

**LICENSURE APPLICATION
for
HOSPICES (INPATIENT)
REGULATION 61-78**

Return the completed application to:

Email address (preferred method):

Hospice@dph.sc.gov

OR

Mailing address:

**Bureau of Health Facilities Licensing
2100 Bull Street
Columbia, SC 29201**

For additional questions, contact us at: 803-545-4370.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

NOTICE: Your license must be renewed prior to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or capacity increases/decreases) from the Department that are in progress at the time the license is due for renewal.

Application must be complete and legible. Any missing information may result in delays in processing this application. Any section that requires additional space or documentation shall be included as an attachment in the 8.5" x 11" format and be labeled to identify the appropriate section. Proof of payment is required for all applications submitted.

Reason for the Application

- Initial: Check this box only if this is the first time you are applying for a license with the Department. DO NOT check this box if this is a change of ownership for an existing licensed service/facility.
- Renewal: Check this box only if you are renewing your license. Enter the license number and expiration date. The name of the service/activity must appear exactly as it did the prior year.
- Amended License Request: Check this box if you are applying for a change that will alter the information on the face of your license; then, ensure that you complete Part D.

Part A: Facility Information

- Facility Information-Please complete the applicant information for the facility.
- For additional buildings: If you have more than 2 buildings, attach an additional sheet with the requested information.
- Contact Person and Corresponding Mailing Address: All correspondence coming from the Bureau of Health Facilities Licensing will be sent to this person and address.
- Qualified Administrator: Please complete each field. If there is more than one Qualified Administrator, please provide the information on a separate piece of paper. Submit a copy of each Administrator's qualifications.

Part B: Operation/Ownership Disclosure

- Licensee Information: Name of the person(s) or entity to be licensed to operate the hospice at the site indicated in Part A.
- Indicate the ownership type: Choose one type per category.
- Complete the requested information:
 - For partnerships, you must provide the name of each partner;
 - For limited liability company (LLC), you must provide the names of members, attach a list with the names and address of the members of the limited liability company;
 - For a corporation, you must provide the name and title of each corporate officer

Part D: Licensure Changes

- For Name or Address changes, complete Section 1.
- For Ownership changes, complete Section 2.
- For participant capacity changes, complete Section 3.

Part E: Verification

- The application shall be signed by the following:
 - If an individual partnership, **the owner(s)**
 - If a corporation, **two** of its **officers** if a corporation
 - If governmental unit, the **head of the governmental department** having jurisdiction
- You must have this page notarized.



Application for Hospices (Inpatient)
Regulation 61-78

Reason for Application		
<input type="checkbox"/> Initial	<input type="checkbox"/> Renewal	<input type="checkbox"/> Change Request <i>(Complete Parts C and D)</i>
License Number:	Expiration Date:	

Part A. Facility Information			
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Total Number of Beds:			
In how many buildings are patient/resident rooms located?			
Name of building:		Number of beds:	
Name of building:		Number of beds:	

Food Service Areas	
Number of Kitchens:	
Is food prepared by a caterer? <input type="checkbox"/> YES <input type="checkbox"/> NO (if yes, please attach a copy of the catering contract)	
Certified Food Protection Manager: (INITIAL APPLICATIONS MUST attach a copy of certification)	
Name:	
Certificate Date:	Expiration Date:
Course Taken:	Institution:

Contact Person and Correspondence Mailing Address:	
<i>(Name of person who can make licensure/operation decisions about facility and address where you want to receive ALL correspondence, including the license, from the Bureau of Health Facilities Licensing.)</i>	
Name:	Title:
Address:	
City:	State:
Zip:	
Telephone Number:	
Primary Email:	
Qualified Administrator: (INITIAL APPLICATIONS MUST provide a copy of qualifications)	
Name:	
Address:	
Telephone Number:	Fax:
Email Address:	

Part B. Operation Disclosure

Licensee Information: *(name of the person(s) or legal entity licensed to operate the business at that site as indicated in Part A)*

***This can be found on your current license OR your documentation from the Secretary of State.**

Licensee Name:

Address:

City:

State:

Zip:

Telephone Number:

Fax Number:

Ownership Type: *(only choose one per category)*

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Corporation | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Limited Liability (LLC)* | |
| <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Government | |

Licensee or Owner Documents Required

1. Secretary of State documentation, if applicable Attached N/A
2. If the licensee is a corporation or partnership, attach a list identifying all officers. Attached N/A
3. If the licensee or owner is a corporation or partnership, attach a list with the name, address and percentage of all owners that possess 5% or more ownership of the company or partnership. Attached N/A
4. If any person or other legal entity can claim liabilities of the licensee or of the facility or service for which this license is requested, attach a list identifying the name, address, percent and type of claim. Attached N/A

Part C: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES

<input type="checkbox"/> Change of Facility Name and/or Location (Complete Section 1)	<input type="checkbox"/> Change of Ownership (Complete Section 2)	<input type="checkbox"/> Change of Capacity (Complete Section 3)
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Section 1 (FACILITY INFORMATION)

PRIOR TO CHANGE

Current License Number: _____

Current Facility Name: _____

Current Facility Address: _____

City: _____	State: _____	Zip: _____
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Facility Telephone Number: _____ Fax Number: _____

AFTER CHANGE

New Facility Name: _____

New Facility Address: _____

City: _____	State: _____	Zip: _____
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New Facility Telephone Number: _____ Fax Number: _____

Section 2 (LEGAL IDENTITY OF OWNERSHIP)
Application must be completed by new owner, as licenses are not transferable.

PRIOR TO CHANGE

Name of Current Owner: _____	License Number: _____
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Address of Current Owner: _____

City: _____	State: _____	Zip: _____
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Telephone Number of Current Owner: _____

Signature of current owner: _____	Date: _____
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AFTER CHANGE

Name of New Owner: _____

Address of New Owner: _____

City: _____	State: _____	Zip: _____
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Telephone Number of New Owner: _____

Signature of new owner: _____	Date: _____
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Section 3 (CHANGE OF CAPACITY)

License Number: _____

Facility Name: _____

Facility Address: _____

City: _____	State: _____	Zip: _____	County: _____
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<input type="checkbox"/> Increase		<input type="checkbox"/> Decrease
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Number of Beds	From: _____	To: _____
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Part D: Verification

The application shall be signed by the following:

- If an individual, the **owner(s)**
- If a limited liability company, the **head of the limited liability company**
- If a corporation, **two** of its **officers**
- If governmental unit, the **head of the governmental department** having jurisdiction

I, the undersigned, being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with the standards set forth in South Carolina Regulation 61-78. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 61-78.

Signature:
Print Name:
Date:

Signature:
Print Name:
Date:

Subscribed and sworn to before me this _____ day of _____, _____.
(Month) (Year)

NOTARY PUBLIC _____

My commission expires _____

NOTARY SEAL