MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS

APPLICATION FOR HOSPICE CERTIFICATION

In accordance with the requirements of the Missouri Hospice Certification Law (Chapter 197, RSMo. Cumulative Supp. 1992) Regulations and Codes, application is hereby made for a certificate to conduct and maintain a Hospice (See Missouri Hospice Certification Law "Definitions", Section 197.250.)

THIS INFORMATION, WITHOUT FURTHER VERIFICATION, WILL BE USED TO UPDATE THE STATE HOME CARE AND REHABILITATIVE STANDARDS DIRECTORY.

NAME OF HOSPICE	TELEPHONE NO.
ADDRESS (STREET, CITY, STATE, ZIP)	**COUNTY**

HOSPICE ADMINISTRATOR	SUPERVISORY NURSE	ADMINISTRATOR's EMAIL ADDRESS

TYPE OF HOSPICE (CHECK ONLY ONE)

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

_____

_____

A. ☐ JCAH Accredited
B. ☐ Non-Accredited
C. ☐ Other Accreditation

_____

TYPE OF CONTROL (CHECK ONLY ONE)

Non-Profit
1. ☐ Church
2. ☐ Private
3. ☐ Other

_____

Proprietary
4. ☐ Individual
5. ☐ Partnership
6. ☐ Corporation
7. ☐ Other

_____

Government
8. ☐ State
9. ☐ County
10. ☐ City
11. ☐ City-County
12. ☐ Combination Government and Nonprofit
13. ☐ Other

_____

CHIEF OFFICER OF GOVERNING BODY

LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

GEOGRAPHIC AREA COVERED BY HOSPICE OPERATION

LIST COUNTY(IES).

SERVICES PROVIDED BY STAFF (By staff, place a "1" in the block(s). If under arrangement, place a "2" in the block(s).)

CORE SERVICES

1. ☐ Physician Services No. of FTE's_____
2. ☐ Nursing Services No. of FTE's_____
3. ☐ Medical Social Services No. of FTE's_____
4. ☐ Bereavement Counseling No. of FTE's_____
5. ☐ Spiritual Counseling No. of FTE's_____
6. ☐ Dietary No. of FTE's_____
7. ☐ Home Health Aide/Homemaker No. of FTE's_____
8. ☐ Physical Therapy
9. ☐ Occupational Therapy
10. ☐ Speech-Language Pathology
11. ☐ Pharmacy
12. ☐ Medical Supplies
13. ☐ Short Term Inpatient Care
14. ☐ Other (Specify) _____

☐ Acute
☐ Respite

Total Number of Volunteers

_____

INPATIENT FACILITY

Total Number of Beds

_____

SATELLITE/INPATIENT LOCATIONS (Identify each location and continue listing on back if necessary)

Address:	***Address:***	***Address:***	***Address:***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Telephone No. _____	Telephone No. _____	Telephone No. _____	Telephone No. _____

CERTIFICATION

_____ and _____

PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP — HOSPICE ADMINISTRATOR

being duly sworn by me on their oath, deposes and says that they have read the foregoing application and that the statements contained therein are correct and true and of their knowledge; and further gives assurance of the ability

and intention of the _____ Hospice to comply with the

EXACT LEGAL NAME

regulations promulgated under the Missouri Hospice Certification Law (Chapter 197, RsMo. Cumulative 1992).

It is further certified that the _____ will comply with all recommendations

NAME OF HOSPICE

for correction and/or improvements as contained in the most recent Licensing Survey Report prepared by the Department of Health and Senior Services and submitted to said Hospice.

SIGNATURES

PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP

HOSPICE ADMINISTRATOR