐	☐	☐	☐
Franklin	☐	☐	☐	☐	☐	☐	☐
Garfield	☐	☐	☐	☐	☐	☐	☐
Grant	☐	☐	☐	☐	☐	☐	☐
Grays Harbor	☐	☐	☐	☐	☐	☐	☐
Island	☐	☐	☐	☐	☐	☐	☐
Jefferson	☐	☐	☐	☐	☐	☐	☐
King	☐	☐	☐	☐	☐	☐	☐
Kitsap	☐	☐	☐	☐	☐	☐	☐
Kittitas	☐	☐	☐	☐	☐	☐	☐
Klickitat	☐	☐	☐	☐	☐	☐	☐
Lewis	☐	☐	☐	☐	☐	☐	☐
Lincoln	☐	☐	☐	☐	☐	☐	☐
Mason	☐	☐	☐	☐	☐	☐	☐
Okanogan	☐	☐	☐	☐	☐	☐	☐
Pacific	☐	☐	☐	☐	☐	☐	☐
Pend Oreille	☐	☐	☐	☐	☐	☐	☐
Pierce	☐	☐	☐	☐	☐	☐	☐
SanJuan	☐	☐	☐	☐	☐	☐	☐
Skagit	☐	☐	☐	☐	☐	☐	☐
Skamania	☐	☐	☐	☐	☐	☐	☐
Snohomish	☐	☐	☐	☐	☐	☐	☐
Spokane	☐	☐	☐	☐	☐	☐	☐
Stevens	☐	☐	☐	☐	☐	☐	☐
Thurston	☐	☐	☐	☐	☐	☐	☐
Wahkiakum	☐	☐	☐	☐	☐	☐	☐
Walla Walla	☐	☐	☐	☐	☐	☐	☐
Whatcom	☐	☐	☐	☐	☐	☐	☐
Whitman	☐	☐	☐	☐	☐	☐	☐
Yakima	☐	☐	☐	☐	☐	☐	☐

3. Key Individuals

A. Complete all that apply:

Administrator Name

Phone (enter 10 digit #)	Fax (enter 10 digit #)
Email Address	Hire Date

Supervisor of Direct Care Services Name (Home Care Only)

Phone (enter 10 digit #)	Fax (enter 10 digit #)
Email Address	Hire Date

Director of Clinical Services Name (Home Health and Hospice)

Phone (enter 10 digit #)	Fax (enter 10 digit #)
Email Address	Hire Date

B. Legal Owner Information–attach additional sheets as needed

List the names, titles, addresses, and phone numbers of the corporate officers, LLC members, partners, individuals owning 10% or more of the agency.

Name	Title
Mailing Address	

City	State	Zip Code	Phone (enter 10 digit #)

Name	Title
Mailing Address	

City	State	Zip Code	Phone (enter 10 digit #)

Name	Title
Mailing Address	

City	State	Zip Code	Phone (enter 10 digit #)

4. Other Office Locations - Attach additional completed pages if you need more space.

Office Name ☐ Approved Medicare Branch Office

Physical Address

Mailing Address (if different from physical)

City	Zip Code	County

Phone (enter 10 digit #)	Fax (enter 10 digit #)

Email Address

On-Site Manager or Supervisor

In-Home services categories provided from this location

☐ Home Health ☐ Home Care ☐ Hospice ☐ Hospice Care Center

Office Name ☐ Approved Medicare Branch Office

Physical Address

Mailing Address (if different from physical)

City	Zip Code	County

Phone (enter 10 digit #)	Fax (enter 10 digit #)

Email Address

On-Site Manager or Supervisor

In-Home services categories provided from this location

☐ Home Health ☐ Home Care ☐ Hospice ☐ Hospice Care Center

Office Name ☐ Approved Medicare Branch Office

Physical Address

Mailing Address (if different from physical)

City	Zip Code	County

Phone (enter 10 digit #)	Fax (enter 10 digit #)

Email Address

On-Site Manager or Supervisor

In-Home services categories provided from this location

☐ Home Health ☐ Home Care ☐ Hospice ☐ Hospice Care Center

5. Change of Ownership Information

Name of Current Legal Owner	
Name of Current Agency	Current Agency License Number
Effective Date of Ownership Change	Current Owner Phone (enter 10 digit #)
Current Agency Physical Address	
Name of Prospective Legal Owner	Prospective Owner Phone (enter 10 digit #)
Name of Prospective Agency	Prospective Owner Email Address
Prospective Agency Physical Address	

Signature of current legal owner Date

Print name of current legal owner Date

Signature of prospective legal owner Date

Print name of prospective legal owner Date

Signature

I certify that I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

Signature of owner/authorized representative

Date

Print Name

Print Title

Washington State Department of Health

Disclosure Statement

I, _____ have never been:

1. **Convicted of a crime against children or other persons.**
   Aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, third degree assault; first, second, or third degree assault of a child; first, second, or third degree rape; first, second, or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promotion prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution; felony indecent exposure; criminal abandonment; or any of these crimes as they be rename in the future.
2. **Convicted of crimes relating to financial exploitation if the victim was a vulnerable adult.**
   A conviction for first, second, or third degree extortion; first, second, or third degree theft; first or second degree robbery; forgery; or any of these crimes that may be renamed in the future. A vulnerable adult is an adult who lacks the functional, mental, or physical ability to care for themselves
3. **Convicted of crimes related to drugs;**
   A conviction of a crime to manufacture, deliver, or possession with intent to manufacture or deliver a controlled substance.
4. **Found in any dependency action under RCW 13.34.040 to have sexually assaulted or exploited any minor or to have physically abused any minor;**
5. **Found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor;**
6. **Found in any disciplinary board final decision to have sexually or physically abuse or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult;**
   Any final decision issued by a disciplining authority under RCW 18.130 or the secretary of the department of health for the following businesses or professions: chiropractic, dentistry, dental hygiene, massage, midwifery, naturopathy, osteopathic medicine and surgery, physical therapy, physicians, practical nursing, registered nursing, and psychology.
7. **Found by a court in a protection proceeding under RCW. 74.34, to have abused or financially exploited a vulnerable adult.**
   The illegal or improper use of a vulnerable adult or that adult's resources for another person's profit or advantage.

Employee Signature _____ Date: _____

Witness Signature _____ Date: _____

Washington State Department of Health

In-Home Services Full-Time Equivalent (FTE) Worksheet

Complete a separate worksheet for each service category your agency is licensed for.

Demographic Information

Agency License # (if applicable)	Service Category (Home Care, Home Health, Hospice)
Agency Name	
Mailing Address	

City	State	Zip Code	County		

Phone (enter 10 digit #)	Email Address

Determine your total full-time equivalent employees

The worksheet on page two is designed to assist In-Home Services agencies in calculating their average 12 month full-time equivalent employees (FTE's). Licensees must report their average 12 month FTEs for each service category when renewing their license. FTEs, in combination with service categories, are used to determine licensing renewal fees. **Applicants for initial licensure should skip steps one and two below and list their anticipated FTEs at start-up at the bottom of page two.**

Step One: Calculating the Total Number of Employees

For the worksheet on page two, you will need to calculate the following:

- Full-Time Employee Calculations (Column X): Insert the number of "full-time" employees of your company who work on average 30 or more hours per week per month during the previous 12 month measurement period.
- Full-Time Equivalent (FTE) Calculations (Column Y): Insert the total number of hours worked by all part-time (all employees who did not work on average 30 or more hours per week per month during the previous 12 month measurement period). Divide each monthly total by 120 as a proxy of a 30 hour work week (e.g., 240 hours worked in January/120 = 2).

Step Two: Calculating the Number of FTEs

For the worksheet on page 2, you will need to calculate the following:

- Add up the subtotal in Column X
- Add up the subtotal in Column Y
- Add up the subtotals in Columns X and Y and divide by 12 for your final full-time employee count.

Full-Time Equivalent (FTE) Worksheet

	Month/Year Example: “January /2017’	Step one: Column X Number of full-time employees	Step one: Column Y Total hours worked by non-full-time employees divided by 120
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
	Subtotals		

Step Two: (X _____+ Y _____) / 12 = _____ FTE average for 12 months

Note: A minimum of 1 FTE is required for each approved service area (e.g. county) per service category (e.g. home care, home health, hospice) according to WAC 246-335-990(3)

Initial Licensure: Skip above steps and indicate your anticipated FTEs at start-up: _____ FTEs

Attestation

I certify the above information is true and complete to the best of my knowledge and belief. The Department of Health reserves the right to request additional documentation in order to verify stated information.

Administrator Name (Print)

Signature Date (mm/dd/yyyy)

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RCW/WAC and Online Website Links

RCW/WAC Links

In-Home Services Laws, Chapter 70.127 RCW

In-Home Services Rules, Chapter 246-335 WAC

Online

Home Care Agencies Web Page

Home Health Agencies Web Page

Hospice Agencies Web Page

Hospice Care Centers Web Page