DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

# HOME SUPPORT AGENCY (HSA)
# LICENSE APPLICATION INSTRUCTIONS

In accordance with **D.C. Law 5-48, the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983**, licensees and prospective licensees must file an application prior to operating a Home Support Agency. Licenses, except for provisional and restricted licenses, are effective for a 12-month period following the date of issue.[1]

- License applications shall be **notarized.**
- The appropriate license fee should be submitted in the form of a check or money order made **payable to "D.C. Treasurer."**

**Mail-in application to:**

Health Regulation and Licensing Administration (HRLA)
Intermediate Care Facilities Division (ICFD)
P.O. Box 37804
Washington DC 20013

**or Walk-in application to:**

Department of Health
HRLA Processing Center
First Floor
899 North Capitol Street NE
Washington DC 20002

Please note that no inspection will be conducted unless a completed application and the appropriate licensure fee has been received by this office.

**License Fee for HSA**
**$400.00**

**Initial Application**
Processing Fee
**$1200.00**

**Renewal Application**
Processing Fee

| No. of Clients | Annual |
|---|---|
| 1 - 50 | **$ 800.00** |
| 51 - 150 | **$1400.00** |
| 151 - 350 | **$2200.00** |
| 351- MORE | **$2600.00** |

**Late Fee/Duplication Fee**
A fee in the amount of **$100.00** shall be charged for any late application(s) and for the duplication of any license(s).

## Section A. *Agency Name/ Demographic*

Enter the legal name (individual or corporation) of the Agency exactly as it should appear on the license. If a trade name is being used, the trade must be registered with the Department of Consumer and Regulatory Affairs, and attached to the application.

Identify a contact person who will be responsible for the application process.

Enter the location and mailing address of the HSA, to include city, state, zip code, telephone number and email address. The address must be within the District of Columbia.

## Section B. *Type of Application*

Identify the type of application by checking the appropriate brackets on the application form.

[1] Provisional and restricted licenses are temporary limitations on the 12-month license that was issued.

**Section C.** ***Application/Owner Information***

Enter information on business operations of the HSA.

**Section D.** ***Director's Information***

Provide the Director's resume and a copy of all professional licenses and certifications to include evidence of a background check.

**Section E.** ***Client Service Coordinator Information***

Identify a Client Service Coordinator if the Director is not a DC licensed registered nurse. The Client Service Coordinator must be licensed in DC as a registered nurse.

**Section F.** ***Governing Body information***

Identify members of the agency's governing body. Enter name, mailing address, telephone number, email address and professional title (if applicable) for each member.

**Section G.** ***Affidavits***

Submit a signed and notarized application.

**Additional Application Forms Required**

Application will **NOT** be considered if the following required forms are not completed and attached to the application:

1. A completed, signed, dated and notarized Application
2. Disclosure of Ownership and Control Interest Statement Form
3. Cleans Hands Self-Certification Form
4. Original Copy of the Certificate of Good Standing
5. Trade Name Registration (if applicable)*
6. Verification of Insurance
7. A Certificate of Occupancy*
8. Reference Letters (3) attesting to the character and qualifications of the Director*
9. Proof of Criminal Background Check for the Director*
10. If Corporation: A copy of the Articles of Incorporation and Bylaws*
11. If Partnership: A copy of the partnership agreement*
12. If Limited Liability Company: A copy of the Articles of Formation and Operating Agreement*
13. Operating Policies and Procedures*

* Documents required only on initial application unless there have been changes that would affect the relevance of the submitted documents

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# HOME SUPPORT AGENCY (HSA)
# LICENSE APPLICATION

## A. AGENCY INFORMATION

| Name of Agency | Email Address | Telephone No. |
|---|---|---|
| Agency Street Address | City | Zip Code |
| Mailing Address (If Different from Street Address) | City | Zip Code |
| Contact Person for this Application: | | |
| Address | Email Address | Telephone No. |

Registered Trade Name (if applicable)_____

## B. TYPE OF APPLICATION

[ ] Initial Application [ ] Renewal Application [ ] Change of Ownership [ ] Relocation

Number of Clients _____

## C. APPLICANT/OWNER INFORMATION

Applicant is a(n)
[ ] Individual
[ ] Limited Partnership
[ ] General Partnership
[ ] Corporation
[ ] Other (Specify) _____.

**If the applicant is a limited partnership or corporation, list the names, document number, and federal identification number registered with the District of Columbia, Division of Corporations within the Department of Consumer and Regulatory Affairs.**

Name of Limited Partnership/Corporation

Address

Document Number Federal Employer Identification Number

**If a limited partnership/corporation, please attach a current copy of your Certificate of Good Standing issued by the Division of Corporations within the Department of Consumer and Regulatory Affairs.**

Is the Corporation _____ for Profit? _____ Not for Profit?

Are the property and building(s) _____ owned by the applicant? _____ Leased or rented? If leased or rented, who is the property owner(s)?

Name Address City/State/Zip Telephone No.

Is the agency to be managed by someone other than the applicant? ____ Yes _____ No, if yes, Provide the name of the management company/individual:

Name Address City/State/Zip Telephone No.

**If the applicant/owner is a corporation, complete the following information on each corporate office, director, individual owner, and partner. Attach additional pages if necessary.**

Corporate President Mailing Address/City/State/Zip Telephone No.

Corporate Vice-President Mailing Address/City/State/Zip Telephone No.

Corporate Secretary Mailing Address/City/State/Zip Telephone No.

Corporate Treasurer Mailing Address/City/State/Zip Telephone No.

Director Mailing Address/City/State/Zip Telephone No.

**If the applicant/owner(s) is an/are individual(s):**

| | | |
|---|---|---|
| Individual Owner | Mailing Address/City/State/Zip | Telephone No. |
| Individual Owner | Mailing Address/City/State/Zip | Telephone No. |
| Individual Owner | Mailing Address/City/State/Zip | Telephone No. |

**If the applicant/owner is a general or limited partnership, or other type of ownership:**

| | | |
|---|---|---|
| Partner Other (specify) | Mailing Address/City/State/Zip | Telephone No. |
| Partner Other (specify) | Mailing Address/City/State/Zip | Telephone No. |
| Partner Other (specify) | Mailing Address/City/State/Zip | Telephone No. |

## D. AGENCY DIRECTOR'S INFORMATION

_____

Name Address

_____

Email Address Telephone No. License No. (if applicable)

What date did the above person begin employment with the agency as the director? _____

Is the Director a licensed registered nurse? _____ YES _____ NO

Does the Director have training and experience in health services administration, including at least one (1) year of supervisory or administrative experience in health service or related health programs? _____ YES _____ NO

Please attach a copy of the Director's resume that includes the Director's professional work history and educational background.

Will the Director be serving as Director of more than this HSA? _____ YES _____ NO

If yes, provide the name of the other facilities:

| Name of Agency | Location Address | License No. |
|---|---|---|
| Name of Agency | Location Address | License No. |

## E. CLIENT SERVICE COORDINATOR INFORMATION

If the Director is not a Registered Nurse, name the Client Service Coordinator:

| Name | Address | |
|---|---|---|
| Email Address | Telephone No | License No |

## F. GOVERNING BODY AND MANAGEMENT

The Governing Body:

| Name | Address | Telephone No. |
|---|---|---|
| Name | Address | Telephone No. |
| Name | Address | Telephone No. |
| Name | Address | Telephone No. |

## G. AFFIDAVIT NOTE: This application must be signed and notarized

I hereby swear that the statements in this application and its attachments are true and correct, and understand that providing false or misleading information may result in a fine, denial, suspension, or revocation of this license.

_____
(Signature of Applicant/Owner)

_____
(Title)

Sworn to (or affirmed) and subscribed before me this _____ day of _____, _____

By _____
(Name of Applicant/Owner)

_____
(Signature of Notary Public)

_____
(Notary Public Seal)

Type of Identification Produced _____

**REPORT FRAUD, WASTE, AND ABUSE:** To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.