

QC = 659 - Initial
 QC = 660 -Renewal
 /CHOW
 LICENSE
 NO. _____

IN-HOME CARE AGENCY

License Application Form

Department of Human Services

Health Care Licensure and Certification

Phone: 971-673-0540 Fax: 971-673-0556

If you need this material in an alternate format, please contact this office.

Type of Action:	New Agency ف* Add/Delete Branch ف	License Renewal ف*	Name/address Change ف	Ownership Change ف*	
*Fee Payment Required (See back of this form for amount)					Note New Fee Schedule effective 1/1/2008
Agency Type:	Parent Agency <input type="checkbox"/> Subunit <input type="checkbox"/>			E-mail	
Agency Name:				Effective Date of Ownership Change:	
Agency Street Address:				Fiscal Year Ending Date: MM/DD	
Mailing Address:					
City	State	Zip Code	CO	Phone:	
				Fax:	
Name of Owner(s)					
If partnership or corporation, list each person having 5% or more interest on an additional page.					
Street Address of Owners (Not P.O. Box)					
City	State	Zip Code	CO	Telephone:	
				Fax:	
Describe geographic service area for this parent agency/subunit:					
Name of Administrator:					
Print or Type					
Ownership Category: Health District <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> State <input type="checkbox"/> Corporation <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> Church <input type="checkbox"/>				Ownership Type: <input type="checkbox"/> For Profit <input type="checkbox"/> Non Profit	

DESCRIPTION OF SERVICES

(If this is a change, indicate if adding or deleting service(s))

Bathing		Medication Services	
Personal Grooming/Hygiene		Housekeeping Services	
Dressing		Laundry	
Toileting and Elimination		Shopping and Errands	
Mobility and Movement		Transportation	
Nutrition/hydration and feeding		Arranging Medical Appointments	
Other (specify):		Nursing Services	

DESCRIPTION OF BRANCH OPERATIONS:

(If this is a change indicate if adding or deleting branch office).

List address and telephone numbers of each branch office. List any additional information on a separate page.

LICENSE RENEWAL

I declare, under penalties of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct and complete. I will notify the Health Care Licensure and Certification Section, in writing, of any changes in this information within 30-days of any such change.

<u>Signature of Administrator</u>	<u>Print Name and Title</u>	<u>Date</u>	<u>Changes</u>	<u>Initials HCLC</u>
_____	_____	_____	Y N	_____

Fee Schedule:

New Agency/Subunit	\$1500.00 and \$750.00 for each Subunit
Yearly Renewal	750.00 and 750.00 for each Subunit
Change of Ownership	350.00 and 350.00 for each Subunit

Make check payable to Oregon Department of Human Services, P.O. Box 14450, Portland, OR 97293-0450.

***Please do not make payment for initial licensure until agency has been approved for licensure.**

HCLC Office Use Only

INITIAL LICENSURE:

Approved _____ Denied _____ Withdrawn: _____

If approved, effective date of initial licensure: _____

Section Manager Signature: _____ Date: _____