State of Illinois
Illinois Department of Public Health

Hospice Residence Renewal Licensure Application

DIRECTIONS: Applicants who wish to renew the license for a **Hospice Residence** must complete this additional application along with the regular hospice application. Submit form with the **$500 fee for renewal of the application for a hospice residence license**.

Expiration Date _____ License Number _____

Name of Hospice _____

Address _____

City _____ State _____ Zip Code _____

Administrator/Contact Person _____ Title _____

Phone number _____ Fax Number _____

Number of Hospice Beds (Maximum of 20) _____

Location of Hospice Residence _____

Address _____

City _____ State _____ Zip Code _____

County: _____ Population: _____

Is the property: ◯ Owned ◯ Leased

If the property is owned by the applicant, complete the following:
Ownership Type (Please check one)

◯ Voluntary Non-Profit Non-Church ◯ Voluntary Non-Profit Church ◯ Governmental Agency ◯ Proprietary

◯ Other (specify) _____

If Proprietary or Other (Corporation, Sole Proprietor, Partnership or Association) complete this section and submit Attachment "A1". If license applicant is a Corporation or Partnership, list name and address of Illinois Registered Agent.

Name of Organization _____

President: _____ City: _____

Illinois Registered Agent or person legally authorized to receive service of process for entity:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone number _____ Fax Number _____

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If it is leased, provide the following information on the actual owner

Name: _____

Address _____

City _____ State _____ Zip Code _____

The following must be included at the time of application:

Application for licensure and fee of $500 ☐

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under the Hospice Program Licensing Act (210 ILCS 60). Disclosure of this information is **REQUIRED.** Failure to provide any information will result in this form not being processed. This form has been approved by Forms Management Center.

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ATTACHMENT (A1)

STATEMENT OF OWNERSHIP

Name of Hospice _____

Address _____

City _____ State _____ Zip Code _____

List name, address, telephone number, and occupation of each person who has entered into contract to manage, operate or who owns or controls (directly or indirectly) shares of stock, or any other financial interest of 5 percent or more of the hospice.

*****Copy next page and continue list, if needed.*****

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

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Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

Name | Address

City, State, Zip Code | Phone #

Occupation | Direct Int % | Indirect Int %

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APPLICATION ADDENDUM

This addendum must be completed as part of the following program/facility applications:

Ambulatory Surgical Treatment Center

Home Health Agency

Hospice Program

Hospital

Section 10-65(c) of the Illinois Administrative Procedure Act, 5 ILCS 100/10-65(c), was amended by P.A. 87-823, and requires individual licensees to certify whether they are delinquent in payment of child support.

APPLICANT IS AN INDIVIDUAL (SOLE PROPRIETOR) ◯ Yes ◯ No

The following question must be answered only if the applicant is an individual (sole proprietor)

I hereby certify, under penalty of perjury, that I ☐ AM ☐ AM NOT more than 30 days delinquent in complying with a child support order.

Signed _____

Date: _____

FAILURE TO SO CERTIFY MAY RESULT IN DENIAL OF LICENSE AND MAKING A FALSE STATEMENT MAY SUBJECT THE LICENSEE TO CONTEMPT OF COURT. (5 ILCS 100/10-65(c)