HOSPICE CARE SERVICES
APPLICATION FORM

ARKANSAS HEALTH SERVICES PERMIT COMMISSION

HEALTH SERVICES PERMIT AGENCY
MOSAIC TEMPLARS STATE TEMPLE
906 BROADWAY, SUITE 200
LITTLE ROCK, AR 72201
(501) 661-2509

INSTRUCTIONS FOR COMPLETION OF PERMIT OF APPROVAL APPLICATION FORM

General Instructions

In accordance with adopted policies pursuant to Arkansas Act 593 of 1987, as amended, all parties desiring to obtain a Permit of Approval are required to provide the requested information on this application form. Failure to supply adequate information may result in a delay in the review, a return of the application, or a denial of the application. Please refer to the Health Services Permit Commission's Policies and Procedures for Permit of Approval for details of the scope of coverage, projects subject to review, and specific procedures for processing applications.

1. **Please review the Commission's adopted Hospice Care need standards and criteria before starting the application process.**

2. **The Agency recommends that each applicant meet with a staff member of the Health Services Permit Agency (by appointment) for a pre-submission conference.**

3. **Each question must be addressed fully. Contact the staff before a response of "not applicable" is made in order to insure that it is an appropriate response.**

4. **One (1) original and one (1) copy of the completed application along with the appropriate fee must be submitted to the Health Services Permit Agency in accordance with the established batching schedule. The original must be signed in blue ink. Please do not send applications in binders or folders.**

APPLICATION FOR HOSPICE AGENCY OR FACILITY

I. GENERAL INFORMATION

A. Identification of applicant

1. Proposed Name of Agency or Facility: _____

Address _____

City_____Zip_____County_____

2. Ownership of Agency or Facility (Check One):

Individual Owner _____ Partnership _____ List names

and addresses of all partners:

_____
_____
_____

Corporation _____

3. Parent Organization: _____

Address: _____

Phone Number: _____ Fax: _____

Email: _____

Does anyone with any ownership or interest in the parent organization or the ownership entity have any ownership of another hospice agency or facility? Yes____ No _____

A. If yes, please list other hospice agencies or facilities (in Arkansas and out of state) in which applicant has ownership or interest.

B. Please list names and addresses of owners.

4. **Project Contact Person: _____**

Corporation, Company or Agency (if applicable): _____

_____

Title: _____Phone: _____

Fax: _____ Email: _____

Address: _____

City: _____Zip Code: _____

B. Hospice facility applicants:

Number of beds requested: _____

County Bed Need: _____

Date your agency began operating: _____ (Please enclose documentation). ***Note: The only eligible applicants for a POA for Hospice Facilities are Hospice Agencies that have been operating for at least 1 year.***

II. PROJECT DESCRIPTION

1. County to be served: _____

Describe the proposed project, including services you plan to provide. (Example: This is new construction of a 23 bed hospice facility which will have 15 patient rooms, common dining room, outdoor courtyard, chapel.)

If the proposed facility will involve construction, please include the detailed plan for construction including square footage for common / family areas, patient rooms and any other space to be included in the facility.

If this proposed facility will involve leased space, please describe any renovation that may be needed. Also include leasing arrangements, use of leased space for patient rooms and other plans for common or family use space.

Agencies must include a description of the services they propose to provide.

2. **Estimated project starting date: _____.**

3. **Transfer of POA: POA transfers are required by law to provide proof of at least $2,500 of assets to be transferred with the Permit. If this application involves transfer of a POA, please list the assets and the value of these assets to be transferred with this Permit.**

III. COMPLIANCE WITH REVIEW CRITERIA

CRITERION #1 The need that the population served or to be served has for the proposed project. How does the application comply with the standard of need found in the HSPA Bed Need Book?

A. Agencies

1. **Number of Potential Hospice Patients _____.**
2. **Is there a new agency or POA in the County? _____.**

   Regardless of numeric need, no new hospice agency will be approved unless each hospice agency servicing the proposed service area has been licensed and operational for at least two years. This provision does not prohibit approval where a new license was granted to an Agency that purchased a hospice agency that had been serving the area for more than two years.

B. Facilities

1. **Number of Hospice beds needed (net need) _____.**
2. **Number of Hospice beds requested _____.**

CRITERION #2 "Whether the project can be adequately staffed and operated when completed.

A. Personnel – list the number of personnel by classification and proposed salary. Include a time-phased plan for hiring staff.

B. Source of Personnel – detail potential sources of required personnel.

CRITERION # 3 "Whether the proposed project is economically feasible"

A. Cost Estimates for Project

1. Financing and other Cash Requirements

Initial Capital Expenditures

Loans Fees	**$_____**
Bond Issue Cost	**$_____**
Legal Fees, Printing, etc.	**$_____**
Financial Feasibility Study	**$_____**
Consultant Fees	**$_____**
Capitalized Interest During Construction	**$_____**
Debt Service Reserve Fund	**$_____**
Lease Space	**$ _____**
Other (Specify)	**$_____**

2. Physical Plant Costs (If the project involves construction)

Construction Costs	**$_____**
Architect's Fee	**$_____**
Engineering Fees	**$_____**
Contingency Factor (Cost Overrun)	**$ _____**
Working Capital Start-up Cost	**$ _____**
TOTAL CAPITAL EXPENDITURE	**$ _____**

B. Please indicate the sources of capital funds:

Source	Amount	Percent
Tax Credits	----------	----------
Commercial Loans	----------	----------
Government Grants & Loans	----------	----------
Retained Earnings	----------	----------
Other Debts Financing	----------	----------
Capital Campaign / Fundraising	----------	----------
Other	----------	----------

C. You are required to attach original letters of commitment or agreements that indicate the above financing can be obtained.

1. Pre-approved loan for Total Capital and Working Capital Start-up Cost.

2. For individual investors or partners, provide proof of bank deposit signed by the corporate offices of the bank or financial statement for the total amount needed for the project signed by an accountant not directly employed by the applicant.

3. For corporations, provide an audited financial statement showing retained Earnings equal or more to the amount needed for the project signed by an Accountant not directly employed by the corporation.

D. Pro-forma Budget Requirements

1. For new agency or facility, a three year pro-forma budget is required as an attachment to the application.

2. For existing agency or facility, provide the last three years audited income and expense report.

3. Provide "Cost per Hospice Day Projection"

<u>CRITERION # 4</u> "Whether the project will foster cost containment through improved efficiency and productivity."

A. In what manner will the proposed project reduce the cost or demand for health care services in the service area? Please provide documentation and discussion.

C. How will the proposal increase efficiency and productivity?

REQUIREMENTS:

Applicants for <u>agencies</u> are required to provide a business plan including:

1. **Documentation of financial support to provide cost efficient hospice care as measured by industry standards and published by The National Hospice and Palliative Care Organization or The National Association of Home Care and Hospice. Please include documentation from one of these Associations.**

2. **A potential office location in the county in which the applicant is applying for a Permit, or documentation that research into a location for an office has been done, with the amount of rent reflected in the budget. An exception exists if an applicant has a hospice office in a contiguous county; in this case, the existing hospice office can serve as the address for the new application.**

3. **A plan to educate physicians, hospital discharge planners and other appropriate health and social service providers about the need for timely referral of potential hospice patients.**

4. **Agreement to provide timely and accurate reporting data to the Health Services Permit Agency as requested.**

Applicants for <u>Facilities</u> are required to provide a business plan including the following:

1. **Documentation of financial support to provide cost efficient hospice care as measured by industry standards The National Hospice and Palliative Care Organization or The Hospice Association of America. Please include documentation from one of these Associations.**

2. **A street address and city for the proposed facility in the county in which the applicant is applying for a Permit.**

3. **Agreement to provide timely and accurate reporting data to the Health Services Permit Agency as requested.**

First 12 Month Period Cost Per Hospice Day Projections

Area	Salary & Benefits	Transportation	Contracted Services	Room & Board	DME	Pharmacy	Lab	Ambulance	Hospital	Annual Total	Ann. Pat. Days	Cost Per Day
Maint. & Operation												
Inpatient Services												
Visiting Services												
Other Services												
Program Costs												
Total												

CERTIFICATION

This form completed by: _____

Name

_____

Title

_____

Address

_____

City State Zip

Phone _____ Fax _____

Email _____

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

_____ _____

Date Signature

_____

Title