

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

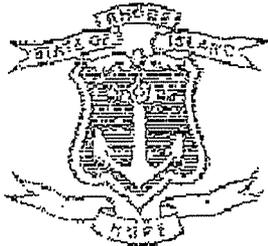
Licensee Number: \_\_\_\_\_

## RI Department of Health

### Application and Instructions for:

# Nursing Service Agency

Reason for application (Please check all that apply):



- Initial Licensure
- Change of address: What is your current license number: \_\_\_\_\_
- Change of ownership: What is your current license number: \_\_\_\_\_
- Licensee Name Change

# INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license will not be issued. Please use a ballpoint pen.
- The fee for this application is \$500. If this application reflects a change of location, there is no fee.
- If this is your secondary license (i.e. you have paid a \$500 fee for your Home Care Provider or Home Nursing Care Provider license) then there is no fee for the Nursing Service Agency License.
- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.
- Sign the completed application and return to:

Rhode Island Department of Health  
3 Capitol Hill, Room 306  
Providence, RI 02908-5097.

- If you have any questions concerning this renewal application, call the office of **Facilities Regulations** at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.
- The Nursing Pool agency shall maintain a premises within the geographical boundaries of the state
- Accreditation: Please note that within 24 months of initial licensure, the provider is required to attain appropriate certification from an accreditation agency.

**You must attach the following items before a license can be issued:**

1. Copies of the required liability and bonding insurance in accordance with section 8.1 (5).
2. A notarized list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.
3. Members of the governing body, if different from item 2.
4. A copy of the policy/contract for supervision of nursing assistants. Section 8.2 (3)
5. Example of employee photo ID badge. Section 8.2 (4)
6. Criminal Record check policy/procedures. Section 10.4
7. Policy on reporting of abuse/neglect. Section 12.0

**Attachments:** If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

**Postage:** The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

**Please complete the following information:**

<b>Additional License Type:</b>  (Please check the appropriate boxes. There is no fee for an additional license type)	1. I wish to apply for a Home Care Provider License:    Yes <input type="checkbox"/> No <input type="checkbox"/>  2. I wish to apply for a Home Nursing Care Provider License:    Yes <input type="checkbox"/> No <input type="checkbox"/>  Please note that if you are renewing or applying for either a Home Care Provider and/or a Home Nursing Care Provider, you must complete a separate application.
<b>License Sub-Type:</b> Please select one	<input type="checkbox"/> Profit <input type="checkbox"/> Non-Profit

**State of Rhode Island and Providence Plantations  
Department of Health**

**Agency Name:**

Please provide the name of the agency (as known to the public).

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

**Agency Contact Person:**

Please provide the name and telephone number of a person we can contact concerning this agency.

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

Phone Number: ( ) \_\_\_\_\_

**Agency Mailing Information:**

Please provide the mailing information for all communication regarding this license.

(Not published on HEALTH website).

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

Address Line 3 \_\_\_\_\_

Address City, State, Zip Code \_\_\_\_\_

Address Country \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

**Agency Location Information:**

Please provide the location information for this facility.

(Published on HEALTH website).

(Please leave this section blank if it is the same as above)

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

Address Line 3 \_\_\_\_\_

Address City, State, Zip Code \_\_\_\_\_

Address Country \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

**Ownership Type:**

Please check ONE

- |  |  |
|--|--|
| <input type="checkbox"/> Corporation         | <input type="checkbox"/> Limited Liability Company |
| <input type="checkbox"/> Governmental Entity | <input type="checkbox"/> Sole Proprietorship       |
| <input type="checkbox"/> Partnership         | <input type="checkbox"/> Limited Partnership       |
| <input type="checkbox"/> Partner             |  |

**Ownership Information:**

Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.

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

**Ownership Address Information:**

Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.

Address Line 1 \_\_\_\_\_  
Address Line 2 \_\_\_\_\_  
Address Line 3 \_\_\_\_\_  
Address City, State, Zip code \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Parent Organization, Group Affiliation:**

Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control

Corporation Type \_\_\_\_\_  
Name of Organization \_\_\_\_\_  
Address Line 1 \_\_\_\_\_  
Address Line 2 \_\_\_\_\_  
Address Line 3 \_\_\_\_\_  
Address City, State, Zip code \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Land/Building Info:**

If the owner of the land and building is other than the operator of this agency/facility, please complete the following:

Name: \_\_\_\_\_  
Address Line 1 \_\_\_\_\_  
Address Line 2 \_\_\_\_\_  
Address Line 3 \_\_\_\_\_  
Address City, State, Zip code \_\_\_\_\_  
Phone: \_\_\_\_\_

**Compliance with Conditions of Approval**

Please check yes or no.

This facility/agency is in compliance with all conditions of approval (i.e. relative to Certificate of Need, Change of Effective Control, Initial Licensure and/or Licensure renewal).

Yes     No

## Acknowledgements

I am aware of Chapter 5-34-1 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed there under, which regulate the operation of this agency.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority conferred under Chapter 29-17-10 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

<p><b>FEIN Number:</b>  (Federal Employer Identification Number)</p> <p><b>Note:</b> If you are a sole proprietor this number may be your Social Security Number.</p>	<p>Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.</p> <p>Please provide below SSN/FEIN for this licensee:</p>
	<p>SSNF/E.I.N. Number: _____</p>

<p><b>Affidavit of Applicant</b></p> <p>Read, sign, and date this affidavit.</p>	<p><b>AFFIDAVIT AND SIGNATURE</b></p> <p><b>This Application Must be Signed</b></p>								
	<p>I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.</p> <p>I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.</p> <p>I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.</p>								
	<table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px solid black; width: 60%;"></td> <td style="border-top: 1px solid black; width: 40%; text-align: center;">Date of Signature (MM/DD/YY)</td> </tr> <tr> <td style="border-top: 1px solid black;">Signature of Authorized Person</td> <td></td> </tr> <tr> <td style="border-top: 1px solid black;">Printed Name of Authorized Person</td> <td></td> </tr> <tr> <td style="border-top: 1px solid black;">Title of Authorized Person</td> <td></td> </tr> </table> <p>Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.</p>		Date of Signature (MM/DD/YY)	Signature of Authorized Person		Printed Name of Authorized Person		Title of Authorized Person	
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