LICENSURE APPLICATION
for
HOSPICES (INPATIENT)
REGULATION 60-78

Return the completed application to:

Email address (preferred method):
Hospice@dph.sc.gov

OR

Mailing address:
Bureau of Health Facilities Licensing
P.O. Box 2046
West Columbia, SC 29171

For additional questions, contact us at: 803-545-4370.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

NOTICE: *Your license must be renewed **prior** to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or capacity increases/decreases) from the Department that are in progress at the time the license is due for renewal.*

Application must be complete and legible. Any missing information may result in delays in processing this application. Any section that requires additional space or documentation shall be included as an attachment in the 8.5" x 11" format and be labeled to identify the appropriate section. Proof of payment is required for all applications submitted.

Reason for the Application

- Initial: Check this box only if this is the first time you are applying for a license with the Department. DO NOT check this box if this is a change of ownership for an existing licensed service/facility.
- Renewal: Check this box only if you are renewing your license. Enter the license number and expiration date. The name of the service/activity must appear exactly as it did the prior year.
- Amended License Request: Check this box if you are applying for a change that will alter the information on the face of your license; then, ensure that you complete Part D.

Part A: Facility Information

- Facility Information-Please complete the applicant information for the facility.
- For additional buildings: If you have more than 2 buildings, attach an additional sheet with the requested information.
- Contact Person and Corresponding Mailing Address: All correspondence coming from the Bureau of Health Facilities Licensing will be sent to this person and address.
- Qualified Administrator: Please complete each field. If there is more than one Qualified Administrator, please provide the information on a separate piece of paper. Submit a copy of each Administrator's qualifications.

Part B: Operation/Ownership Disclosure

- Licensee Information: Name of the person(s) or entity to be licensed to operate the hospice at the site indicated in Part A.
- Indicate the ownership type: Choose one type per category.
- Complete the requested information:
    - For partnerships, you must provide the name of each partner;
    - For limited liability company (LLC), you must provide the names of members, attach a list with the names and address of the members of the limited liability company;
    - For a corporation, you must provide the name and title of each corporate officer

Part D: Licensure Changes

- For Name or Address changes, complete Section 1.
- For Ownership changes, complete Section 2.
- For participant capacity changes, complete Section 3.

Part E: Verification

- The application shall be signed by the following:
    - If an individual partnership, ***the owner(s)***
    - If a corporation, ***two*** of its ***officers*** if a corporation
    - If governmental unit, the ***head of the governmental department*** having jurisdiction
- You must have this page notarized.

SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Application for Hospices (Inpatient)

Regulation 60-78

Reason for Application			
☐ Initial	☐ Renewal		☐ Change Request *(Complete Parts C and D)*
	License Number:	Expiration Date:	

Part A. Facility Information			
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Total Number of Beds:			
In how many buildings are patient/resident rooms located?			
Name of building:		Number of beds:	
Name of building:		Number of beds:	

Food Service Areas	
Number of Kitchens:	
Is food prepared by a caterer? ☐YES ☐NO (if yes, please attach a copy of the catering contract)	
Certified Food Protection Manager: (INITIAL APPLICATIONS MUST attach a copy of certification)	
Name:	
Certificate Date:	Expiration Date:
Course Taken:	Institution:

Contact Person and Correspondence Mailing Address: *(Name of person who can make licensure/operation decisions about facility and address where you want to receive ALL correspondence, including the license, from the Bureau of Health Facilities Licensing.)*		
Name:		Title:
Address:		
City:	State:	Zip:
Telephone Number:		
Primary Email:		
Qualified Administrator: (INITIAL APPLICATIONS MUST provide a copy of qualifications)		
Name:		
Address:		
Telephone Number:		Fax:
Email Address:		

Part B. Operation Disclosure		
Licensee Information: *(name of the person(s) or legal entity licensed to operate the business at that site as indicated in Part A)* ***This can be found on your current license OR your documentation from the Secretary of State.***		
Licensee Name:		
Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Ownership Type: (*only choose one per category*)		
☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership	☐ Corporation ☐ Limited Liability (LLC)* ☐ Government	☐ Other:

Licensee or Owner Documents Required

1. Secretary of State documentation, if applicable ☐ Attached ☐ N/A
2. If the licensee is a corporation or partnership, attach a list identifying all officers. ☐ Attached ☐ N/A
3. If the licensee or owner is a corporation or partnership, attach a list with the name, address and percentage of all owners that possess 5% or more ownership of the company or partnership. ☐ Attached ☐ N/A
4. If any person or other legal entity can claim liabilities of the licensee or of the facility or service for which this license is requested, attach a list identifying the name, address, percent and type of claim. ☐ Attached ☐ N/A

Part C: ONLY COMPLETE THIS SECTION FOR LICENSURE CHANGES		
☐ Change of Facility Name and/or Location (Complete Section 1)	☐ Change of Ownership (Complete Section 2)	☐ Change of Capacity (Complete Section 3)

Section 1 (FACILITY INFORMATION)		
PRIOR TO CHANGE		
Current License Number:		
Current Facility Name:		
Current Facility Address:		
City:	State:	Zip:
Facility Telephone Number:	Fax Number:	
AFTER CHANGE		
New Facility Name:		
New Facility Address:		
City:	State:	Zip:
New Facility Telephone Number:	Fax Number:	

Section 2 (LEGAL IDENTITY OF OWNERSHIP) *Application must be completed by new owner, as licenses are not transferable.*		
PRIOR TO CHANGE		
Name of Current Owner:	License Number:	
Address of Current Owner:		
City:	State:	Zip:
Telephone Number of Current Owner:		
Signature of current owner:	Date:	
AFTER CHANGE		
Name of New Owner:		
Address of New Owner:		
City:	State:	Zip:
Telephone Number of New Owner:		
Signature of new owner:	Date:	

Section 3 (CHANGE OF CAPACITY)			
License Number:			
Facility Name:			
Facility Address:			
City:	State:	Zip:	County:
☐ **Increase**		☐ **Decrease**	
Number of Beds	From:	To:	

Part D: Verification

The application shall be signed by the following:

- If an individual, the ***owner(s)***
- If a limited liability company, the ***head of the limited liability company***
- If a corporation, ***two*** of its ***officers***
- If governmental unit, the ***head of the governmental department*** having jurisdiction

I, the undersigned, being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with the standards set forth in South Carolina Regulation 60-78. I understand that non-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 60-78.

Signature:
Print Name:
Date:

Signature:
Print Name:
Date:

Subscribed and sworn to before me this _____day of _____, _____.
(Month) (Year)

NOTARY PUBLIC_____

My commission expires _____ **NOTARY SEAL**

Application for Licensure Hospice Facility (Inpatient)
Instructions for Completing 3290-ENG-DPH

PURPOSE: This is an external form used by customers to apply for a health license or service regulated by Healthcare Quality.

AUDIENCE: DPH Customers.

INSTRUCTIONS: Customers will complete this application when applying for a healthcare facility or service regulated by Healthcare Quality. This application is to be used in conjunction with the facility's regulation.

OFFICE MECHANICS & FILING: The completed form will be stored on the Bureau of Operations Support's SharePoint Site / OneDrive. This form is maintained by retention schedule 16327 — Masterfiles. Once the 10-year retention period has been met and quality review has been completed, an ARM-11 destruction request should be submitted and approved prior to disposal of the original form.