STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, NH 03301
TDD Access: Relay NH 1-800-735-2964
Agency Phone: 603-271-9039

APPLICATION FOR INDIVIDUAL HOME CARE SERVICE PROVIDER REGISTRATION

REGISTRATION #: _____ EXPIRATION DATE: _____

THIS APPLICATION SHALL BE FILLED OUT IN ACCORDANCE WITH RSA 151:4. **PLEASE BE SURE TO COMPLETE THE ENTIRE APPLICATION**. IF A SECTION DOES NOT APPLY TO YOUR FACILITY MARK NOT APPLICABLE (N/A). FAILURE TO COMPLETE THE APPLICATION WILL RESULT IN A DELAY IN THE REGISTRATION PROCESS. SEND THE COMPLETED FORM TO THE ADDRESS ABOVE.

Check all applicable items:

Renewal: ☐ Change in address: ☐ Other (please explain): ☐ New ☐

NAME : _____TELEPHONE #: (___)_____
FAX #: (___)_____
STREET ADDRESS:_____CITY:_____STATE:____ZIP:_____
MAILING ADDRESS:_____CITY:_____STATE:____ZIP:_____
E-MAIL ADDRESS_____

OWNERSHIP

a. Type of ownership: LLC: ☐
Individual: ☐

FEES: (EFFECTIVE JULY 1, 2013)

Personal Care Providers (820)	Less than 10 clients $25.00, Ten or More clients $250.00

A check or money order (payable to: **STATE OF NEW HAMPSHIRE, TREASURER)**, must be attached to this application.

Applications submitted by those facilities exempt under RSA 151:4 are not required to pay the license fee.

APPLICATION SHALL INCLUDE:

1. Be submitted at least 120 days prior to expiration of the current registration. **(Yearly)**

2. Attach qualifications, including education, experience and copies of all applicable licenses for the administrator. **(Initial)**

3. Secretary of State Information. **(Initial-if applicable)**

4. Results of Criminal Background Check. **(Initial)**

5. Results of State registry check through Bureau of Elderly and Adult services pursuant to RSA 161-F:49. (**Initial)**

FACILITY SERVICE DESCRIPTION:

The following information will be used to determine which category your facility shall be placed in.

I. Provide a detailed description of the services and programs you wish to provide.

SIGNATURES:

This application must be signed by:

1. The Individual Home Care Service Provider.

"I affirm that I am familiar with and in full compliance with the provisions of RSA 151:2,v and He-P 820. I also affirm that I have not been convicted of a felony in this or any other state, have not been convicted for sexual assault, other violent crime, assault, fraud, abuse, neglect, exploitation or any other criminal offense that suggests that they may pose a threat to the health, safety or well-being of a client, and have not been found to have to committed assault, fraud, abuse, neglect or exploitation by the department or any other administrative agency in this or any other state. I understand that providing false information shall be grounds for denial or revocation of the registration and the imposition of a fine."

"Advisory: The New Hampshire Department of Health and Human Services is authorized to require all licensed home care providers to read and understand the Home Care Clients' Bill of Rights set forth in RSA 151:21-b, and to distribute the law to all of their clients. The Department recommends that all individual home care service providers read and understand the Home Care Clients' Bill of Rights and share the information with their clients."

DATE: _____ SIGNED: _____

(NAME AND TITLE)

BHFA OFFICE USE ONLY

CHECK NUMBER: _____ AMOUNT: _____
APPLICATION COMPLETE: _____ NOT COMPLETE: _____
(Describe in comments)

NEW ☐ RENEWAL ☐ CHANGE ☐

QUALIFICATIONS OF ADMINISTRATOR Required ☐ Not Required ☐ Received ☐
SECRETARY OF STATE INFORMATION Required ☐ Not Required ☐ Received ☐

CATEGORY:

☐ 20 Individual Home Care Service Provider

REVIEWED BY: _____
(NAME & TITLE) (DATE)

ISSUE ANNUAL REGISTRATION: YES _____ NO _____

REGISTRATION DATES: FROM _____ TO _____

NOTES:

COMMENTS ON CERTIFICATE: