

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

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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.