MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SUPPLEMENTAL HEALTH CARE SERVICES AGENCY

DO NOT WRITE IN THIS SPACE		
AGENCY REGISTRATION NUMBER		
☐ RENEWAL ☐ NEW AGENCY		
EXPIRATION DATE		
DATE FEE REC'D	CHECK NO/ JET PAY NO	AMOUNT $

APPLICATION FOR REGISTRATION TO OPERATE A SUPPLEMENTAL HEALTH CARE SERVICES AGENCY
(One application per registered agency location)

Applications must be received **at least 60 days prior to** the expiration of the current registration. **Applications will not be considered for review until payment has been received.**

Agency Information

1. AGENCY INFORMATION – The name of the Agency must be indicated exactly as you want it to appear on the registration. Include the mailing address of the Agency, if different from the street address.

Name of Agency/Doing business as (D.B.A)			
Agency Physical Address			
City	County	State	Zip
Agency Telephone Number	Fax Number		
Mailing Address or ☐ Same as above			
City	County	State	Zip
Agency E-mail Address			
Agency Website (optional)			
Responsible Person	Responsible Person Email and Phone Number (if different from Agency)		

Indicate if this application is a result of a new registered agency or renewal:

☐ **New Agency ($1,000 fee)** ☐ **Renewal ($750 fee)**
Each application for registration must be accompanied by a registration fee outlined above. *Attach a cashier's check, personal or certified check, company check, or money order payable to the Department of Health and Senior Services. If fee is submitted online, attach fee receipt. This fee is nonrefundable and not proratable.*

List the days and hours of regular operation. (**NOTE:** Inspections by the department will occur during the business hours submitted.)

DAY OF THE WEEK	OPENING TIME (indicate A.M. or P.M.)	CLOSING TIME (indicate A.M. or P.M.)
☐ Sunday		
☐ Monday		
☐ Tuesday		
☐ Wednesday		
☐ Thursday		
☐ Friday		
☐ Saturday		

2. OWNER INFORMATION – Please complete the following for each of the agency's owner(s). Attach multiple copies of this page if necessary.

Owner Name(s) *The name of the owner must be the exact legal name. If the owner is any entity other than a sole proprietor, the owner name must match the Missouri Secretary of State filing. The owner name should not be the name of any individual stockholder, partner, or member.*

Federal Employer Identification Number (EIN)	State Tax ID #	
Mailing Address or ☐ Same as Agency Mailing Address		
City	State	Zip
Contact Name		
Contact Telephone Number	Contact E-mail Address	

Description of Owner (check one):

☐ Corporation
☐ Limited Liability Company
☐ Limited Partnership
☐ Individual
☐ Sole Proprietor
☐ Other-explain

A. Individual and/or Entity Ownership of Owner as listed in section 2 above – Provide the information for each controlling person. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	TITLE OR POSITION	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (or SSN if sole proprietor)	% OWNERSHIP

B. Board Members and Officers of Owner – If the owner is a legal entity, provide the information for each individual or entity that serves as an officer or is on the board of directors of the owner, if applicable. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER
Board Member/Officer			
Board Member/Officer			
Board Member/Officer			
Board Member/Officer			
Board Member/Officer			
Board Member/Officer			

C. Articles – If the owner is a legal entity, attach copies of the owner's articles and current bylaws to this application.

☐ Attached

3. OPERATOR INFORMATION – Please complete the following for the entity(s) operating the agency.

☐ **Check mark this box if the operating entity(s) is the same as the owner. If checked, skip ahead to #1 below.**

Operator Name(s) *The name of the operator must be the exact legal name. If the operator is any entity other than a sole proprietor, the operator name must match the Missouri Secretary of State filing. The operator name should not be the name of any individual stockholder, partner, or member.*

Mailing Address or ☐ Same as above

City	State	Zip
Contact Name		
Contact Telephone Number	Contact E-mail Address	

Description of Operator (check one):

☐ Corporation
☐ Limited Liability Company
☐ Limited Partnership
☐ Individual
☐ Sole Proprietor
☐ Other-explain

A. Individual and/or Entity Ownership of Operator as listed in section 3 above – Provide the information for each controlling person. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	TITLE OR POSITION	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (or SSN if sole proprietor)	% OWNERSHIP

B. Board Members and Officers of Operator – Provide the information for each individual or entity (corporation, partnership, association) that serves as an officer or is on the board of directors.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER
Board Member/Officer			
Board Member/Officer			
Board Member/Officer			
Board Member/Officer			
Board Member/Officer			
Board Member/Officer			

1. Does the operator currently operate or own any other Supplemental Health Care Services Agencies?

☐ Yes ☐ No

If the operator currently operates or owns any other supplemental health care services agencies, then list below or attach a list of such agency or agencies, including their names, address(es), type of registrations and registration number.

☐ Attached ☐ Previously submitted; no amendment or change

Financial Information

Each registrant must submit financial information demonstrating that the operator has the financial capacity to operate an agency.

Each agency must provide proof of financial responsibility through one of the following methods documenting at least four weeks of back wages per employee:

- Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit;
- Obtaining and maintaining an unexpired irrevocable letter of credit established. Such letters of credit shall be nontransferable and nonassignable and shall be issued by any bank or savings association organized and existing under the laws of this state or the United States.

AND

Provide the name and address of the bank, savings bank, or savings association in which the agency will deposit the agency's employee's income tax withholdings. If the agency is not responsible for employee income tax withholding, the agency shall provide the name and address of each personnel for whom income taxes will not be withheld.

☐ Attached ☐ Previously submitted; no amendment or change

Other Information

1. Provide proof that the agency or that the health care personnel has medical malpractice insurance (professional liability insurance is acceptable);

☐ Attached

2. Provide proof of current worker's compensation coverage as required by Missouri Statutes, Chapter 287 RSMo, or if any personnel are independent contractors, provide proof of occupational accident insurance.

☐ Attached

Acceptable forms of worker's compensation coverage include: a certificate of insurance supplied by an authorized Worker's Compensation insurance carrier pursuant to Chapter 287, RSMo. The certificate shall include the name of the registrant, the name of the corporation legally responsible for the registrant, or the name the registrant is doing business as. The certificate must be effective prior to the issuance of an initial registration or have an effective date on or after the effective date of a renewal registration. OR provide approval from the MO Department of Labor to be self-insured.

You cannot be issued a registration and may not operate as a supplemental health care services agency unless acceptable evidence of compliance with workers' compensation coverage provisions is provided.

Affidavit

I attest that I as an individual, or that the operating entity for which I sign, have/has adequate financial resources to properly operate the Agency referred to in this application.

I further attest I am familiar with the requirements of a supplemental health care services agency as set out in Chapter 198 of the Missouri Revised Statutes and the regulations of the Department of Health and Senior Services promulgated thereunder.

I further attest to refrain in any contract with any health care personnel or health care facility from requiring the payment of liquidated damages, employment fees, or other compensation should the health care personnel be hired as a permanent employee of a health care facility;

I further attest that the agency does not restrict in any manner the employment opportunities of its health care personnel;

I further attest that each health care personnel meets all licensing or certification requirements and all training and continuing education standards for the position in which the personnel would be working;

I further attest that each health care personnel complies with requirements related to background checks in sections 192.2490 and 192.2495.

I further attest that all documents and information required by the Department of Health and Senior Services to be provided pursuant to this application are true and correct to the best of my knowledge and belief, that the statements contained in this application and any attached information are true and correct to the best of my knowledge and belief, and that all required documents are either included with the application or are currently on file with the Department of Health and Senior Services. I understand that if it is determined by the Department of Health and Senior Services that the statements contained herein are not true and correct, the application may be denied and any registration issued based on the application may be revoked.

I further attest that I have the express authority to sign this application on behalf of the owner and operator.

My signature attests to the truth and accuracy of the foregoing attestations.

Authorized Signature of Agency	Telephone Number
Printed or Typed Name and title of Signatory	Telephone Number

Subscribed and sworn to before me this_____of_____. I am commissioned as a notary public within the
(DAY) (MONTH,YEAR)

County of_____, State of_____, and my commission expires on_____.
(NAME OF COUNTY) (NAME OF STATE) (DATE)

_____ _____

Signature of Notary *Date*