MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Office of Inspector General - Licensure Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953
FAX: (406) 444-1742

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

☐ **Initial Application** ☐ **Change of Ownership**

Facility Name: ____

Facility Address: ___________________________________ PO Box: ____________________

City: ______________________________ State/Zip: ________________________________

Facility Telephone Number: _______________________ FAX: ___________________________

Name of Applicant: ____

Applicant (or contact) e-mail: ____

Name of Administrator: ____

Administrator Address: ___________________ City: __________________ State/Zip: _________

Administrator e-mail: ____

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

Name of Company:_______________________Address of Company: ______________________

Phone:___________________________________e-mail: ____________________________

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

- **If a partnership, firm or association, list every member thereof.**
- **If a corporation, list the names and address thereof and the names of its officers.**
- **State Affiliated Organization**

NAME ADDRESS

____

____

____

____

(attach additional list if necessary)____

List name and License number of all health care professionals employed by your agency.

NAME	LICENSE NUMBER
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

(attach additional list if 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 Application for licensure for Home Infusion Therapy agency is hereby submitted under the provisions of MCA 50-5-101 through 50-5-208.

SIGNED:____DATE:__________________________

TITLE:____

ADDRESS:________________________________CITY:____________STATE/ZIP: _________________

Enclose a check or money order payable to the *Department of Public Health & Human Services* to cover the license fee. The fee is determined as follows:
(a) Facilities with 20 or less beds = $20.00
(b) Facilities with 21or more beds = $1.00 per bed.
(c) Facilities with no beds = $20.00
This fee will be deposited in the State Treasury and is non-refundable.