

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

*Quality Assurance Division
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953
FAX: (406) 444-1742*

HOME INFUSION THERAPY LICENSE APPLICATION

Home Infusion Therapy Service Name: _____
Address: _____ PO Box: _____
City: _____ Zip: _____ County: _____
Telephone Number: _____ FAX: _____
E-mail/Web page Address: _____
Regional Administrator (if applicable): _____
Name of Administrator: _____
Administrator Address: _____ City: _____ State/Zip: _____
County: _____ Telephone Number (if different than above): _____
Administrator (or contact) e-mail address: _____

Operating Organization: State Individual Partnership Church
 Corporation Association

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

<i>NAME</i>	<i>ADDRESS</i>
_____	_____
_____	_____
_____	_____
_____	_____

(Please attach additional sheets as needed.)

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

NAME	LICENSE NO.	NAME	LICENSE NO.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Continued on following page

The following information is required for an out-of-state home infusion therapy service for submission prior to licensure:

- The Mail Order Number assigned when registered with the Montana State Board of Pharmacy as a Mail Order Pharmacy: _____ **OR** a copy of the Out of State Mail Service License **AND**
- The Mail Order Number assigned when registered with the Montana Secretary of State's Office:

The applicant and managing personnel have never been convicted of a felony. Section 50-5-207 (c) 50-5-207 MCA. Denial, suspension, or revocation of health care facility license -- provisional license. (c) The applicant or any person managing it has been convicted of a felony and denial of a license on that basis is consistent with [37-1-203](#) or the applicant otherwise shows evidence of character traits inimical to the health and safety of patients or residents.

The applicant and managing personnel have never been denied a license. (Section 50-5-207 (C) including stipulations of Section [37-1-203](#)).

37-1-203 MCA. Conviction not a sole basis for denial. Criminal convictions shall not operate as an automatic bar to being licensed to enter any occupation in the state of Montana. No licensing authority shall refuse to license a person solely on the basis of a previous criminal conviction; provided, however, where a license applicant has been convicted of a criminal offense and such criminal offense relates to the public health, welfare, and safety as it applies to the occupation for which the license is sought, the licensing agency may, after investigation, find that the applicant so convicted has not been sufficiently rehabilitated as to warrant the public trust and deny the issuance of a license.

The applicant has the financial ability to operate the facility in accordance with law or rules or standards adopted by the Licensure Department (Section 50-5-207 (d)).

Application for a Home Infusion Therapy license is hereby submitted under the provisions of Section 50-5-101 through 50-5-228. (See attached)

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.**

For additional information on the Internet:

<http://www.dphhs.mt.gov>

<http://www.dphhs.mt.gov/aboutus/divisions/qualityassurance/index.shtml>