

Electronic Submission of License Applications

Effective September 30, 2006, the Department of Health's Plan of Correction system will include on-line submission of license applications and payment of license fees. This change will also include a requirement that facilities must meet the Governor's Office of Administration's password standards. All facilities' passwords used to access the Plan of Correction and On Line Licensing site will now require the following:

- 1. Passwords must be comprised of a minimum of six alphanumeric characters.
- 2. Accounts that are inactive for 180 consecutive days will be disabled.
- 3. Accounts will be disabled after three consecutive invalid access attempts.
- 4. Passwords must be changed every 60 days.
- 5. The system will retain three prior passwords to prevent the re-use of prior passwords.
- 6. If an account is disabled or you forgot your password, there is a link "Forget your password or account disabled" that you can click in order to get a password or to enable your account.

The first time a facility attempts to log into the POC or On Line Licensing system, they will be required to change their password as indicated above.

Submission of license applications will now be accomplished on-line via the facility Add Response page, the same site where Plans of Correction are submitted. When a license is due for renewal, or another licensing action such as change of address, ownership, number of beds, etc. occurs, an email message will be sent to the facility stating that the license application is available on the web for submission to the Department of Health. Additionally, the capability to pay on the web via credit/debit card is provided.

TO ACCESS THE FACILITY WEB SITE:

1. Enter this address into the Address Field of your web browser; or, if you have received this message electronically you may click on the site address: <u>www.health.state.pa.us/facility</u>

NOTE: This address is only for health care facilities and is not available via public web site links. To save this address in your browser, click on "Favorites" on your browser tool bar menu and then click on <u>Add to Favorites</u>. Also, you may wish to keep this message for a quick reference to the site address.

| http://ecapps.h | ealth.state.pa.us/CommonPOC/Default.asp - Microso | ft Internet Explorer provided by PA 🖥 🐨 🔀 🖪 🖉 🔝 💶 🗗 ≥ |
|-------------------|---|---|
| File Edit View | Favorites Tools Help | |
| 🕁 Back 🔹 🔿 🚽 | Add to Favorites | - 3 m - E |
| Address 🛃 http:// | e Organize Favorites | ▼ ∂Go Links ' |
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| | Ciber 12c Development | - Excilition |
| | Department of Health Intranet | e racintres |
| | Download Database | |
| | FirstGov.gov - Official website for searching the | |
| | Forms And Publications - IRS | |
| | HCFA Medicare, Medicaid, and the State Children | lity, |
| | Health Statistics | Inty |
| | httpciberwebdev-21training- | |
| | Anto-ciberwebdev-21uat-content-facilityweb-Lo | |
| | Attpecapps.health.state.pa.us-CommonPOC-D | esponse |
| | http://www.hcfa.gov-pubforms-pub07pdf-AP-Q | |
| | intranet.prn | heginentry |
| | Invalid syntax error | 7 |
| | Long Term Care in PA - Home Page | 2 |
| | MSN.com | nformation: |
| | MSN | ed to the facility database |
| | My Documents | and to low in |
| | Wursing Home Compare - Home | leed to log in. |
| | Nursing Home Data Link - Login | ud tested using Microsoft Internet Explorer as the |
| | Nursing Homes County Map | rk well with this site. You may obtain Internet |
| | Nursing Homes-Directory of Pennsylvania Nursin | on the button below. |
| to://www.medicare | R 🛃 DA Department of Concerci Services | |

2. When you first log on, the first page that you will see is the **ADD Response** page. Once on this page, click the square under "<u>Click here to begin entry</u>".



3. The next page that you come to is called the **POC/Online Licensing - Login** page. This page will also give you access to the Facility Message Board.

| HEALIH | POC/Online Lic | ensing - Login Page |
|--------|--------------------------------|-----------------------------------|
| | Login ID Password Login | Change Pasoword |
| | | Message Board |
| | ALL Acute & Ambulatory Care | |

4. Facilities shall be able to change their password using the Change Password button, which will launch the POC/Online Licensing-Change Password page.

| DE PA RIMENT OF | Pennsylvania Department of Health POC/Online Licensing - ChangePassword |
|---|---|
| Password Guidelines: characters long and no r Passwords can not be ch immediately. | Login ID Old Password New Password Retype New Password Passwords must be changed at least every 60 days. New passwords must be at least 6 alphanumeric nore than 20 characters long. New passwords must be different than the previous three passwords. hanged more than once per day. If you suspect your password has been compromised, change it |

The user completes the fields and clicks the Change Password button. If the user enters an incorrect Login ID, the following error is displayed and he must try again: "Invalid Login ID. Please reenter your information."

5. If the user enters either of the passwords incorrectly, the following page/error is displayed and he must try again:

| DE PA RIMENT OF | Pennsylvania Department of Health POC/Online Licensing - ChangePassword |
|---|--|
| | Old password and new password must be different. Login ID Old Password New Password Retype New Password |
| Password Guidelines characters long and no Passwords can not be immediately. | SP Passwords must be changed at least every 60 days. New passwords must be at least 6 alphanumeric more than 20 characters long. New passwords must be different than the previous three passwords. changed more than once per day. If you suspect your password has been compromised, change it |
| | Change Password Cancel |

The Change Password button returns the user to the Log In Page.

| DEPARTMENT OF | Pennsylvania Department of Health |
|---|---|
| HEALTH | POC/Online Licensing - Login Page |
| | |
| | Password successfully changed. You can use your new password to log in. |
| | Login ID |
| | Password |
| | Login Change Password |
| | ALL Message Board |
| | |
| Please note: Password If your account has be | is must be changed every 60 days. Accounts that are inactive for 180 consecutive days will be disabled. en disabled, please contact the appropriate Department of Health office to get your account activated. |

6. Once the facility has logged into the system, a new menu page will appear. They will need to select from either "POC" or "On-Line Licensing" (for nursing homes only) on this page. They will then be routed to the appropriate function.

| DEPARTMENT OF | Penn. POC/Online I | sylvania Department of Health Licensing - Select the WEB |
|---------------|-----------------------|---|
| | POC | Online Licensing |

7. Clicking on the Online Licensing link will bring up the Online Licensing – Main View page.

| PA | TOF H | Onl | Pennsyl ine Lic | vania Departme ensing • | nt of Health - Main | View |
|------------------------|-----------------------|----------------------|--------------------|----------------------------|------------------------|--|
| Application Type | Application Status | License Effective | License Expires | License Type | License Status | Action |
| Renewal Application | Payment Received | 03/31/2007 | 03/31/2008 | Regular | Active | Launch Application Payment received Print License - N/A View History |
| Renewal Application | Open | 03/31/2007 | 03/31/2008 | Regular | Active | Launch Application Submit Payment - N/A Print License - N/A View History |
| Renewal Application | Closed | 03/31/2006 | 03/31/2007 | Regular | Active | Launch Application - N/A Submit Payment - N/A Print License - N/A View History |
| Renewal Application | Closed | 03/31/2005 | 03/31/2006 | Regular | Active | Launch Application - N/A Submit Payment - N/A Print License - N/A View History |
| Renewal Application | Closed | 03/31/2004 | 03/31/2005 | Regular | Active | Launch Application - N/A Submit Parment - N/A Print License - N/A <u>View History</u> |
| Renewal Application | Closed | 03/31/2003 | 03/31/2004 | Regular | Active | Launch Application - N/A Submit Payment - N/A Print License - N/A View Histerx |
| Renewal Application | Closed | 03/31/2002 | 03/31/2003 | Regular | Active | Launch Application - N/A Submit Payment - N/A Print Lucense - N/A |

The Online Licensing – Main View page provides the facility name, address, facility ID and License Number at the top. Other data elements are the application type, status, effective date, expiration date, license type and license status. Additionally, there is a column for four action links: a Launch Application link that provides the application for completion; a Submit Payment link that allows on-line payment via credit/debit card; a Print License link that will allow the facility to print the most current license; and a View History link that shows licensing history for the facility.

8. Clicking the Launch Application link generates the application form as in the following example. Please note that required fields are identified with red asterisks. Questions regarding ownership, trustees and board members, and financial interests in other health care facilities provide a capability to attach electronic files such as Microsoft Word and Adobe Acrobat pdf files that are located on the applicant's computer or network.

| DEPARTMENT OF | Pennsylvania Department of Health NCF License Application Form |
|--|--|
| | |
| (Scti)I'' | • Step 2: Review • Step 3: Agreement • Step 4: Pdyment |
| To a "oid data loss du = to unexped | -d session ti"out, plos= re[T]=[T]br to save yourch one-s fr-quently |
| (using 'Scov=button or Alt-S). C=rt in inforiTLotion on this onlin= Hb Di ision of NCFat (717)787- | icense 'Pplk, stion can only be upd, sted by contilleding the Deport III and B |
| County Phone Number | Type of Renewal Application Application (Open) |
| Email A.ddress | Type of Non Profit-corporation Ownership |
| | Type of Non-Proft Operation |
| * Have you increased your be greater within the last 2 years? ≇r Yes ∎r No | d capacity by 10'o'o or more, or by 10 beds, whichever is |
| If yes | r r |
| Give year of change | current beds Prior beds |
| Current Licensed Capacity Current License Number 01 2 | Expiration Date of Current License 3/31/2008 002 Requested Capacity |
| Name | License Number |
| *Home Address | |
| * Are there any directors, offi organization who have ever bus such programs established by Ti rves rNo Has there been a change 1n ownership or control within the | zers, agents, or managing employees of the institution, agency or zer convicted of a command offense related to their involvement in ties XVIII, XIX, or XX? Do you anticipate any change of Do you anticipate filting for ownership or control within the banknotox, within the year? If |
| rves | ;S ves |
| last year? If yea when? | I (mrn/dd/vvvv) |
| In No. | year/iryes, when? yes, when? |
| | (mm/dd/vvvv) |
| If county operated or sponso commiSSioners. | Remember address of Board of New More Sciences and name of Commissioner |
| Address | |
| iioner | |
| " Is the facility and/or building- | " Is the facility managed by an organization |
| r Owned r Leased | |
| If leased,list the name and add | ress of lessor. If yes, list the name and address of the |
| | organizatiOn. |
| List name and address of all dorument.Make sure to click Att | persons having ownership of SOloor more (Type in or attach a ach button after you select a file.) |
| | |
| | browse |
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| L | |
| If appropriate, list the nam a dorument.Make sure to click A | e and address of trustees or boardmembers. (Type in or attach ttach button after you select a file.) |
| | Browse |
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| Attach | |
| ATe there any individuals o interest of S percent or more in a criminal offense related to the proorams established by Titles y r Yes rNo | r oroanizations havino a direct or indirect ownership or control the institution,organizations,or agency that have been convicted of a involvement of such persons, or organizations m any of the (VIII, XII X,or XX? |

 ATe there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's, or agency's fiscalintermediary or carrier within the previous 12 months? (Title XVIII providers only)

| Are there any individuals currently employed by the institution, agency, or organization in managerial, accounting, auditing, or similar capacity who were employed by the institutic organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XN providers only) ☐ Yes | n a m's VIII |
|--|--------------------|
| * Is the facility's ownership involved with a pyramid or parent corporate structure? If applical list name and address of parent corporation or pyramid corporate structures. Explain necessary. (Type in or attach a document. Make sure to click Attach button after you select a file □ Yes | ble, as e.) |
| | 4 |
| | Ŧ |
| Attach | |
| * Does owner(s) or corporate members have financial interest in other health care facilities? Yes No | |
| If yes, list name and address of all other health care facilities in which the owner or corpor members have financial interest. (Type in or attach a document. Make sure to click Attach but after you select a file.) | ate ton |
| | <u>_</u> |
| Erowse | |
| Attach | |
| * Does owner(s) or corporate members have financial interest in other health care facilities? Yes No | |
| If yes, list name and address of all other health care facilities in which the owner or corpor members have financial interest. (Type in or attach a document. Make sure to click Attach but after you select a file.) | ate ton |
| | <u> </u> |
| | - |
| Erowse | |
| Payment: A \$382.00 licensure fee must accompany this application. Please submit payment online or v check or money order. Click here for <u>Payment Information</u> . | ria |
| Please, select payment method: Ry credit/debit card | |
| By check/money order | |
| Save Submit to Pennsylvania Department of Health | |

- 9. The user should complete the application, selecting the desired payment method, and click the Submit to Pennsylvania Department of Health button. If the application cannot be completed but the user does not want to lose information that has already been entered, they can click the Save button. The application can then be completed at a later time.
- 10. After the user clicks the Submit to Pennsylvania Department of Health button, the completed application will be displayed on the screen.

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|---|---|----------------------|---------------|---------------------|-------------|
| PARTMENT OF | Peni | nsylvania Departme | nt of Health | | |
| EALTH | NCF Lice | ense Applie | cation | Form | |
| | | | | | |
| | | | | | |
| | | | | | |
| Step 1: Application 🔸 | Step 2: Review | ⊃ → Step 3: Agreeme | nt 👂 Step 4: | Payment | |
| | | | | | |
| Please review the application in If information is correct, click th | formation below. ie "Continue to Submi | it" button below. | | | |
| Otherwise, click the "Back to Ed | it" button to make ch | anges. | | | |
| County | | Type of | Renewal A | pplication | |
| Phone Number | | Application | (Open) | | |
| Email Address | | Type of Ownership | Non Profit- | -Corporation | |
| Name of Immediate Owner | | Type of Operation | Non-Profit | | |
| | | | | | |
| * Have you increased your I within the last 2 years? | ped capacity by 10 | % or more, or by 10 | beds, which | never is greater | |
| Yes | | | | | |
| M No | | | | | |
| 16 une | | | | | |
| Ir yes, | | | | | |
| Give year of change | Current beds | Prior b | eds | | |
| Current Licensed Capacity | 141 | Expiration Date of C | urrent Licens | e 3/31/2008 | |
| Current License Number 01 | .2002 | Requested Capacity | | 141 | |
| | | | | 1 | |

If any changes are needed, click the Back to Edit button at the bottom of the screen.

| × | |
|---|--|
| Browse | |
| Attach | |
| | |
| * Does owner(s) or corporate members have financial interest in other health care facilities? | |
| V No | |
| | |
| If yes, list name and address of all other health care facilities in which the owner or corporate members have financial interest. (Type in or attach a document. Make sure to click Attach button | |
| after you select a file.) | |
| | |
| | |
| | |
| * | |
| Browse | |
| Attach | |
| Democrati | |
| A \$382.00 licensure fee must accompany this application. Please submit payment online or via | |
| check or money order. Click here for <u>Payment Information</u> . | |
| *Please, select payment method: | |
| V By credit/debit card | |
| By check/money order | |
| Back to Edit Continue to Submit | |

11. After all changes are completed or if no changes are needed, click the Continue to Submit button. This will launch the Licensing – Agreement Form page.

| | Licensing Main View | oqou |
|---|---|------|
| PARTMENT OF | Pennsylvania Department of Health | |
| <i>IEALTH</i> | Licensing - Agreement Form | |
| | ARBUTUS PARK MANOR 207 OTTAWA STREET JOHNSTOWN, PA 15904 Facility ID: 012002 License #: 012002 | |
| Step | 1: Application > Step 2: Review > (Step 3: Agreement) > Step 4: Payment | |
| | | |
| In submitting this docu | ment, I affirm that I am the individual authorized by the governing body of | |
| | | |
| Fotor authorized outport | | |
| (Enter authorized owner r | name) | |
| (Enter authorized owner r to sign this application | name) on behalf of | |
| (Enter authorized owner r to sign this application | name) on behalf of | |
| (Enter authorized owner r to sign this application (Enter facility name) | name) on behalf of | |
| (Enter authorized owner r to sign this application (Enter facility name) I understand that any relating to unsworn fal: | name) on behalf of false statements made in this submission are subject to the penalties of 18 PA C.S. §4 sification to authorities. | 4904 |
| (Enter authorized owner r to sign this application (Enter facility name) I understand that any relating to unsworn fal: Signature Authority | name) on behalf of false statements made in this submission are subject to the penalties of 18 PA C.S. §4 sification to authorities. | 4904 |
| (Enter authorized owner of to sign this application (Enter facility name) I understand that any relating to unsworn fal: Signature Authority | name) on behalf of false statements made in this submission are subject to the penalties of 18 PA C.S. §4 iffication to authorities. | 4904 |
| (Enter authorized owner of to sign this application (Enter facility name) I understand that any relating to unsworn fal: Signature Authority (Enter director/administra | name) on behalf of false statements made in this submission are subject to the penalties of 18 PA C.S. §4 sification to authorities. | 4904 |

12. Complete all fields on this page and click the Confirm Agreement and Continue Submitting Application button. This will launch the Online Licensing-Submit Payment page.

| DEPARTMENT OF | Pennsylvania Department of health |
|--|--|
| HEALTH | Online Licensing - Submit Payment |
| | |
| Step | 1: Application > Step 2: Review > Step 3: Agreement > <u>Step 4: Payment</u> |
| Your "Renewal Applica | tion" license application has been successfully submitted to the PA Department of Health. |
| Reference Number: 1 | 1575910 |
| Please remember to s approval. | submit payment for any required fees. If applicable, payment is required prior to final License |
| A credit or debit card of the fee, must accor on checks or money of | payment, check or money order payable to the Commonwealth of Pennsylvania for the amoun mpany this application. Currency is not acceptable. Please include the facility's License Numbe rders. |
| Regular Licenses: The | e regular fee per license is \$250.00 plus \$2.00 for each bed in excess of 75 beds. |
| Provisional Licenses: First provisional - Second provisional - Third provisional - Fourth provisional - | The fee per license for a provisional license is as follows: \$400.00 + \$4.00 per bed \$600.00 + \$6.00 per bed \$800.00 + \$0.00 per bed 1000.00 + \$10.00 per bed |
| Please submit paymer | it of \$382.00 online or via check or money order. |
| The address to mail c Pennsylvania Departm Nursing Care Facilities 526 Health & Welfare Forster And 7th Street Harrisburg, PA 17120 | heck or money order: lent of Health Building Is |
| Payment Method: | rd |
| 🗆 By check/money | order |
| If paying by check or to Main View or Logou | money order, no further steps are required within the Online Licensing website. Please retur t. Remember to submit your check or money order to complete this license process. |
| | Submit Payment Online |

13. If the user chose to pay by credit/debit card, the Online Licensing – Submit Payment page launches.

| | on the Licensening - Submit Pulyment |
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| | |
| | REVIEW & PAYMENT |
| 1. Confirm your 2. Enter your bill 3. Enter your cre | payment total. ng information. dit/debit card information. |
| P | ayment Total |
| Application Fee: | \$250 |
| Bill | ing Information |
| First Name: | |
| Last Name: | |
| Address: | |
| | |
| City: | |
| State: | AK 💌 |
| Zip Code: | |
| Credit/D | ebit Card Information |
| Card Type: | |
| Card Number: | |
| Cardholder's Nar | ne: |
| Expiration Date: | |

14. The user should complete the billing information and click the Submit Payment button. Successful submission of payment results in the payment success screen.

| E ARTMENT OF | Pennsylvania Department of health |
|----------------------------|--|
| HEALIH | Online Licensing - Submit Payment |
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| | |
| | Payment Success |
| Payment for | Payment Success |
| Payment for Reference N | Payment Success your License Application has been accepted. Your credit card has been charged \$382. umber: 11575910 |

- 15. If the user chose to pay by check or money order, they should send the check/money order to the address provided on the payment page.
- 16. The Department of Health staff will be notified via email when the facility has completed the application and if the payment is via credit or debit card, they will be notified when payment is received. They will then review the application. If there are any problems with the application or payment, an email will be sent to the facility and will provide instructions for resolution. After review, if no issues exist, an email will be sent to the facility indicating that the license is available on the same site and may be printed by clicking the Print License link on the Online Licensing Main View page.

IMPORTANT: PLEASE NOTIFY YOUR FIELD OFFICE IMMEDIATELY WITH ANY CHANGE IN YOUR E-MAIL ADDRESS

DIVISION OF NURSING CARE FACILITIES:

PITTSBURGH FIELD OFFICE Telephone: (412) 565-2836 Fax: (412) 564-2893

SCRANTON FIELD OFFICE Telephone: (570) 963-4331 Fax: (570) 963-3415

LIONVILLE FIELD OFFICE Telephone (610) 594-8041 Fax: (610) 594-9267

JOHNSTOWN FIELD OFFICE Telephone: (814) 248-3125 Fax: (814) 248-3058

WILLIAMSPORT FIELD OFFICE Telephone: (570) 651-1040 Fax: (570) 651-1043 **JACKSON CENTER FIELD OFFICE Telephone: (724) 662-6050** Fax: (724) 662-6067

LEHIGH VALLEY FIELD OFFICE Telephone: (610) 861-2117 Fax: (610) 861-2123

NORRISTOWN FIELD OFFICE Telephone: (610) 270-3475 Fax: (610) 270-1152

HARRISBURG FIELD OFFICE Telephone: (717) 783-3790 Fax: (717) 772-3641

Division of Acute and Ambulatory Care:

| Central office | 717-783-8980 |
|----------------|--------------|
| Jackson Center | 724-662-4008 |
| Pittsburgh | 412-565-5176 |
| Johnstown | 814-248-3129 |
| Harrisburg | 717-772-3640 |
| Scranton | 570-963-3047 |
| Norristown | 610-270-3636 |
| | |

DIVISION OF HOME HEALTH

MONESSEN FIELD OFFICE Telephone: (724)684-2940 Fax: (724) 684-2933

SCRANTON FIELD OFFICE Telephone: (570) 963-4212 Fax: (570) 963-3415

NORRISTOWN FIELD OFFICE Telephone: (610) 270-1707 Fax: (610) 270-1152

DANVILLE FIELD OFFICE Telephone: (570) 849-2144 Fax: (570) 275-7006

MEADVILLE FIELD OFFICE Telephone: (814) 336-1163 Fax: (814) 724-6883 **JACKSON CENTER FIELD OFFICE Telephone: (724) 662-6050** Fax: (724) 662-6067

WHITEHALL FIELD OFFICE Telephone: (610) 821-6381 Fax: (610) 821-6564

CHESTER FIELD OFFICE Telephone: (610) 619-3490 Fax: (610) 447-3008

HARRISBURG FIELD OFFICE Telephone: (717) 783-1379 Fax: (717) 772-0232

PITTSBRUGH FIELD OFFICE Telephone: (412) 770-3991 Fax: (412) 880-0447