

## GENERAL INSTRUCTIONS

This application form should be used by proposed home care services organizations seeking initial approval as a licensed home care services agency or organizations seeking approval for a proposed change of ownership or operator, an acquisition or a change in control of an existing licensed home care services agencies pursuant to State Public Health Law Sections 3605 and 3611-a and Part 765 of Title 10 NYCRR.

### Reference Material

The following reference materials may be of assistance when completing this application:

- Article 36 of the Public Health Law.
- Approval and Licensure of Home Care Services Agencies – Part 765 of 10 NYCRR.

The review process for applicants seeking approval requires presentation of staff reviews and recommendations concerning the application to the Public Health and Health Planning Council.

### Instructions to Schedules and Attachments

In addition to these general instructions, instructions for the completion of specific portions of the application also are included within the application itself. Any responses to questions that require an attachment should be identified by number. Any non-duplicating numbering system may be used, but all instructions and questions which require attachments must have such attachment number noted in the appropriate section. Additional attachments may also be submitted if they are noted in the same manner.

### Submission Requirements

Submit four copies of the application to:

Bureau of Project Management, Division of Health Facility Planning  
Office of Primary Care and Health Systems Management  
New York State Department of Health  
ESP, Corning Tower  
Room 1842  
Albany NY, New York 12237

One of the copies must contain the original signature authorizing the application. The remaining copies may have copies of the signature.

Effective April 1, 2009, an application fee in the amount of \$2,000 is required for application submission pursuant to sections 3605 (13) and 3611-a (3) of the Public Health Law.

### Acknowledgement/Completeness Review

The Office of Health Systems Management will acknowledge receipt of the application in a letter to the applicant. Included in the acknowledgement letter will be the project number which should be used in all correspondence referring to the application. If the application is determined to be incomplete it will be returned for revision and resubmission.

As part of the review process, applicants should be aware that additional information may be requested. When submitting additional information, four copies must be sent.

### Whom to Contact for Assistance

Any questions concerning the application process should be directed to the Division of Home and Community Based Services, Office of Primary Care and Health Systems Management, New York State Department of Health by e-mail at [Homecare@health.state.ny.us](mailto:Homecare@health.state.ny.us)

**I. IDENTIFYING DATA****Instructions**

Enter the name and address of the agency as it is to appear on the license.

Enter the name of the operator. Corporations applying for approval should enter the legal corporate name as it appears on the Certificate of Incorporation. If the names and addresses of the operator are the same as for the agency, enter "same."

Enter the name of the person who is assigned to provide additional information regarding the application.

Check the box which indicates the type of ownership and class of operator for the agency named in Item 1.

Existing Corporate applicants should attach a board resolution authorizing the application. Public applicants should attach a resolution from the local legislature, board of supervisors or other governing body having jurisdiction over the agency or program. Indicate the attachment number in the place indicated.

**THE INDIVIDUAL DELEGATED AUTHORITY BY THE APPLICANT TO SUBMIT THE APPLICATION MUST SIGN THIS PAGE.**

**Name of Agency:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
STREET

\_\_\_\_\_ CITY STATE ZIP

**Telephone:** \_\_\_\_\_

**Name of Operator if different from above:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
STREET

\_\_\_\_\_ CITY STATE ZIP

**Telephone:** \_\_\_\_\_

**Name of Person to Contact for Additional Information:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
STREET

\_\_\_\_\_ CITY STATE ZIP

**Telephone:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Type of Ownership:**  Individual  Partnership  For-Profit Corporation  Not-for-Profit Corporation  Limited Liability Company  
 State  County  City  Town or Village  Other: \_\_\_\_\_

**Board Resolution**

Attach a certified copy of the resolution of the Board of Directors or Trustees, or the local legislature, Board of Supervisors or other governing body having jurisdiction over the agency program.

Attachment # \_\_\_\_\_

**Authorizing Signature**

I, the undersigned, hereby certify under penalty of perjury that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto, with the exception of those schedules pertaining to personal qualifying and disclosure information which must be individually certified, is accurate, true and complete in all material aspects.

**Name (print or type):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_

## II. PROJECT NARRATIVE

In the space provided below, check the box which best describes the purpose of this application and briefly describe.

Initial Licensure     Purchase or Merger     Assisted Living     Change of Stock Ownership     Other Acquisition of Control     Limited Licensure

Description:

## III. PROGRAM ANALYSIS

1. Indicate on Table 1 all services you will be providing, their method of delivery and their availability. Indicate the number of personnel needed by full-time equivalent and estimate the number of cases and visits for the first year of operation. In all categories report those full-time equivalent staff involved in the provision of patient care.

**Table 1 – Service Availability**

	Method of Provision (Direct or Contract)	Availability Hours & Days/Week	Projected # of Cases & Visits CASES	VISITS
Nursing	_____	_____	_____	_____
Home Health Aide	_____	_____	_____	_____
Personal Care	_____	_____	_____	_____
Physical Therapy	_____	_____	_____	_____
Occupational Therapy	_____	_____	_____	_____
Respiratory Therapy	_____	_____	_____	_____
Speech-Language Pathology	_____	_____	_____	_____
Audiology	_____	_____	_____	_____
Medical Social Services	_____	_____	_____	_____
Nutrition	_____	_____	_____	_____
Homemaker	_____	_____	_____	_____
Housekeeper	_____	_____	_____	_____

2. Attach a brief description of the organizational structure of the agency, including a table of organization and relationship to any existing or proposed parent entity or controlling person. Identify the scope of all medical and non-medical services provided, and list the client, patient groups and all counties to be served.

Attachment # \_\_\_\_\_

3. Provide a list of any contractual relationships you may have with other state agencies to provide services to such state agencies. Include all cooperative agreements with these agencies.

Attachment # \_\_\_\_\_

**III. PROGRAM ANALYSIS (continued)**

4. For those licensed services to be provided by the agency through a contract, rather than directly, give the name and address of the contractor for each service. If more than one contract, attach additional information using the same format.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET

\_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP

Type of Service: \_\_\_\_\_

5. Indicate anticipated sources of referral, and list agreements with hospitals/facilities for accepting discharged patients. Describe your proposed and/or existing relationship with local department of social services, hospitals, residential health care facilities, community alternative systems agencies, third party payers, health, mental health, developmental disabilities, Social Services and Office for the Aging providers in your community as it relates to the referral, case management and discharge of home care patients. Existing agencies should list the number of admissions or re-admissions in the most recent calendar year for nursing, home health aide or personal care services by referral source.

Attachment # \_\_\_\_\_

6. Attach a description of the quality assurance program which will be used to evaluate the home care services provided.

Attachment # \_\_\_\_\_

7. All applicants must include a summary of operating costs.

**Table 2 – Summary of Operating Costs**

	Present Annual Costs (If Applicable)	Estimated Operational Costs – First 12-Month Period
<b>1. SALARIES</b>		
a. Director/Administrator	_____	_____
b. Supervisors	_____	_____
c. Registered Professional Nurses	_____	_____
d. Home Health Aides	_____	_____
e. Personal Care Workers	_____	_____
f. Clerical Staff	_____	_____
g. Other	_____	_____
<b>2. TRANSPORTATION COSTS</b>	_____	_____
<b>3. SERVICES PURCHASED FROM OTHER AGENCIES OR UNDER ARRANGEMENTS (Contract Services)</b>	_____	_____
<b>4. MEDICAL AND NURSING SUPPLIES (Including non-depreciable equip.)</b>	_____	_____
<b>5. SPACE OCCUPANCY COSTS</b>	_____	_____
<b>6. OFFICE COSTS</b>	_____	_____
<b>7. OTHER GENERAL COSTS (specify)</b>	_____	_____
<b>TOTAL</b>	_____	_____

### III. PROGRAM ANALYSIS (continued)

This statement must be reviewed and signed by a duly authorized representative of the applicant as an indication that no services requiring home care services agency licensure are presently being provided and will not be provided until such time as a license is received.

NAME OF AGENCY: \_\_\_\_\_

According to Article 36 of the Public Health Law, a home care services agency subject to licensure is an organization engaged in arranging and/or providing, either directly or through contract arrangement, nursing, home health aide or personal care services.

Please confirm the following by signing this statement in the space provided below:

- The applicant is not providing home health aide or personal care by referral, contract or directly at the current time.
- The applicant is not providing registered nurse or licensed practical nurse services in the home at this time outside of that provided as an individual practitioner within the scope of their license.
- Regardless of the title of the workers, the applicant is not providing any individuals, either directly, by contract or through referrals, that deliver "hands on" personal care services to patients in their home.
- The applicant is aware that they may not commence operation of the home care agency until after the application has been approved by the Public Health and Health Planning Council and the agency has obtained a license from the Department of Health.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### IV. ESTABLISHMENT INFORMATION

#### Instructions

This must be completed by all applicants.

Select the structure below (from Sections A through G) which applies to this application, and make a check mark in the appropriate box. Note the submissions required by the category checked, and identify all submitted attachments by number in the line reserved for attachment listings.

Review the information required in Section H (Related Organization Information) and, if appropriate, provide the required details as an attachment.

Schedule 1 must be completed as indicated in Sections A through H. Note that these sections must be signed individually. Make photocopies as needed.

A. SOLE PROPRIETOR

- The sole proprietor must submit Schedule 1
  - Copy of the existing or proposed certificate of doing business under an assumed name. Attachment # \_\_\_\_\_
  - Copy(s) of any agreement(s) relating to the proposed transfer of the business interest in the Agency's operation. Attachment # \_\_\_\_\_

B. PARTNERSHIP

- Each partner must submit Schedule 1.
- The partnership must submit the following:
  - Complete list of partners. Attachment # \_\_\_\_\_
  - Copy of the existing or proposed certificate of doing business under an assumed name. Attachment # \_\_\_\_\_
  - Copy of the existing or proposed partnership agreement. Attachment # \_\_\_\_\_
  - Copy(s) of any agreement(s) relating to the proposed transfer of partnership interests. Attachment # \_\_\_\_\_

#### IV. ESTABLISHMENT INFORMATION (continued)

C. LIMITED LIABILITY COMPANY

- Each member must submit Schedule 1.

The Limited Liability Company must submit the following:

- Complete list of members indicating the percent of ownership of each member. Attachment # \_\_\_\_\_
- Complete list of any managing members. Attachment # \_\_\_\_\_
- If the limited liability company will be managed by managers who are not members, a copy of the existing or proposed management agreement between the limited liability company and the manager. Attachment # \_\_\_\_\_
- Copy of existing or proposed Articles of Organization. Attachment # \_\_\_\_\_
- Copy of existing or proposed Operating Agreement. Attachment # \_\_\_\_\_
- Copy of an existing or proposed certificate of doing business under an assumed name. Attachment # \_\_\_\_\_
- Copy(s) of any agreement(s) relating to the proposed transfer of membership interests. Attachment # \_\_\_\_\_

D. BUSINESS CORPORATION

New or existing corporation proposing the operation of the Agency.

- Each principal stockholder (holder of 10% or more of the issued and outstanding stock), officer and member of the Board of Directors must submit Schedule 1.

The corporation must submit the following:

- Copy of the existing or proposed certificate of incorporation or copy of the executed or proposed certificate of amendment, merger, or consolidation or application for authority where appropriate. Attachment # \_\_\_\_\_
- Copy of the existing or proposed certificate of doing business under an assumed name. Attachment # \_\_\_\_\_
- Complete list of all board officers, directors and principal stockholders indicating position or title of each (i.e. board member, treasurer, etc.) and the number of shares of stock to be owned by each. Attachment # \_\_\_\_\_
- Copy of bylaws. Attachment # \_\_\_\_\_

E. BUSINESS CORPORATION (Transfer of Stock)

- Each individual that will become a principal stockholder and any board officer or member of the Board of Directors of the acquired or acquiring entity must submit Schedule 1.

- Copy(s) of any agreement(s) relating to the proposed transfer of stock interests. Attachment # \_\_\_\_\_

F. NOT-FOR-PROFIT CORPORATION

- Each board officer and director must submit Schedule 1.

The corporation must submit the following:

- Copy of the existing or proposed certificate of incorporation or copy of the executed or proposed certificate of amendment, merger or consolidation, or application for authority where appropriate. Attachment # \_\_\_\_\_
- Copy of the existing or proposed certificate of doing business under an assumed name. Attachment # \_\_\_\_\_
- Complete list of officers and directors indicating position or title of each (i.e. board member, treasurer, etc.). Attachment # \_\_\_\_\_
- Copy(s) of any agreement(s) relating to the proposed transfer of the business interest in the agency operation. Attachment # \_\_\_\_\_

G. GOVERNMENT SUBDIVISION

- The Government subdivision must submit the full name and address, and the license/certificate number, for all agencies or facilities that are operated by the applicant and certified or licensed for the provision of health care. Attachment # \_\_\_\_\_

**IV. ESTABLISHMENT INFORMATION (continued)**

**H. RELATED ORGANIZATION INFORMATION**

1. List the full legal name and the address of the principal office and place of doing business of any existing or proposed parent corporation, controlling person or controlling organization which directly or indirectly, through one or more intermediaries, possesses or will possess the ability to direct or cause the direction of the actions, management or policies of the person, corporation, organization or other entity that is licensed as the operator of the subject home care agency or that is applying for approval as a licensed home care agency.

Attachment # \_\_\_\_\_

2. With respect to each parent corporation, controlling person or other controlling organization identified in response to question (1) above:

(a) List the full name of each member of the Board of Directors, board officer, controlling person, principal stockholder, sponsor of such parent corporation or controlling person or organization. Each principal stockholder, board officer and member of the Board of Directors must submit Schedule 1.

Attachment # \_\_\_\_\_

(b) List the full legal name and the address of the principal office and place of doing business of any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency, or other health care facility or program, regardless of location, owned or operated by such parent corporation or controlling person or organization, together with a photocopy of any operating license, permit or certificate issued for such facility or program, the full name of the issuing agency and dates of ownership.

Attachment # \_\_\_\_\_

(c) Describe in detail the relationship between the applicant and any parent corporation, controlling person or organization and describe in detail the method or mechanism by which control over the licensed home care services agency is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement).

Attachment # \_\_\_\_\_

3. With respect to any existing or proposed parent corporation or controlling person or organization identified in response to question (1) above:

(a) List the full legal name and the address of the principal office and place of doing business of any subsidiary corporation or organization that owns or operates any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency or other health care facility or program, regardless of location, and the full legal name and the address of the principal office and place of doing business of any such health care facility or program, together with a photocopy of any operating license, permit or certificate issued for such facility or program, and the full name of the issuing agency and dates of ownership.

Attachment # \_\_\_\_\_

(b) List the full name of each of the members, directors, controlling persons, principal stockholders, board officers and sponsors of each subsidiary corporation or organization identified in response to (3) (a) above.

Attachment # \_\_\_\_\_

(c) Describe in detail the relationship between the applicant, parent corporation, controlling person or organization and each subsidiary corporation or organization identified in response to (3) (a) above and describe in detail the method or mechanism by which control over the subsidiary is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement).

Attachment # \_\_\_\_\_

## 1. Personal Identifying Information (Print or Type)

Name: \_\_\_\_\_  
LAST FIRST M.I.

Address: \_\_\_\_\_  
STREET  
 \_\_\_\_\_  
CITY STATE ZIP

Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
MM/DD/YY COUNTY/STATE

Current or Proposed Position with Proposed Organization: \_\_\_\_\_

Business Name: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET  
 \_\_\_\_\_  
CITY STATE ZIP

Telephone: \_\_\_\_\_

## 2. Formal Education

Institution	Address	Attended		Degree	Date Rec'd
		From	To		
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

## 3. Licenses Held

Type of Professional License & License Number (Include Specialty)	Institution Granting License (Mailing Address, Phone & E-mail)	Effective Date	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

#### 4. Employment History for the Past 10 Years

Currently Employed       Retired      If retired, please specify date of retirement: \_\_\_\_\_  
MM/DD/YY

Start with MOST RECENT employment and include employment during the last 10 years. A resume or curriculum vitae (CV) may be substituted for this portion of the application but any additional information requested below and not contained in such resume or CV should be added. Please photocopy and attach additional sheets, if necessary.

Attachment # \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

STREET

CITY

STATE

ZIP

Dates of Employment: \_\_\_\_\_  
FROM TO

Position/Responsibilities: \_\_\_\_\_

Reason for Departure: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

STREET

CITY

STATE

ZIP

Dates of Employment: \_\_\_\_\_  
FROM TO

Position/Responsibilities: \_\_\_\_\_

Reason for Departure: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

STREET

CITY

STATE

ZIP

Dates of Employment: \_\_\_\_\_  
FROM TO

Position/Responsibilities: \_\_\_\_\_

Reason for Departure: \_\_\_\_\_

## 5. Offices Held or Ownership in Health Facilities

The purpose of this section is to obtain a listing of any affiliations as referenced below with which the owners, board officers, directors, controlling persons or partners of the proposed organization have been associated in the past 10 years. Affiliation, for the purposes of this section, includes serving as either a voting officer, director or principal stockholder of any health care, adult care, behavioral or mental health facility, program or agency requiring licensure or certification in New York State. Officerships and directorships in similar facilities or programs outside of New York State must also be disclosed. Include facilities for which applications were previously disapproved or withdrawn.

Provide documentation from the appropriate regulatory agency in the states (other than New York State) where you note affiliations, reflecting that the affiliated facilities, programs and agencies operated in substantial compliance with applicable codes, rules and regulations for the past ten years (or for the period of your affiliation, whichever is shorter). Instructions for the out-of-state review, a sample letter of inquiry and a recommended form are provided in Schedule 2D to assist you in securing this information.

### A. Applicant's Offices/Ownership Interests If not applicable, please check box:

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

**B. Relative's Ownership Interests** If not applicable, please check box:

Name of Relative: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

Name of Relative: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

Name of Relative: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

Name of Relative: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

Name of Relative: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Office Held/Nature of Interest: \_\_\_\_\_

Name of Licensing Agency: \_\_\_\_\_ Address of Licensing Agency: \_\_\_\_\_

### C. Enforcement Actions

During the period of your (or your relative's) affiliation, were any of the facilities subject to an enforcement or administrative action taken by the State regulatory agency due to the facility's violation of applicable laws and regulations?

Yes  No If Yes, please provide the following information:

Nature of Violation

Agency or Body Enforcing Violation (Name & Address)

Has the enforcement or administrative action been resolved?

Yes  No If No, provide an explanation:

### D. Affirmative Statement of Qualifications

For individuals who have not previously served as a director/officer nor have had managerial experience with a health facility/agency, please provide in the space below an affirmative statement explaining why you are qualified to operate the proposed facility/agency. This statement should include, but not be limited to, any relevant community/volunteer background and experience.

### 6. Record of Legal Actions

- 1. Except for minor traffic violations, have you ever been convicted of, or had a sentence imposed for, a crime?  Yes  No
- 2. Are there any criminal actions pending against you?  Yes  No
- 3. Have you ever been named as a defendant in any civil action, including but not limited to malpractice, fraud or breach of fiduciary responsibility?  Yes  No
- 4. Are there now or have there ever been any civil or administrative actions pending against you involving Medicaid or Medicare issues?  Yes  No
- 5. Are there now or have there ever been any civil or administrative actions pending against you or any professional/business entity with which you are affiliated?  Yes  No
- 6. Are there now or have there ever been any insurance arbitration awards against you or any professional/business entity with which you are affiliated?  Yes  No
- 7. Have you ever been involved in a hearing before an official body in relation to the operation of a home or institution caring for people?  Yes  No

If the answer to any of the above questions is "Yes," complete the section below. Attach additional sheets, if necessary. Attachment # \_\_\_\_\_

Date of Action: \_\_\_\_\_ Type of Action: \_\_\_\_\_ Location of Action: \_\_\_\_\_

Persons and/or Facilities Involved: \_\_\_\_\_

Give Any Further Details \_\_\_\_\_

**6. Record of Legal Actions (continued)**

8. Have you ever changed your name (including a maiden name) or used an alias?  Yes  No

If **Yes**, provide details below:

9. During the last 10 years, have you been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has such a license held by you during such period been suspended, revoked or otherwise subjected to administrative action?  Yes  No

10. Have you ever been involved in an action or proceeding brought by any public or governmental licensing agency or regulatory authority for violation of any securities, insurance, workers compensation, taxes, labor law or regulation or health law or regulation?  Yes  No

11. Have you ever been an officer, trustee, management employee or controlling stockholder of a company, including the applicant company, where you occupied any such position or served in any such capacity wherein the company:
- a) became insolvent, declared or was forced to declare bankruptcy or was placed in receivership or conservatorship?  Yes  No
  - b) was enjoined from or ordered to cease and desist from violating any securities, insurance or health law or regulation?  Yes  No
  - c) was the subject of an investigation by either federal or state law enforcement agencies on issues related to Medicare or Medicaid fraud?  Yes  No
  - d) was required to enter into a Corporate Integrity Agreement as part of a settlement with the Office of Inspector General of the U.S. Department of Health and Human Services?  Yes  No
  - e) suffered the suspension or revocation of its certificate of authority or license to do business in any state?  Yes  No
  - f) was denied a certificate of authority or license to do business in any state?  Yes  No

If the answer is **Yes** to Questions 9, 10, or 11, attach an explanation, including, where applicable, the date, type, and location of the action, and all relevant details. Attachment # \_\_\_\_\_

12. Have you ever been in a position that required a fidelity bond?  Yes  No

If yes, were any claims made against that bond?  Yes  No

If **Yes**, provide details below:

13. Have you ever been denied a fidelity bond or had such fidelity canceled or revoked?  Yes  No

If **Yes**, provide details below:

**Has the original of this document been signed and notarized?**  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print or Type Name \_\_\_\_\_ Title \_\_\_\_\_

Notary \_\_\_\_\_ Date \_\_\_\_\_