HOME CARE ORGANIZATION LICENSEE APPLICANT INFORMATION

This form must be completed by all applicants for a Home Care Organization license, (i.e., all individuals, each partner in a partnership, or chief executive officer or authorized representative in a corporation.) If more space is required, attach additional sheet. Please type or print clearly.

IDENTIFYING INFORMATION

NAME	SOCIAL SECURITY NUMBER (VOLUNTARY FOR I.D. ONLY)	SEX (M/F)	DATE OF BIRTH
TITLE	DRIVER'S LICENSE NUMBER/IDENTIFICATION CARD NUMBER	STATE ISSUED	ALIEN REGISTRATION CARD NUMBER

HOME ADDRESS	AREA CODE/TELEPHONE ( )

OTHER NAME(S) USED BY HOME CARE ORGANIZATION APPLICANT

PRIOR LICENSURE STATUS

STATUS OF DISCIPLINARY ACTIONS

A. HAVE YOU EVER BEEN REVOKED, DENIED, EXCLUDED, FORFEITED, OR HAD OTHER DISCIPLINARY ACTION TAKEN, OR ARE YOU IN THE PROCESS OF ACTION BEING TAKEN AGAINST A LICENSED CLINIC, HEALTH CARE FACILITY, COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY FOR PERSONS WITH CHRONIC LIFE-THREATENING ILLNESS, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION? ☐ YES ☐ NO *IF YES, COMPLETE A1 – A5 BELOW.*

A1. NAME AND ADDRESS OF FACILITY/HOME CARE ORGANIZATION/LICENSED CLINIC	A2. EFFECTIVE DATES OF LICENSURE _____ TO _____	A3. FACILITY TYPE

A4. PLEASE EXPLAIN THE ACTIONS TAKEN?

A5. HOW WAS THE ACTION(S) RESOLVED?

STATUS OF LICENSE/REGISTRATION

B. DO YOU HAVE PRIOR OR PRESENT SERVICE AS AN ADMINISTRATOR, GENERAL PARTNER, CORPORATE OFFICER, OR DIRECTOR IN A COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION? ☐ YES ☐ NO *IF YES, COMPLETE B1 – B3 BELOW.*

B1. NAME AND ADDRESS OF FACILITY/HOME CARE ORGANIZATION	B2. EFFECTIVE DATES OF LICENSURE _____ TO _	B3. FACILITY TYPE

C. HAVE YOU EVER HELD OR CURRENTLY HOLD A BENEFICIAL OWNERSHIP INTEREST OF 10% OR MORE IN A COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION? ☐ YES ☐ NO *IF YES, COMPLETE C1 – C3 BELOW.*

C1. NAME AND ADDRESS OF FACILITY/HOME CARE ORGANIZATION/LICENSED CLINIC	C2. EFFECTIVE DATES OF LICENSURE TO _____	C3. FACILITY TYPE

D. HAVE YOU EVER BEEN REGISTERED WITH THE TRUSTLINE REGISTRY PROGRAM? ☐ YES ☐ NO

BUSINESS EXPERIENCE

A. HAVE YOU WORKED IN THE HOME CARE SERVICES INDUSTRY WITHIN THE LAST FIVE (5) YEARS? ☐ YES ☐ NO *IF YES, PLEASE COMPLETE THE FOLLOWING:*

B. HAVE YOU OWNED/CO-OWNED OR OPERATED ANY BUSINESS WITHIN THE LAST THREE (3) YEARS? ☐ YES ☐ NO *IF YES, PLEASE COMPLETE THE FOLLOWING:*

Name of Business	Number of Employees	Your Title	Date Started	Date Ended	Reason for Leaving
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

I DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS FORM ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE	COUNTY WHERE SIGNED	DATE

Federal law (at Title 5 United States Code Section 552a Note) states that: Any federal, state, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.