

This application may be completed online and mailed to the address listed below.

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
REGULATION AND LICENSURE  
CREDENTIALING DIVISION

Renewal Date

06/30/2010

Hospice Renewal Application

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM SERVICE ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LICENSE NO: \_\_\_\_\_  
ADMINISTRATOR: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
FAX NUMBER: \_\_\_\_\_

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: \_\_\_\_\_

4. NUMBER OF PATIENT ADMISSIONS IN PAST YEAR: \_\_\_\_\_

5. ACCREDITATION AGENCY: (if any) JCAHO  CHAP  Other

6. CERTIFICATION (if any) Medicare  Medicaid

7. GEOGRAPHICAL AREA SERVED (List by counties): \_\_\_\_\_

8. LOCATION OF SATELLITE OFFICE (List address): \_\_\_\_\_

OWNERSHIP INFORMATION

1. OWNERSHIP OF FACILITY: \_\_\_\_\_

(Legal Name of Individual or Business Organization)

MAILING ADDRESS: \_\_\_\_\_

(Street Address)

\_\_\_\_\_  
(City, State, Zip)

2. BUSINESS ORGANIZATION: (Check one)

- Sole Proprietorship
- Partnership
- Limited Partnership
- Corporation
- Limited Liability Company
- Governmental ( State,  District,  County,  City or Municipal)
- Other (Please Specify) \_\_\_\_\_

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application and on the attached documents are true and correct and I/we hereby apply for a license.

PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires "Applications shall be signed by

- (1) the owner, if the applicant is an individual or partnership,
- (2) two of its members, if the applicant is a limited liability company,
- (3) two of its officers, if the applicant is a corporation, or
- (4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit."

Sign Here \_\_\_\_\_  
AUTHORIZED REPRESENTATIVE DATE AUTHORIZED REPRESENTATIVE DATE

Sign Here \_\_\_\_\_  
AUTHORIZED REPRESENTATIVE DATE AUTHORIZED REPRESENTATIVE DATE