APPLICATION FOR THE OPTIONAL SERVICES OF END OF LIFE CARE IN A BASIC CARE FACILITY

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 60906 (04-15)

DEPARTMENT USE ONLY

License Number
Bed Capacity
Licensure Period

This form does not replace your Basic Care Facility Licensure Application. Need to complete Attestation.

INSTRUCTIONS: Type or print clearly. Attach other information as requested with the application. 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 Basic Care Facility		NPI Number	
Street Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code
County	Business Telephone Number	Fax Number	Bed Capacity
E-Mail Contact	E-Mail Address		

MANAGEMENT AND PERSONNEL

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
Name of Basic Care Facility's General Liability Insurance Company	Name of Agent		
Mailing Address of Agent	City	State	ZIP Code
Name of Administrator			
Name and Title of Emergency Contact	Emergency Contact's Cell Phone Number		

PLEASE ATTACH A COPY OF THE FACILITY'S POLICY AND PROCEDURES REGARDING END OF LIFE CARE.

Applicant agrees to the following when providing end of life care to one or more residents:

1. To complete E-Scores weekly or with a significant change in the resident's evacuation capability and adjust facility staffing accordingly;
2. To provide 40 hours of onsite licensed nurse staffing;
3. To submit initial notification to the department when the resident elects end of life;

ATTESTATION OF COMPLIANCE WITH THE LICENSURE REQUIREMENTS TO PROVIDE OPTIONAL SERVICES OF END OF LIFE CARE IN A BASIC CARE FACILITY

Facility			
Address	City	State	ZIP Code

Prior to providing end of life care to any resident in the basic care facility this form must be completed and submitted with the requested information to the Department of Health (DOH) for approval. DOH will review your submitted information. Upon approval DOH will provide a new license identifying that the optional services of end of life care in the basic care facility has been approved.

Provide an answer or submit the requested information to DOH:

1. The facility has a written agreement with a state licensed and Medicare certified hospice provider delineating responsibilities? ☐ Yes ☐ No

Provider's Name

A written agreement is required for each certified hospice provider chosen by the resident or family. Availability of the written agreement(s) will be requested at the time of the survey.

2. The required staff education training has been completed within the required time frames? ☐ Yes ☐ No

   The documentation for the staff training will be reviewed at the time of the survey. The training must include, but is not limited to:
   - Ambulation assistance, including transfers with a gait belt;
   - Universal precautions;
   - Changing an occupied bed;
   - Repositioning;
   - Toileting using a bedpan/commode;
   - Partial bed bath;
   - Catheter care and emptying a urinary drainage bag;
   - Hospice philosophy;
   - Ethical and privacy consideration;
   - Hospice eligibility and services;
   - Communication techniques;
   - Spiritual care services;
   - Bereavement and grief explorations; and
   - Alternative therapies.

3. Is the facility located in a building that meets the health care occupancy requirements of the Life Safety Code? ☐ Yes ☐ No

4. Is the facility located in a building equipped with a NFPA 13 or 13R automatic sprinkler system? ☐ Yes ☐ No

5. Does the facility have additional staffing available to respond to changes in E-scores as the resident's condition changes? ☐ Yes ☐ No

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a license to operate a basic care facility with the optional service of end of life care subject to the provisions of North Dakota Century Code Chapter 23-09.3 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and all attachments and to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.

Administrator's Signature	Date

State	County

Signed and sworn to (or affirmed) before me on	Date

Name(s) of Individual(s) Making Statement	Affix Notary Stamp
Signature of Notary Public or Other Authorized Officer	
Commission Expiration Date (if not listed on stamp)	