I. IDENTIFYING DATA

Instructions

1. Enter the name and address of the agency as it is to appear on the license.
2. Enter the name and address of the operator. Corporations applying for approval should enter the legal corporate name as it appears on the Certificate of Incorporation. If the names and addresses of the operator are the same as for the agency, enter "same."
3. Enter the name of the person who is assigned to provide additional information regarding the application.
4. Check the box which indicates the type of ownership for the agency.

Name of Agency _____

Street Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____

Name of Operator (If different from Agency) _____

Street Address _____

City _____ State _____ Zip _____

Telephone _____

Name of Contact Person for Additional Information

☐Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name _____

Street Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ E-mail _____

Type of Ownership

☐ Sole Proprietor ☐ Partnership ☐ For-Profit Corporation ☐ Not-for-Profit Corporation ☐ Limited Liability Company ☐ Public

☐ Other _____

Resolution (Required for all applicants)

A certified copy of the resolution of the Board of Directors or Trustees of a corporation, members of a Limited Liability Company, partners in a partnership, the local legislature or Board of Supervisors for public agencies or other governing body having jurisdiction over the agency program is required. This is an official document authorizing the application to be submitted to the NYS Department of Health for licensure.

Authorizing Signature

I, the undersigned, hereby certify under penalty of perjury that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto, with the exception of those schedules pertaining to personal qualifying and disclosure information which must be individually certified, is accurate, true and complete in all material aspects.

Name (Print or type) _____ Date _____

Signature _____ Title _____

Moratorium Enacted in the NYS 2018-2019 Budget, Effective April 1, 2018 (through March 31, 2020)

The NYS Budget for 2018-2019 includes a moratorium on processing and approving LHCSA applications, with the following limited exceptions:

A. Applications for Licensure of a LHCSA associated with an application for an Assisted Living Program (ALP). The applicant must include the ALP application submission number. LHCSA applicants must have identical ownership to the ALP applicant. Applications are restricted to serving the ALP residents *only.*

B. Applications to transfer ownership of a LHCSA that has been in operation *at least five years* and which is to consolidate two or more *currently operational* LHCSAs. (Please note that the buyer, if a licensed LHCSA, must also be currently operational). The applicant will need to provide verification that both the buyer and seller meet the requirements, as applicable.

C. Applications seeking licensure to address a serious concern, such as lack of access in a geographic area, or lack of access due to inadequate language or cultural or special population competence. There is a presumption of adequate access if there are two or more LHCSAs in the county. The applicant *must provide data-driven evidence* of the lack of access, that no existing agencies can address the concern, and that the applicant can address the concern. If more than one county is requested, the proof must be demonstrated for each county individually. Approval will be restricted to the specifically identified area or population.

Please see the LHCSA Application Instructions for more information.

II. PROJECT NARRATIVE

1. Is this application being submitted as an exception to the moratorium (see grey box above)? ☐ Yes ☐ No

   A. Is this application associated with an Assisted Living Program (ALP)? ☐ Yes ☐ No

      If yes, ALP application please provide the following information:

      ALP application number: _____

      ALP operator name: _____

      Do the ALP and LHCSA have identical ownership? ☐ Yes ☐ No

   B. Is this application to Change ownership or control of an existing LHCSA? ☐ Yes ☐ No

      If yes, be advised that the agency being acquired must be currently providing home care services and must have been doing so for a minimum of five years, and the application must request approval to acquire all the sites of the existing agency. Additionally, if the purchaser is an existing LHCSA, the buyer agency must be currently providing home care services. The following must be attached and uploaded as part of the submission:

      1. The currently approved operator of the LHCSA being acquired must submit a signed and notarized attestation, to be attached to the application that includes:

         a. the number of patients served in each county for which they are approved to serve and the number and types of staff employed, currently and in each of the previous five years.

         b. A statement that reads "In accordance with the requirements of 10 NYCRR 765-2.3 (g) ***{Agency Name}*** will promptly surrender their Licensed Home Care Services Agency license(s) to the NYS Department of Health when they cease providing home care services."

         c. A statement that that indicates the operator understands that the actual transfers of ownership interest may not occur until after all necessary approvals are acquired from the New York State Department of Health and the Public Health and Health Planning Council.

2. If the proposed operator is an existing LHCSA, the applicant must submit a signed and notarized attestation, to be attached to the application that includes:
   a. the number of patients served in each county for which they are approved to serve and the number and type of staff employed currently.
   b. A statement that reads "In accordance with the requirements of 10 NYCRR 765-2.3 (g) *{Agency Name}* will promptly surrender their Licensed Home Care Services Agency license(s) to the NYS Department of Health when they cease providing home care services."

C. Is this application to address a serious concern / lack of access? ☐ Yes ☐ No

If yes, please note there is a presumption of adequate access if there are two or more LHCSAs approved for the proposed county(ies). Approved LHCSAs include both operational and approved but not-yet-operational agencies. If more than one county is requested, all required material must be submitted for each county, with a maximum of five counties. The following must be attached and uploaded as part of the submission:

1. A description of the population to be served.
2. Data-driven proof showing the lack of access for the population described above, including but not limited to demographics, disposition and referral sources, projected utilization, and payor mix, as well as satisfactory documentation that no existing LHCSA can provide services to the population.
3. Satisfactory documentation that the proposed LHCSA will be able to provide services to the population.

2. Check the box below that best describes the category of this application.

☐ Initial Licensure ☐ Purchase or Merger ☐ Change of Stock Ownership ☐ Other Acquisition of Control

☐ Limited Licensure

3. Is this project associated with a Franchise? ☐ Yes ☐ No

If yes, a copy of the Franchise Agreement is required.

4. Is there a Management Agreement associated with this project? ☐ Yes ☐ No

If yes, a copy of the management agreement is required. Be advised that management agreements must receive prior approval by the NYS Department of Health.

III. INITIAL LICENSURE APPLICATIONS ONLY

Instructions: This statement must be reviewed and signed by a duly authorized representative of the applicant seeking approval for initial licensure as an indication that no services requiring home care services agency licensure are presently being provided and will not be provided until such time as a license is received.

Name of Applicant _____

According to Article 36 of the Public Health Law, a home care services agency subject to licensure is an organization engaged in arranging and/or providing, either directly or through contract arrangement, nursing, home health aide or personal care services.

Please confirm the following by signing this statement in the space provided below:

- The applicant is not providing home health aide or personal care by referral, contract or directly at the current time.
- The applicant is not providing registered nurse or licensed practical nurse services in the home at this time outside of that provided as an individual practitioner within the scope of their license.
- Regardless of the title of the workers, the applicant is not providing any individuals, either directly, by contract or through referrals that deliver "hands on" personal care services to patients in their home.
- The applicant is aware that they may not commence operation of the home care agency until after the application has been approved by the Public Health and Health Planning Council and the agency has obtained a license from the Department of Health.

Authorized Signature _____ Date _____

Print Name _____ Title _____

IV. PROGRAM ANALYSIS

1. Attach a project narrative that describes the purpose of the application.
2. Attach a description of the organizational structure of the agency, including level of authority.
3. Attach an organizational chart depicting the relationship to any existing or proposed parent entity, controlling person or subsidiary. This should include: Agency name, Board of Directors, all appropriate branches, divisions and subdivisions and all parent and sibling entities; subsidiaries.

   For Change of Ownership Applications: Provide two (2) organizational charts, one depicting current ownership and one depicting proposed change(s).
4. Attach a description of the client and patient groups proposed to be served.
5. Attach a list of the counties proposed to be served at the time of initial licensure. Be advised that a new LHCSA may only be approved to open one office site at the time of initial licensure.
6. Attach a list of your *anticipated* sources of referral within the proposed service area. The list must include the specific names and addresses of the anticipated referral sources and is required for all applicants.
7. Attach a description of your proposed and/or existing contractual relationship with: other state agencies, local departments of social services, hospitals, residential health care facilities, community alternative systems agencies, third party payers, health, mental health, developmental disabilities, Social Services and Office for the Aging providers in your community as it relates to the referral, case management and discharge of home care patients.
8. Attach a description of the Quality Assurance Program, which will be used to evaluate the home care services provided. Please refer to the Quality Assurance Guidelines provided to assist you in developing your Quality Assurance Program. Please note: The Quality Assurance Committee must include at least one nurse.
9. Indicate on Table 1 the services you propose to provide, the method of delivery and hours and days of availability. Indicate the number of personnel needed by full-time equivalents and estimate the number of cases and visits for the first year of operation. In all categories report those full-time equivalent staff involved in the provision of patient care.

   Please note that at least one (1) Registered Nurse must be employed directly by the agency for the purpose of supervision of Home Health Aides and/or Personal Care Aides. Other nursing services may also be offered either directly by agency staff or by contract.

Table 1 – Service Availability

				Projected Number	
	Method of Provision (Direct or Contract)	Full-Time Equivalent	Availability Hours & Days	Cases	Visits
Nursing					
Home Health Aide					
Personal Care Aide					
Physical Therapy					
Occupational Therapy					
Respiratory Therapy					
Speech-Language Pathology					
Audiology					
Medical Social Services					
Nutrition					
Homemaker					
Housekeeper					
Medical Equipment, Supplies		N/A			

10. In anticipation of operating the proposed agency, please provide a projection of your first year's operating costs and current operating costs, if applicable.

Table 2 – Summary of Operating Costs

Personnel Costs	**Current** Operating Costs (If Applicable)	Estimated Operating Costs (For the First 12 Months of Operation)
Director/Administrator		
Supervisors		
Nurses (RNs/LPN's)		
Home Health Aides		
Personal Care Aides		
Homemakers/Housekeepers		
Professional Staff		
Clerical Staff		
Other Staff		
Employee Benefits		
Other Than Personnel Services		
Space Occupancy (Rent/Utilities)		
Office Supplies		
Contract Services		
Transportation		
Medical and Nursing Supplies		
Other (Please Specify)		
Total		

V. ESTABLISHMENT INFORMATION

Instructions: This section must be completed by all applicants. Select the structure below (from Sections A through G) which applies to this application, and make a check mark in the appropriate box. Note that the submissions required by the category are checked. Review the information required in Section H (Related Organization Information) and, if appropriate, provide the required details as an attachment. Schedule 1 must be completed as indicated in Sections A through H. Note that the Schedule 1's must be signed individually.

☐ A. SOLE PROPRIETOR

Submit the following:

- Schedule 1
- Copy of the existing or proposed certificate of doing business under an assumed name
- Copy(s) of any agreement(s) relating to the proposed transfer of the business interest in the Agency's operation

☐ B. PARTNERSHIP

Submit the following:

- Schedule 1 for each partner
- Complete list of partners, with percent partnership.
- Copy of the existing or proposed certificate of doing business under an assumed name
- Copy of the existing or proposed partnership agreement
- Copy(s) of any agreement(s) relating to the proposed transfer of partnership interests

☐ C. LIMITED LIABILITY COMPANY
Submit the following:

- Schedule 1 for each member
- Complete list of members indicating the percent of ownership of each member
- Complete list of any managing members
- If the limited liability company will be managed by managers who are not members, a copy of the existing or proposed management agreement between the limited liability company and the manager
- Copy of existing or proposed articles of organization
- Copy of existing or proposed operating agreement
- Copy of an existing or proposed certificate of doing business under an assumed name
- Copy(s) of any agreement(s) relating to the proposed transfer of membership interests (if applicable)

☐ D. BUSINESS CORPORATION
New ***or*** existing corporation proposing the operation of the agency. Submit the following:

- Each principal stockholder (holder of 10% or more of the issued and outstanding stock), board officer and member of the board of directors must submit a Schedule 1
- Copy of the existing or proposed certificate of incorporation and a copy of the executed or proposed certificate of amendment, merger, or consolidation or application for authority where appropriate.
- Copy of the existing or proposed certificate of doing business under an assumed name (if applicable).
- Complete list of all board officers, directors, indicating position or title of each (i.e. board member, treasurer, etc.)
- Complete list of all principal stockholders, including: the number of authorized shares, the number of issued shares, the number of shares of stock to be owned by each and the number of unissued shares.
- Copy of the existing or proposed bylaws.
- Copy of certificate of approval to do business in New York State (if applicable).

☐ E. BUSINESS CORPORATION (Transfer of Stock)
Submit the following:

- Each individual that will become a principal stockholder and any board officer or member of the board of directors of the acquired or acquiring entity must submit a Schedule 1.
- Copy(s) of any agreement(s) relating to the proposed transfer of stock interests.

☐ F. NOT-FOR-PROFIT CORPORATION
Submit the following:

- Each board member and director must submit a Schedule 1.
- Copy of the existing or proposed certificate of incorporation or copy of the executed or proposed certificate of amendment, merger or consolidation, or application for authority where appropriate.
- Copy of the existing or proposed certificate of doing business under an assumed name.
- Complete list of officers and directors indicating position or title of each (i.e. board member, chairperson, treasurer, etc.).
- Copy(s) of any agreement(s) relating to the proposed transfer of the business interest in the agency operation.
- Copy of the existing or proposed bylaws.

☐ G. PUBLIC AGENCIES/PUBLIC BENEFIT CORPORATIONS
The Public Agency/Public Benefit Corporation must submit the full name and address, and the license/certificate number, for all agencies or facilities that are operated by the applicant and certified or licensed for the provision of health care.

☐ H. RELATED ORGANIZATION INFORMATION

1. List the full legal name and the address of the principal office and place of doing business of any existing or proposed parent corporation, controlling person or controlling organization which directly or indirectly, through one or more intermediaries, possesses or will possess the ability to direct or cause the direction of the actions, management or policies of the person, corporation, organization or other entity that is licensed as the operator of the subject home care agency or that is applying for approval as a licensed home care agency.
2. With respect to each parent corporation, controlling person or other controlling organization identified in response to item (1) above:
   a. List the full name of each member of the board of directors, board officer, controlling person, principal stockholder, sponsor of such parent corporation or controlling person or organization. Each principal stockholder, board officer and member of the board of directors must submit a Schedule 1.
   b. List the full legal name and the address of the principal office and place of doing business of any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency, or other health care facility or program, regardless of location, owned or operated by such parent corporation or controlling person or organization, together with a photocopy of any operating license, permit or certificate issued for such facility or program, the full name of the issuing agency and dates of ownership.
   c. Describe in detail the relationship between the applicant and any parent corporation, controlling person or organization and describe in detail the method or mechanism by which control over the licensed home care services agency is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement).
3. With respect to any existing or proposed parent corporation or controlling person or organization identified in response to question (1) above:
   a. List the full legal name and the address of the principal office and place of doing business of any subsidiary corporation or organization that owns or operates any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency or other health care facility or program, regardless of location, and the full legal name and the address of the principal office and place of doing business of any such health care facility or program, together with a photocopy of any operating license, permit or certificate issued for such facility or program, and the full name of the issuing agency and dates of ownership.
   b. List the full name of each of the members, directors, controlling persons, principal stockholders, board officers and sponsors of each subsidiary corporation or organization identified in response to (3) (a) above.
   c. Describe in detail the relationship between the applicant, parent corporation, controlling person or organization and each subsidiary corporation or organization identified in response to (3) (a) above and describe in detail the method or mechanism by which control over the subsidiary is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement).