



APPLICATION FOR LICENSE TO OPERATE A HOSPICE PROGRAM

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 8932 (R10-19)

DEPARTMENT USE ONLY

License Number

INSTRUCTIONS: Type or print clearly. Return one completed, notarized copy to: ND Department of Health, Division of Health Facilities, 600 E Boulevard Ave. Dept. 301, Bismarck, ND 58505 – 0200. Keep a copy for your records.

Official Name of Hospice Program		NPI Number	
Street Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
County	Business Telephone Number	Fax Number	
E-Mail Contact Name	E-Mail Address		

TYPE OF APPLICATION

<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change of Facility Ownership	<input type="checkbox"/> Change in Service Area	<input type="checkbox"/> Name Change
<input type="checkbox"/> Location Change	<input type="checkbox"/> Change in Services	<input type="checkbox"/> Change in Facility Operator	<input type="checkbox"/> Other Change:	

MANAGEMENT

HOSPICE OPERATOR (Check One)				
<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Home Health Agency	<input type="checkbox"/> Freestanding Hospice	
<input type="checkbox"/> Residential Hospice Facility		<input type="checkbox"/> Inpatient Hospice		
TYPE OF CONTROL (Check One)				
GOVERNMENTAL	<input type="checkbox"/> State	<input type="checkbox"/> County	<input type="checkbox"/> County & City	<input type="checkbox"/> Municipal
NONPROFIT	<input type="checkbox"/> Association	<input type="checkbox"/> Corporation	<input type="checkbox"/> Religious Affiliation	
PROPRIETARY	<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	

OWNER-OPERATOR

Name of Hospice Program Owner				
Mailing Address	City	State	ZIP Code	
Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)				
Mailing Address	City	State	ZIP Code	
Name of Chairman of Governing Body				
Mailing Address	City	State	ZIP Code	
Has ownership of this hospice changed in the last twelve months? <input type="checkbox"/> No <input type="checkbox"/> Yes	Has the legal entity responsible for operation of this hospice changed in the last twelve months: <input type="checkbox"/> No <input type="checkbox"/> Yes			

INSURANCE INFORMATION

Name of Hospice's General Liability Insurance Company				
Name of Agent				
Mailing Address of Agent	City	State	ZIP Code	

HOSPICE PROGRAM PERSONNEL

Name of Administrator		Title		
Is the administrator affiliated with a hospital, nursing facility, home health agency, or some other provider? <input type="checkbox"/> No <input type="checkbox"/> Yes – What facility				
Medical Director (Physician)			License Number	
Nurse Supervisor (RN)			License Number	
Name and Title of Emergency Contact			Emergency Contact's Cell Phone Number	
List Hospice Services Provided Directly by the Hospice Program Below				

