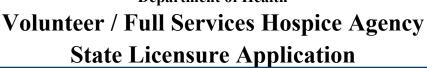


Department of Health





DUE DATE: 90 DAYS PRIOR TO THE EXPIRATION OF YOUR CURRENT LICENSE (AS 47.32.060)

Pursuant to the AS 47.32 Licensing Statute and the regulations of the Department of Health Health Facilities Licensing requirements (7 AAC 10 and 7 AAC 12).

Litti	ising requirements (7 AAC 10 and 7 AA	10 12).		
	application can be used for initial licensur elow to indicate the purpose of this application		ns and biennial license renev	wals. Please check the appropriate
Type	of License Applying for (select one):	☐ Initial P	rovisional Licensing	☐ Biennial Renewal License
Gene	ral Instructions:			
1	 Application should be complete, clear signed in permanent ink and submitted team. Contact info is located below. 			
2	. If more space is needed, additional pag that does not fit within the given space			
3	. This application must be executed and corporation, association or governmen			wo officers in the case of a
4	There are licensure fees associated with regarding the fees due for your facility 2483.			
5.	. A separate application is required for f under a separate license number. Separately, even though owner	rate applicati	ions are required for each in	
1. <u>F</u>	ACILITY DEMOGRAPHIC			
	State Licensing Number:		-	
	Legal Name:			
	Doing Business as:			
	Physical Address:			
	City:			
	Mailing Address:			
	City:			
	Primary Phone Number:			per:
	Primary Fax Number:			er:

Revised 02/12/2024 Page 1 of 13

Generic Email (info@abcfacility.com):



Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application



Other Locations Under Same Licensure:

Other locations under same licensure include facilities that are located in services area as the parent facility and shares administration, supervisors, and/or services with the parent facility on a daily basis.

Please provide the name and location Name:	Location:
Name:	Location:
Name:	Location:
ADMINISTRATION	
Please provide the information below for	all positions as they apply to your facility type.
a. Administrator (for initial application	ns, attach resume as Exhibit I):
Name:	Title:
Direct Phone:	Fax:
Email:	
b. Medical Director / Director of Clini	ical Services (for initial applications, attach resume as Exhibit II):
Name:	Title:
Direct Phone:	Fax:
Email:	
c. Supervising Nurse / Director of Nur	
Name:	Title:
Direct Phone:	Fax:
Email:	
ACCREDITATION (if applicable)	
Is the facility be fully approved by and account	creditation organization? Yes*: □ No: □
If yes, please provide the following inform	nation:
Accrediting Organization:	
	Type of Survey:
	Frequency of Accreditation Cycle:

Revised 02/12/2024 Page 2 of 13

^{*}Facilities with accreditation through a nationally recognized organization may be eligible to waive their biannual State licensing survey for the current/upcoming licensing period. To apply, and for more information, please see the State Licensing Survey Waiver Application attached at the end of this application.



4. OWNERSHIP & CONTROL

State of Alaska

Department of Health

Volunteer / Full Services Hospice Agency



State Licensure Application

Gov	ernmental:		State		Borough			City/Community	y	
Non	Non for Profit:		Church Operated of	ated or Affiliated				Corporation		
Prop	orietary:		Individual		Partnership			Corporation		
Othe	er (please ex	plain):								
	· ·	. , _								
a.	Individual	or Parti	nership Owned (lis	t all	persons who	own the	e fa	cility)		
	Number	Name		Ad	ldress					
	1.									
	2.									
	3.									
	4.									
b.	Names und	ler whic	h person(s) in (a.)	do b	usiness (other	than th	ie f	facility indicated	on this applica	tion)
	Number	Name	;			Busine	ess			
	1.									
	2.									
	3.									
	4.									
c.	Corporate (Ownersh	nip							
	Name of Co	orporatio	n:							
			Firm or Organizatio							
			address of each con							
			•	рого						
	Number	Title	Name		Address	5				
	2.									
	3.									
	4.									
d.	List names	and add	resses of each shar	ehol	lder holding n	nore tha	ın :	5% of shares OF	Rownership	
	Number	Name						St	tate of	Percent of
								R	esidence	Shares
	1.									
	2.									
	3.									
	1	1								

Revised 02/12/2024 Page 3 of 13



Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application



e	. If the property or building this facility is operating in is on a lease or rental agreed ownership.	ment, please spe	cify
f	Trust or Endowment Operated		
	Trustee Name:		
	Address:		
	City:State:Zip Code:		
	If yes, attach a list of names and explanations as Exhibit III :	Yes: □	No: □
5.	CRIMINAL BACKGROUND CHECKS		
	Does the facility have a system in place for performing criminal background checks and 7 AAC 10.900 - 990 through the Alaska Background Check Program (BCP)?	in accordance wit	th AS 47.05
		Yes: □	No: □
6.	INSURANCE		
	Does this facility have current Malpractice Insurance?	Yes*: □	No: □
	Company:		
	Address:		
	Expiration Date:		

Revised 02/12/2024 Page **4** of **13**



Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application



7. SUBUNITS & BRANCHES

Branch office is located in the s	same service area	as the parent agency	and shares	administration,	supervision,	and
service with the parent agency of	on a daily basis: a	branch office is not	reauired to	be separately	licensed.	

Does the	agency have any subunits or branch offices?	Yes: □	No:
Provide	the name and location of any subunits or branch offices of the hospice a	gency:	
Name	Location	Subunit (Yes or No)	Branch (Yes or No)
B. TYPE OF	HOGDIGE AREXAMBLE		
☐ Hospita		☐ Free Standin	g Hospice
☐ Hospita	_	☐ Free Standin	g Hospice
☐ Hospita	l Skilled Nursing Facility Home Health Agency	☐ Free Standin	g Hospice
☐ Hospita ☐ Other: ☐ AUTHOR If the hospi	l ☐ Skilled Nursing Facility ☐ Home Health Agency		
☐ Hospita ☐ Other: ☐ AUTHOR If the hospi authority or	1 Skilled Nursing Facility Home Health Agency ITY & SUPERVISION ce has established lines of authority or supervision, provide an organizar		
☐ Hospita ☐ Other: ☐ AUTHOR If the hospita authority on If yes, at	Skilled Nursing Facility Home Health Agency ITY & SUPERVISION ce has established lines of authority or supervision, provide an organiza supervision.	tion chart that prov	rides the line o
☐ Hospita ☐ Other: ☐ Other: ☐ AUTHOR If the hospita authority of the service of	ITY & SUPERVISION ce has established lines of authority or supervision, provide an organiza supervision. tach chart and explanation as <u>Exhibit VI</u> .	tion chart that prov	rides the line o
Hospita Other: Other: AUTHOR If the hospita authority of the second	ITY & SUPERVISION The has established lines of authority or supervision, provide an organization supervision. TRATIVE (Full-Service Hospice Only - as of completion date)	tion chart that prov	vides the line o
Hospita Other: Other: AUTHOR If the hospi authority of If yes, at 10. ADMINS' Does the Does the	ITY & SUPERVISION the has established lines of authority or supervision, provide an organizat supervision. tach chart and explanation as Exhibit VI. FRATIVE (Full-Service Hospice Only - as of completion date agency have a governing body?	tion chart that prov of this application	vides the line o

Revised 02/12/2024 Page 5 of 13



Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application



Does the age	ncy maintain	records of liv	0 11						
Does the age		iccords of in	censure of all pi	ofessional emp	ployees?		Yes]
	ncy have a re	egistered nurs	e who coordina	tes therapeutic	services?		Yes]
Does the age	ncy have an i	interdisciplina	ary team?				Yes]
Provide a list o	of disciplines:								
									_
Provide numbe	er of clients (u	unduplicated	N (if this is an admissions) ser	ved during the	last full calend	ar year (f	Í	nuary 1	
rovide numbe hrough Decem	er of clients (unber 31):	anduplicated a	•	ved during the	last full calend	ar year (f	rom Jan		
rovide numbe nrough Decem	er of clients (unber 31):	anduplicated a	admissions) ser	ved during the	last full calend	ar year (f	above):		_
rovide numbe hrough Decem	er of clients (unber 31):ents served in	anduplicated	admissions) ser	ved during the	last full calend	ar year (f	above):	:	
Provide numbe hrough Decem Number of clie	er of clients (unber 31):ents served in	anduplicated	admissions) ser	ved during the	last full calend	ar year (f	above):	:	

Revised 02/12/2024 Page 6 of 13



Department of Health





12. PERSONNEL/STAFFING

Provide full time equivalents (FTEs), part time equivalents (PTEs) & paid volunteers (PVs) for the following staffing areas.

*Vacancies: The total number of FTE's & PTE's MUST include any vacant positions. A vacancy does not reduce the total number of positions.

If you indicate vacancies, please provide a yes or no response to the "actively recruiting" and "qualified person acting" column.

Positions	FTE	PTE	PV	Vacancies*	Actively Recruiting (Yes or No)	Qualified Person Acting (Yes or No)
Administration						
Medical Director						
Physician or PAC						
R.N.						
LPN						
Nurse Practitioner						
Physician Assistant						
Home Health Aide						
Personal Care Attendant						
Dietitian						
Occupational Therapist						
Physical Therapist						
Speech Pathologist						
Audiologist						
Medical Social Worker						
Health Care Professional						
Non-Health Care Professional						
Total					N/a	N/a

Revised 02/12/2024 Page 7 of 13



Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application



13. **VOLUNTEERS**

This section refers to voluntee Personnel/Staff above.	ers providing care	or services not requ	niring licensure and	not listed in Section 12 –
Number of Volunteers:				
Total combined volunteer	hours of care & se	ervices provided pe	er week (approximat	e hour):
14. ADMINSTRATOR'S AFF Does the administrator have other	_	h a ligangad hama l	haalth hagniaa hag	aital or nursing homo?
Does the administrator have on	ici arimations wit		s (If yes, provide inf	
Facility Name:		Address:		
15. SOURCES OF INCOME Provide the information as required.	uested below for s	source(s) of income	e:	
Sources			Percentage	Income
Medicare Part A				
Medicare Part B Medicaid				
Third Party Payers (Health In	nsurance VA Wo	rkers Comp. ect.)		
Fees from Patients	isurunee, v11, wo	rkers comp, cet.)		
Other (Grants, Contributions	, Bequests, Fund F	Raising, ect)		
Total			100%	
16. SERVICES (attach additional Service Category	onal sheet if mor Services Pro	-		Outside Contractor
Physician Services*	☐ Direct	☐ Contract		
Nursing Services*	☐ Direct	☐ Contract	- 	
Social Services*	☐ Direct	☐ Contract		
Pastoral Counseling*	☐ Direct	☐ Contract		
Bereavement Counseling*	☐ Direct	☐ Contract	_	
Dietary Counseling*	☐ Direct	☐ Contract		
, 6				

Revised 02/12/2024 Page 8 of 13



Department of Health

Volunteer / Full Services Hospice Agency



State Licensure Application

Short-Term Inpatient (respite)**		Direct		Contract	
Shor-Term Inpatient (acute)**		Direct		Contract	
Aide Service		Direct		Contract	
Homemaker		Direct		Contract	
Physical Therapy		Direct		Contract	
Occupational Therapy		Direct		Contract	
Speech/Language Pathology		Direct		Contract	
Medical Supplies		Direct		Contract	
Drugs & Biologicals		Direct		Contract	
Medical Equipment		Direct		Contract	
Personal Care		Direct		Contract	
IV Infusion		Direct		Contract	
*5	Servi	ces required	to q	uality as Full-Service	e Hospice
** Short-Term inpatient	care	can only be	prov	rided in a licensed ho	spital or skilled nursing facility.
17. GEOGRAPHICAL AREA SI	ERV	ED			
			ne ag	ency. Provide specif	ic areas or regions. The Department wil
not accept descriptions such as "S		•	_	•	•

Revised 02/12/2024 Page 9 of 13



Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application



18. COMPLIANCE AGREEMENT

A. Volunteer Hospice Agency Only

7 AAC 12.317. Scope of service: volunteer hospice agency.

- (a) Subject to (b) of this section, a volunteer hospiceagency shall provide each of, and only, the following services:
 - (1) direct service volunteers;
 - (2) spiritual and emotional support services to the client, the client's family, and caregivers if these services are desired during the time the client is receiving hospice care;
 - (3) supervision, orientation, and training to direct service volunteers and other hospice staff;
 - (4) bereavement counseling services to assist the client's family and caregivers in coping with grief experiencedafter the client's death; and
 - (5) volunteer services in accordance with 7 AAC 12.336.
- (b) A volunteer hospice agency may provide short-term respite care to the client's family for the relief of the client's daily care.
- (c) A volunteer hospice agency shall investigate, analyze, and respond to client grievances related to client care.
- (d) A volunteer hospice agency shall ensure that each client has a plan of care approved by the attending physician or advanced nurse practitioner, and by the program manager.
- (e) A volunteer hospice agency shall develop and implement written policies and procedures consistent with this chapter that govern each service provided by the agency, including policies relating to confidentiality, training, and admissions. The policies and procedures must accurately describe the agency's goals, the methods by which the goals are achieved, and the mechanisms by which basic hospice care services are delivered. The agency must review its policies and procedures at least annually. The program director shall document each review by dating and signing an attestation. The agency shall revise its policies and procedures if determined necessary by the agency or by the department to ensure that each policy and procedure iscurrent and adequate for purposes of carrying out the agency's functions and maintaining consistency with this chapter.
- (f) Volunteer services in a volunteer hospice agency must be directed by a coordinator of volunteer services who shall.
 - (1) implement a direct service volunteer program;
 - (2) coordinate the orientation, education, support, and supervision of direct service volunteers; and
 - (3) coordinate the use of direct service volunteers with other hospice staff and community resources.

DOES THE VOLUNTEER HOSPICE AGENCY MEET ALL THE ABOVE SCOPE OF SERVICE REQUIREMENTS?

No*

*If not please provide an explanation on a separate sheet as Exhibit V

Revised 02/12/2024 Page 10 of 13



Department of Health

Volunteer / Full Services Hospice Agency State Licensure Application



B. Full-Service Hospice Only

7 AAC 12.316. Scope of service: full-service hospice agency.

- (a) A full-service hospice agency shall provide
 - (1) physician or advanced nurse practitioner services to provide directed medical care that meets the client'smedical needs for palliative care and management of terminal illness;
 - (2) nursing care and services provided by or under the supervision of a registered nurse;
 - (3) social work services provided in accordance with
 - (4) spiritual and emotional counseling services in accordance with 7 AAC 12.337 to the client, the client's family, and caregivers if these services are desired during the time the client is receiving hospice care;
 - (5) bereavement counseling services in accordance with 7 AAC 12.337 to the client's family and caregivers afterthe client's death:
 - (6) volunteer services in accordance with 7 AAC 12.336;
 - (7) dietary counseling services in accordance with 7 AAC 12.337;
 - (8) pharmaceutical hospice services in accordance with 7 AAC 12.343;
 - (9) services related to the referral and transfer of clients for laboratory services that are provided by an organization other than the hospice; the referral and transfer services must be provided in accordance with a written plan that delineates available services and the procedures for referring and transferring clients;
 - (10) services related to the transfer of specimens for laboratory services that are provided by an organization other than the hospice; the transfer services must be provided in accordance with a written plan that delineates available services and the procedures for transferring specimens; and
 - (11) short-term respite care to the client's family for the relief of the client's daily care.
- (b) In addition to meeting the requirements of (a) of this section, the hospice agency shall evaluate each client's
 - (1) access to emergency medical services, including ambulance service;
 - (2) access to service, equipment, and supplies;
 - (3) safety and emergency preparedness within the client's place of residence.
- (c) The hospice agency shall make nursing services, physician or advanced nurse practitioner services, and drugs and biologicals available on a 24-hour basis to the extent necessary to meet the client's needs for palliative care and management of terminal illness and related conditions.
- (d) The hospice agency shall arrange for short-term inpatient care if home care is not feasible for pain control, symptom management, and respite purposes. The agency shall ensure that any short-term inpatient care is provided in a licensed facility that is most appropriate to meet the client's needs.
- (e) The hospice agency shall offer hospice care in the least costly setting that can assure the quality of care and each type and amount of service that is necessary to meet the client's needs.
- (f) The hospice agency shall have a risk management program that includes procedures to investigate, analyze, and respond to client grievances related to client care.
- (g) The hospice agency shall develop and implement written policies and procedures consistent with this chapter that govern each service provided by the agency, including policies relating to confidentiality, training, and admissions. The policies and procedures must accurately describe the agency's goals, the methods by which the goals are achieved, and the mechanisms which basic hospice care services are delivered. The agency shall review its policies and procedures at least annually. The program director shall document each review by dating and signing an attestation. The agency shall revise its policies and procedures if determined necessary by the agency or by the department to ensure that each policy and procedure is current and adequate for purposes of carrying out the agency's functions and maintaining consistency with this chapter.

DOES THE FULL-SERVICE HOSPICE AGENCY
MEET ALL THE ABOVE SCOPE OF SERVICE REQUIREMENTS?

Yes

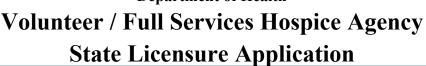
*If not, please provide an explanation on a separate sheet as Exhibit VI

□ No*

Revised 02/12/2024 Page 11 of 13



Department of Health





This form must be completed to finalize the transaction.

Licensing renewal fee amounts can be reviewed under **7 AAC 12.615**. For more information or for assistance calculating the fees for your facility, please contact HFLC at 907-334-2483 or by email at dhcs.hflc@alaska.gov

We accept payments by check and credit card.

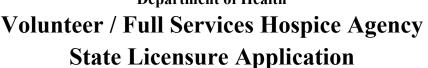
To make a credit card payment by phone: **Call 907-334-2400**, **opt. 3**. You will be asked to provide the <u>full facility name</u>, <u>state licensing number</u>, and <u>exact payment amount</u>.

State Licensing Number:	
Facility Type:	Payment Type:
Facility Name:	
Facility Contact:	
Payment Amount (includes licensing an	nd bed / branch fees if applicable): \$
Date of Credit Card Payment (indicate	ed the date you made a payment by phone):
Payment by Check: Check #:	Check Date:
Make (Checks Payable to: State of Alaska – HFLC
Н	HFLC Mailing/Physical Address: State of Alaska ealth Facilities Licensing & Certification 4601 Business Park Blvd. Bldg. K Anchorage, AK 99503
For	r State of Alaska Accounting Use ONLY
DEPT : 06 FUND : 100	04 UNIT: 4011 APPR: 062330704 REVENUE: 5101
Activity: 4HF0 - License/Renewa	al Fee □ 4HF1 - Revisit □ 4HF2 - Modification □ 4HF3 - Fine
Payment Received on:	Check # / CC Auth#:
Payment Received & Coded by:	:
Notes/Comments:	

Revised 02/12/2024 Page 12 of 13



Department of Health





19. ATTESTATION

The applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that the contents of this application and the information provided with it are true, accurate, and complete.

In addition, the applicant, or the person authorized to submit the application on behalf of an applicant that is not an individual, declares and certifies that he or she has reviewed the regulatory requirements contained in 7 AAC 10.900 - 990 (Barrier Crimes, Criminal History Checks, and Centralized Registry), 7 AAC 10.9500 - 9535 (General Variance), 7 AAC 10.9600 - 9620 (Inspections and Investigations), the applicable requirements of 7 AAC 12.310 - 349 (Hospice Agencies) and the applicable requirements of 7 AAC 12.600 - 990 (General Provisions).

The undersigned give assurance that the facility is in compliance to the best of his/her knowledge, and he/she is prepared for an on-site inspection to validate compliance.

Printed Administrator or Designee Name:	Date:
Signature of Administrator or Designee:	

Submit this application and all required attachments via mail, hand delivered, faxed or email:

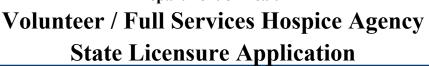
Health Facilities Licensing & Certification
4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503

Email: dhcs.hflc@alaska.gov

Revised 02/12/2024 Page 13 of 13



Department of Health





State Licensure Survey Waiver Application

Facilities with accreditation through a nationally recognized organization may be eligible to waive their biannual State licensing survey for the current/upcoming licensing period. To learn more about the survey waiver an eligibility, please refer to 7 ACC 12.925 and AS 47.32.030(a)(9)(A-C). To apply, please provide the following information.

Facility Type:			AK License Number:		
Facility Name:					
Satellite Locations:	Yes*: □	No: □	(*if yes, inspection reports for those sites are also required)		
Physical Address:					
Primary Phone:			Primary Fax:		
Email for facility distrib	ution list:				
Administrator:			Administrator's Phone:		
Administrator's E-Mail:					
Secondary Contact			Title:		
Secondary's Phone	condary's PhoneSecondary's E-Mail:		Secondary's E-Mail:		
Name of Accrediting Or	ganization (AO)):			
Date of last inspection:			Frequency of accreditation cycles:		
Were any deficiencies id	dentified during	last inspection?	*Yes: □ No: □		
*If yes, have t	the deficiencies	been corrected?	Yes: □ No: □		
For surveys conducted i	n the past 2-3 m	onths, in which t	the facility has not received the report or have an approved plan		
correction – when do yo	u expect to rece	ive these docume	ents?		
Name of Person Comple	eting Form:		Date:		
A copy of your la	st inspection re		f correction MUST be submitted with the application or the vill be denied		
		FOR D	DIVISION USE ONLY		
Date Application Receiv	/ed:		All attachments included: Yes: \(\square\) No: \(\square\)		
Application Reviewed b	y:		Date Reviewed:		
Application is: Approve	d: □	Denied*: □			
Reason for Denial:					
Signature:			Date:		

Revised 02/12/2024 Page 1 of 1