MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division – Licensure Bureau
2401 Colonial Drive, PO Box 202953
Helena MT 59620-2953
FAX: (406) 444-1742

APPLICATION FOR MONTANA STATE HEALTH CARE FACILITY/SERVICE LICENSE
HOME INFUSION THERAPY APPLICATION

Initial Application ☐ **Renewal Application** ☐

Home Infusion Therapy Service Name: _____

Montana Specific Information:

Montana Address: _____ PO Box: _____

City: _____ Zip: _____ County: _____

Telephone Number: _____ FAX: _____

E-mail/Web page Address: _____

Name of Administrator: _____

Administrator Address: _____ City: _____ State/Zip: _____

County: _____ Telephone Number (if different than above): _____

Administrator (or contact) e-mail address: _____

Name of Chief Pharmacist: _____ MT License #:_____

Regional Administrator (if applicable): _____

Regional Administrator Address: _____ City/St/Zip: _____

If the parent company is an out of state company, list the following:

Name of Company: _____ Address of Company: _____

Phone: _____ e-mail: _____

Operating Organization

Information on ownership, contract, or lease agreement if operated by a person other than the owner:

☐ **If a partnership, firm or association, list below every member thereof.**

☐ **If a corporation, list below the name and address thereof and the names of its officers.**

☐ **If a State Affiliated Organization, list below:**

NAME	ADDRESS
_____	_____
_____	_____
_____	_____

List name and license number of all licensed professionals employed by your Agency.

NAME	LICENSE NUMBER

Please attach additional sheets as necessary.

Submission of the following information is required for a Home Infusion Therapy Agency which utilizes an out-of-state source for pharmaceuticals:

• The Out-of-State Mail Order Pharmacy License number assigned by the Montana State Board of Pharmacy:
License Number: _____

• The ID Folder Number assigned by the Montana Secretary of State's Office:
ID Folder Number: _____

I certify that the information submitted to DPHHS is true and accurate. This license Application to operate a Home Infusion Therapy service hereby submitted under the provisions of MCA 50-5-101 through 50-5-208.

SIGNED: _____ DATE: _____

TITLE: _____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

Enclose a check, money order or draft for $20 made payable to the Department of Public Health & Human Services to cover the license fee.
This fee will be deposited in the State Treasury and is non-refundable.