Indiana Department of Health

Eric J. Holcomb
Governor

Kristina M. Box, MD, FACOG
State Health Commissioner

HOSPICE
CHANGE OF OWNERSHIP APPLICATION
FOR MEDICARE AND MEDICAID OR STATE LICENSE ONLY

To: Applicant

From: Program Director
Division of Acute and Continuing Care

Dear Applicant:

In accordance with your request, we are enclosing the necessary forms for a change of ownership (CHOW) for a Hospice. Please complete the forms and return them to this office along with a copy of **Bill of Sale, Transfer of Assets Agreement, or comparable document, document from the Internal Revenue Services that lists the name of corporation and EIN number and document from the Secretary of State's office that lists the name of corporation or d/b/a name if applicable.**

If you are buying an existing certified entity, the previous owner's provider agreement(s) will automatically be assigned to you provided that your application is approved.

Please note that in assuming the previous owners' provider agreements you will also be assuming responsibility and liability for implementing and/or abiding by the terms of the previous owner's plan for correcting any deficiencies.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on grounds of race, color or national origin in any program receiving federal financial assistance. Although your entity may have already given assurance in connection with other federal programs, the Department nevertheless requires facilities to submit to their State agency a copy of the email submitted by the OCR to the facility when they have successfully submitted all of their clearance materials. (**NOTE:** do not submit the HHS 690, Assurance of Compliance or the OCR checklist with policies

to the Department.) **Any question concerning the Civil Rights Application should be directed to the Office of Civil Rights.**

To qualify for payment, your facility must be in compliance with the requirements for participation, the requirements for reimbursement (including financial solvency), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, the latter three of which determination is made by the Office of Civil Rights in Chicago.

In order to expedite your application make sure the application is accurate and complete. If the application is not completed accurately and/or documentation is missing it hinders and delays the process of the application.

Ensure that all forms in this application, including duplicate forms, have original signatures. The processing of the application for change of ownership cannot be processed until this Division has received all of the required completed forms and documentation.

Review all rules and regulations before submitting your application to the Indiana Department of Health.

LIST OF ENCLOSED FORMS TO BE COMPLETED AND RETURNED WITH CHOW APPLICATION:

- Application for License Approval to Operate Hospice Program (State Form 43813). *Submit all documentation requested on the application.*
- Hospice Request for Certification in the Medicare Program (Form CMS-417). *General instructions and definitions included.*
- Home Health Agencies/Hospice Agencies Geographic Area Served. *Submit one original.*
- Three (3) copies of the Health Insurance Benefits Agreement (Form CMS-1561). *Submit all three (3) originals – not applicable for state license only.*

NOTE: On the second line of the Health Insurance Benefits Agreement (Form CMS 1561) after the term, Social Security Act, enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). Ordinarily, this is the same as the business name used on all official IRS correspondence concerning payroll withholding taxes, such as W-3 or 941 forms. For example, the ABC Corporation, owner of the Community General

Hospital, would enter on the agreement: "ABC Corporation d/b/a Community General Hospital". A partnership of several persons might complete the agreement to read: "Robert Johnson, Louis Miller, and Paul Allen, partners, Easy Care Home Health Services". A sole proprietorship would complete the agreement to read: "John Smith d/b/a Mercy Hospital". The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners of the enterprise to enter into this agreement. If the Health Insurance Benefits Agreement is signed by someone other than an officer, director or partner of the enterprise, the one of the officers, directors or partners of the enterprise as listed on the Medicare Provider/Supplier General Application (Form CMS-855A) must give that individual written permission to sign. Please submit a copy of the letter of authorization.

- A copy of the email sent to your facility, by the Office of Civil Rights, when you have successfully submitted all of your clearance materials. Contact the Office of Civil Rights for questions regarding the Civil Rights Application.

DOCUMENTATION/INFORMATION TO BE SUBMITTED WITH CHOW APPLICATION:

- A copy of the "Articles of Incorporation" or "Certificate of Assumed Business Name" signed by the Indiana Secretary of State for doing business in Indiana
- A copy of SS-4 form or comparable document from the Internal Revenue Services (IRS) that reflects the corporation name and EIN number
- $100.00 Licensure Fee
- Copies of current valid Indiana licenses and limited criminal history checks on staff if there has been a staff change. In addition, submit a letter reflecting the staff names and effective date of the staff change.
- A copy of Bill of Sale, Transfer of Assets Agreement or comparable document. The document **must** contain the elements listed below:
    - ✓ The name of the buyer and seller
    - ✓ The complete date of transaction (effective date of agreement)
    - ✓ The signature of buyer and seller

SUBMIT YOUR COMPLETED APPLICATION TO THE ADDRESS BELOW:

Indiana Department of Health
Cashier's Office 2nd Floor
2 N Meridian Street
Indianapolis IN 46204

Indiana Department of Health

Eric J. Holcomb
Governor

Kristina M. Box, MD, FACOG
State Health Commissioner

Dear Provider:

Due to recent requests from the Regional office, and in an effort to become more efficient when processing your Change of Ownership (CHOW) applications, the department will require the following information to be submitted in conjunction with each CHOW.

Change of Ownership (CHOW) Requirements

Cover Letter – Each CHOW application must contain an acceptable cover letter. If a CHOW occurs with multiple facilities involved with the same buyer, a separate cover letter and documentation is required for each facility. The cover letter should address only one (1) facility. Please ensure that the cover letter is submitted in conjunction with the submission of the CHOW application. The cover letter should include the following:

A brief description of the type of transaction that took place
Projected or actual effective date of the transaction'
Names of the parties involved in the Change of Ownership (CHOW)
Statement regarding the CMS 855-whether an 855 has been field, approved, or will be filed

Example
This notice is to confirm that, effective 01/01/2021, a Change of Ownership took place between the buyer, ABC Corporation, EIN Number, 12-345678 and the seller WXY Corporation, d/b/a AAA Homecare, EIN Number 98-765432.

Facility Address: Please list the complete d/b/a name and address of the seller.
Seller's CCN Number of License Number, if applicable:

Other:
Example: *The buyer/seller's CMS 855 application will be/has been filed with the provider's fiscal intermediary. We will notify the department once an approval notice has been received.*

Changes that took place as a result of the CHOW

Name Change – did the name of the agency/clinic change as a result of the CHOW?
Staff changes (if applicable): New Administrator, Clinical Supervisor, etc.?
Days/Hours of operation changed (if applicable)
Mailing Address changed or added (if applicable)
Other changes (please describe)

IMPORTANT!!!

Prior to submission of the cover letter and the application, the buyer must submit to the department the following notices. *(Notices should be submitted at least thirty days in advance of the transaction taking place):*

- *A Notice or Intent to Sell letter from the Seller – the notice must be on the Seller's letterhead and must be signed by the seller or the seller's authorized representative*

- *A Notice or Intent to Purchase from the Buyer – the notice must be on the Buyer's letterhead and must be signed by the buyer or an authorized agent.*

Please contact the Program Coordinator at 317-233-7302 if you have questions regarding this notice.

APPLICATION FOR LICENSE
APPROVAL TO OPERATE A HOSPICE PROGRAM

State Form 43813 (R5/5-05)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-25-3)
Form Approved By State Board of Accounts-2003

Division of Acute Care Use Only

Date Received_____ **Date Approved**_____

- All questions on this application must be answered completely in printed or typed script. Supporting documentation must be attached. An incomplete or illegible application will be returned without being processed.
- License and/or approval renewal must be obtained annually.
- This application and the license, and/or approval which may be issued as a result, are neither assignable nor transferable.
- Previous receipt of a certification is not a guarantee that a license and/or approval will be issued.
- A non-refundable application fee in the amount of $100.00 must accompany this application. No license and/or approval shall be issued without receipt of this fee.

Please Type or Print Legibly

SECTION I - TYPE OF APPLICATION

Application *(check appropriate item)*

☐ Change of Ownership *(Anticipated date of Sale/Purchase/Lease)*_____ ☐ New Facility
Submit a dated and signed copy of the bill of sale, lease or other document of transfer

☐ Medicare ☐ Medicare and Medicaid ☐ State License Only

SECTION II - IDENTIFYING INFORMATION

A. Practice Location *(facility/dba)*

If the d/b/a is different from the direct owner submit Articles of Incorporation from the Office of the Secretary of State listing the d/b/a. The d/b/a should be registered with the Office of the Secretary of State and appear on the Articles of Incorporation submitted to ISDH with the application.

Name of Facility		
Street Address		P.O. Box
City	County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's office hours *(i.e. 8:00 a.m. – 4:00 p.m. Monday - Friday)*

B. Mailing Address *(if different from practice location)*

Street Address		P.O. Box
City	State	Zip Code +4

C. Licensee/Ownership Information *(owner)*

The owner/entity as registered with the Office of Secretary of State and appears on the Articles of Incorporation form submitted to ISDH. Submit Articles of Incorporation from the Office of Secretary of State along with a W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.

Licensee/Owner/Entity of the facility d/b/a *(The entity's name as registered with the secretary of state and that appears on the form/certificate)*			
Street Address			P.O. Box
City	State		Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number *(submit documentation to validate)*	Fiscal Year End Date *(mm/dd)*

D. Site Offices *(applicable for change of ownership – do not complete if initial application)*

Does the facility have other sites? ☐Yes ☐No

If yes, please provide the name, address, and telephone number of each site location. *(use additional sheet if necessary)*

Name	Address (street address/city/zip)	Telephone Number

E. Type of Hospice

Is this facility a provider based facility? *(owned by a separately licensed entity)* ☐Yes ☐ No

If yes, provide Medicare number

If yes, include a copy of the license with the application

License number of licensed entity _____ Date issued_____ Date expires_____

Please mark appropriate box for the type of hospice you are providing.

☐ Home Health Agency ☐ Hospital ☐ Intermediate Care Facility

☐ Skilled Nursing Facility ☐ Freestanding Hospice

SECTION III – STAFFING

A. Home Health Aides

Does the applicant employ, contract, or use home health aides in providing services to its patients? ☐Yes ☐ No

B. Volunteers

Does the applicant use volunteers in providing services to its patients? ☐Yes ☐ No

C. Medical Director *(physician)*

Name (enter full name)	Indiana license number

1. Submit a current copy of the Medical Director's *(Physician)* Indiana license and current criminal history check.

2. Has the Medical Director *(Physician)* ever been convicted of any criminal offense relating to, or in any way associated with, the provision of health services?

   ☐Yes ☐No *(If yes, attach a separate sheet of paper, that explains the facts of each case, completely and concisely and how it was resolved.)*

3. Has the Medical Director's *(Physician)* license ever lapsed, been suspended, or revoked? ☐Yes ☐No

   (If yes, attach on a separate sheet of paper that explains the place, date, and agency initiating the action, action taken, and the reason.)

D. Administrator

Name *(enter full name)* *Submit the Administrator's name*

E. Patient/Family Care Coordinator

Name *(enter full name) Submit the name of the Patient/Family Care Coordinator*	Indiana license number *(if applicable)*

List of post-secondary and hospice experience

_____

_____

_____

1. Has the coordinator ever been convicted of any criminal offense relating to, or in any way associated with, the provision of health care services?

   ☐Yes ☐No *(If yes, attach a separate sheet of paper, that explains the facts of each case, completely and concisely and how it was resolved.)*

2. Has the coordinator's license (if applicable) ever lapsed, been suspended, or revoked? ☐Yes ☐No ☐NA

   (If yes, attach a separate sheet of paper that explains the place, date, agency initiating the action, action taken, and the reason.)

SECTION IV – DISCLOSURE OF APPLICANT ENTITY

A. Directors/Officers/ Partners/Managing Agents/Managing Employees

List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, president, vice president, secretary, etc.). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

Officer or Partner Name	Title	Business Address *(street address/city/state/zip)*	Telephone Number

B. Type of Ownership *(applicable for change of ownership – do not complete if initial application)*

☐ Asset Purchase Agreement ☐ Assignment of Interest ☐ Lease
☐ Merger ☐ New Partnership ☐ Sale

☐ Termination of Lease ☐ Transfer of Asset Agreement ☐ Other _____

Submit a bill of sale or comparable document, which includes corporation/owner(s) name(s) and buyer/seller signature(s) and effective date of transaction with the application.

For Profit	NonProfit	Government
☐ Individual ☐ * Partnership ☐ ** Corporation ☐ *** Limited Liability Company ☐ Sole Proprietorship ☐ Other *(specify)* _____	☐ Church Related ☐ Individual ☐ * Partnership ☐ ** Corporation ☐ *** Limited Liability Company ☐ Other *(specify)* _____	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District ☐ Federal ☐ Other *(specify)*

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate of Authority to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

C. Licensure/Operating History

Have the owners or managers of the facility operated any facility within Indiana, or any other state that had a record of denial of licensure or operation with less than a full license (i.e. probationary, provisional, denial of annual license renewal, etc)? ☐Yes ☐No

(If "Yes", attach a separate sheet of paper that identifies the name of each facility, and explains the facts completely and concisely)

1. If any applications have been denied or withdrawn, so state with a full explanation. *(use additional sheet if necessary)*

2. If any license has been granted, state the date granted and expiration date. *(use additional sheet if necessary)*

SECTION V – GOVERNING BODY

List the name and addresses of the Governing Body Officers

Name	Business Address of Officer (street address/city/state/zip)

SECTION VI - CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate a hospice in the State of Indiana and, in support of this application, represents and shows that the applicant is able to comply with the hospice licensure/approval Statute, IC 16-25-3 and accompanying regulations.

I swear or affirm under the penalty of perjury that all statements made in this application, and any attachments thereto, are correct and complete and that I will comply with all laws, rules and regulations governing the licensing of hospice programs in Indiana.

Applicant's signature or signature of the applicant's authorized agent should appear below.

If signed by any individual (e.g., the administrator) other than indicated in section IV of this application, an affidavit must be submitted with the application, affirming that said person has been given the power to bind the applicant/licensee.

Name of Authorized Representative *(Typed)*	Title
Signature of Authorized Representative	Date

SECTION VII – DOCUMENTATION THAT MUST BE SUBMITTED WITH THE LICENSE APPLICATION

1. The non-refundable license fee ($100.00).

2. Disclosure document (refer to page 7 of this application).

3. A copy of the Medical Director's (Physician) current Indiana physician's license (a **legible full- size copy** that shows the expiration date), resume and current limited criminal history check.

4. The name of the current Administrator

5. A copy of the Patient/Family Care Coordinator's license (**full- size** copy of current Indiana license(s) that shows the expiration date.

6. Completed criminal history checks from the Indiana State Police Central Repository must be submitted with the application for the Medical Director.

7. Articles of Incorporation and/or other documents from the Office of the Secretary of State must be submitted:

   - If a limited Partnership, submit a copy of the "Application for Registration" and ""Certificate of Registration" signed by the Indiana Secretary of State.
   - If a Corporation, submit a copy of the "Articles of Incorporation" and Certificate of Incorporation" signed by the Indiana Secretary of State.
   - If applicant is an out of state corporation (foreign corporation), submit a copy of the "Certificate of Authority" to do business in the State of Indiana" signed by the Indiana Secretary of State.
   - If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.
   - If the "doing business as" (dba) name is different from the corporation's (direct owner) name submit "Certificate of Assumed Business Name" or "Articles of Incorporation" that list the d/b/a name signed by the Indiana Secretary of State that list the d/b/a name.

8. Submit a W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.

Please submit the payment of $100.00 by check or money order to:

Indiana State Department of Health
Attn: Cashier's Office, 2nd Floor
2 N. Meridian Street
Indianapolis, IN 46204-3003

SECTION VIII – DISCLOSURE STATEMENT

In order for the Department to grant an application for licensure or approval of a hospice program, the applicant must be able to demonstrate its ability to comply with the minimum standards established by IC 16-25-3, effective July 1, 1999. This ability to comply is demonstrated by the applicant through what is known as a "Disclosure Statement", which is submitted each year along with the initial or renewal application.

There is no required format for a Disclosure Statement; however, two (2) topics, services and supplies and patient rights, must be addressed. In addition, a toll free number for the facility must be provided should an individual have any questions or comments about a program.

Listed below are those minimum standards that must be included in the applicant's Disclosure Statement. Additional information may be included.

1. A description of all hospice services to include:

   a. **Core Services:**
      (1) Physician services;
      (2) Nursing services;
      (3) Medical social services; and
      (4) Counseling Services.

   b. **Other services**, including but not limited to:
      (1) Physical therapy;
      (2) Occupational therapy;
      (3) Speech therapy;
      (4) Home health aide;
      (5) Homemaker;
      (6) Medical supplies; and
      (7) Short term inpatient care.

2. A description of supplies provided to clients, including how those supplies are made available or Delivered.

3. A statement of patient rights, to include:

   a. Acknowledgement that hospice services and supplies shall be dispensed on a patient's individual needs.

   b. Description of an internal dispute resolution process to include:

      (1) How the dispute resolution process is initiated;
      (2) The name of the ultimate decision-maker; and
      (3) How the patient may appeal a decision rendered under this procedure

   c. A statement that patient has the right to participate in the planning of his care

   d. A statement that the patient has the right to refuse any component of the hospice's services or supplies.

   e. The Indiana State Department of Health's hot line toll-free number: 1-800-227-6334.

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act, _____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

INSTRUCTIONS FOR COMPLETING HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

STATEMENT CONCERNING INFORMATION COLLECTION REQUIREMENTS AND USES:

This form is required to obtain or retain Medicare benefits. It serves two purposes. First, it provides basic information about the Hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions are met.

Answer all questions as of the current date. Complete and return this form to your State Agency (found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/state_agency_contacts.pdf), and retain a copy for your files.

Detailed instructions are given for questions other than those considered self-explanatory.

Item I:

- Request to establish eligibility in—current Hospice Benefits are available only through the Medicare program.
- Medicare certification number:
  Insert the facility's six digit Medicare Certification Number. Leave blank on initial requests for certification.
- State/County and State/Region Codes:
  Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.
- Related certification number:
  If Hospice is affiliated with any other type Medicare provider, insert the related facility's six digit Medicare Certification Number.

Item IV:

- If a service is provided directly by the facility place a "1" the appropriate block.
- If a service is provided through an outside source (i.e., by contract/arrangement), place a "2" in the appropriate block.
- If a service is provided both directly and through arrangement, place a "3" in the appropriate box.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0313

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

I. Identifying Information

Name of Hospice	Street Address	
Request to Establish Eligibility In 1. ☐ Medicare PH1	City, County and State	Zip Code
Medicare/Certification Number PH2 / State/County PH3	State/Region PH4 / Telephone Number *(include area code)* PH5	Related Certification Number PH6

II. Type of Hospice *(Check One)* PH7

1. ☐ Hospital
2. ☐ Skilled Nursing Facility
3. ☐ Intermediate Care Facility
4. ☐ Home Health Agency
5. ☐ Freestanding Hospice

For Hospitals Only *(Check One)*

A. ☐ The Joint Commission Accredited
B. ☐ AOA Accredited
C. ☐ Both The Joint Commission and AOA Accredited
D. ☐ Non-Accredited

Fiscal Year Ending Date

III. Type of Control *(Check One)* PH8

Non-Profit:	Proprietary:	Government:	
1. ☐ Church	4. ☐ Individual	8. ☐ State	12. ☐ Combination Government and Nonprofit
2. ☐ Private	5. ☐ Partnership	9. ☐ County	13. ☐ Other
3. ☐ Other	6. ☐ Corporation	10. ☐ City	
	7. ☐ Other	11. ☐ City-County	

IV. Services Provided:

By staff, place a "1" in the block(s)
If under arrangement, place a "2" in the block(s)
If by staff and arrangement, place a "3" in the block(s)

Core:

1. ☐ Physician Services
2. ☐ Nursing Services
3. ☐ Medical Social Services
4. ☐ Counseling Services
5. ☐ Physical Therapy
6. ☐ Occupational Therapy
7. ☐ Speech-Language Pathology
8. ☐ Hospice Aide
9. ☐ Homemaker
10. ☐ Medical Supplies
11. ☐ Short Term Inpatient Care
12. ☐ Other(Specify)

PH9 PH10
A. _____Acute
B. _____Respite

Name and Address of Contractee

Medicare Certification/Supplier Number

V. Number of Employees/ Volunteers Full-time Equivalent

Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18)

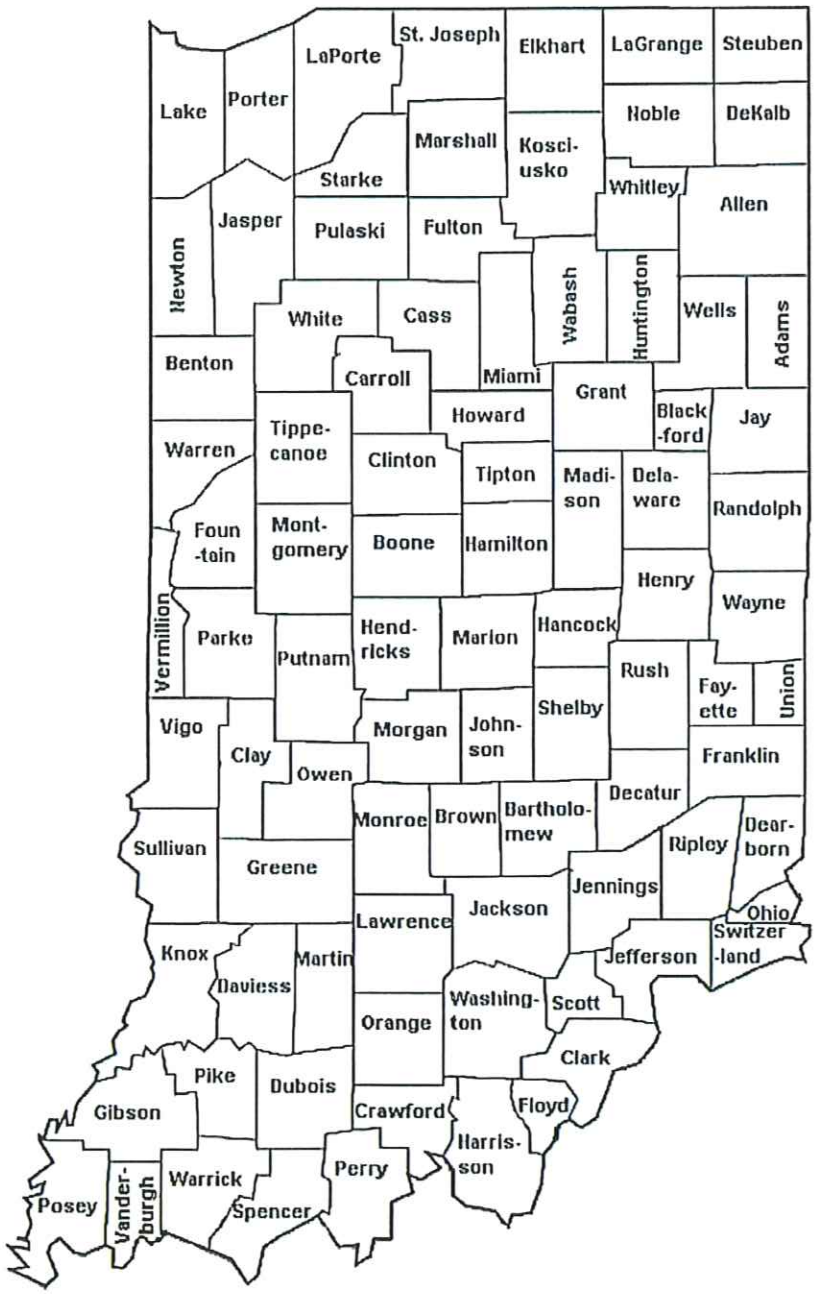
Physicians PH11		Registered Professional Nurses PH12		Licensed Practical Nurses/ Licensed Vocational Nurses PH13		Medical Social Workers PH14		Total Number PH19	
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.		
Homemakers PH15		**Hospice Aide PH16**		**Counselors PH17**		**Others PH18**		Employees	Volunteers
Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	A.	B.

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date PH20

IDENTIFY THE COUNTIES SERVED

C = CURRENT N = NEW R = REMOVE



GEOGRAPHIC AREA SERVED

PLEASE MARK THE COUNTIES ACCORDINGLY

C = CURRENT N = NEW R = REMOVE

Adams ☐	Franklin ☐	Lawrence ☐	Rush ☐
Allen ☐	Fulton ☐	Madison ☐	St. Joseph ☐
Bartholomew ☐	Gibson ☐	Marion ☐	Scott ☐
Benton ☐	Grant ☐	Marshall ☐	Shelby ☐
Blackford ☐	Greene ☐	Martin ☐	Spencer ☐
Boone ☐	Hamilton ☐	Miami ☐	Starke ☐
Brown ☐	Hancock ☐	Monroe ☐	Steuben ☐
Carroll ☐	Harrison ☐	Montgomery ☐	Sullivan ☐
Cass ☐	Hendricks ☐	Morgan ☐	Switzerland ☐
Clark ☐	Henry ☐	Newton ☐	Tippecanoe ☐
Clay ☐	Howard ☐	Noble ☐	Tipton ☐
Clinton ☐	Huntington ☐	Ohio ☐	Union ☐
Crawford ☐	Jackson ☐	Orange ☐	Vanderburgh ☐
Daviess ☐	Jasper ☐	Owen ☐	Vermillion ☐
Dearborn ☐	Jay ☐	Parke ☐	Vigo ☐
Decatur ☐	Jefferson ☐	Perry ☐	Wabash ☐
DeKalb ☐	Jennings ☐	Pike ☐	Warren ☐
Delaware ☐	Johnson ☐	Porter ☐	Warrick ☐
Dubois ☐	Knox ☐	Posey ☐	Washington ☐
Elkhart ☐	Kosciusko ☐	Pulaski ☐	Wayne ☐
Fayette ☐	LaGrange ☐	Putnam ☐	Wells ☐
Floyd ☐	Lake ☐	Randolph ☐	White ☐
Fountain ☐	LaPorte ☐	Ripley ☐	Whitley ☐