pennsylvania
DEPARTMENT OF HEALTH

FOR STATE USE ONLY
☐ Amount Rec'd $_____
☐ Date Rcvd:_____
☐ Transmittal No#_____
☐ Inspection Date_____

Pennsylvania Department of Health
Bureau of Non-Long-Term Care
Temporary Health Care Agency Program
2525 North 7th Street Ste 210
Harrisburg, PA 17110
dh-qatempagency@pa.gov

APPLICATION FOR Temporary Health Care Service Agency (THCSA) REGISTRATION of ACT128

Registration Status:	Payment of the Registration Fee:
☐ **Initial** Registration ☐ **Annual** Renewal Registration ☐ **Change** of Registration Information	The fee is **$500** to register as a Temporary Health Care Service Agency (THCSA). Payment must be submitted with the application and supporting documentation. The check or money order should be made payable to "*PA Temporary Health Care Agency Program.*"

Instructions:
For **Initial Registration**: Complete *all* information requested on this Application form.
For **Annual Renewal Registration**: Complete *all i*nformation requested on this Application form.
For **Change of Registration Information:** *Update* this Registration Application with any new or corrected information.

FACILITY INFORMATION					
Name of Entity			AssignedFacility DoH ID #00		
Telephone Number			Email Address		
Street Address			Mailing Address (if different)		
City	State	Zip Code	City	State	Zip Code
FACILITY OWNERSHIP *Attach additional primary owners to this application.*					
Name of Owner			Telephone Number	Email Address	
Street Address			Mailing Address (if different)		
City	State	Zip Code	City	State	Zip Code
FACILITY CONTACTS					
Name of Contact 1			Telephone Number	Email Address	
Street Address			Mailing Address (if different)		
City	State	Zip Code	City	State	Zip Code
Name of Contact 2			Telephone Number	Email Address	
Street Address			Mailing Address (if different)		
City	State	Zip Code	City	State	Zip Code

APPLICATION FOR Temporary Health Care Service Agency (THCSA) REGISTRATION

Employer Identification Number

Provide the business:
Federal EIN:

PA EIN Or
Out of State ID:

Additional Primary Locations

Provide the address and telephone number for every **operating location** (i.e., an address used by the agency for 90 calendar days or more to interview applicants, accept applications, or to solicit job orders from client companies).
If there are additional primary locations, please attach to this application.

Facility Name	Address	Phone	Email	Contact

Additional Documentation to Send

Does the applicant currently employ or contract health care personnel? **_Yes** **_ No**

If No: Does the applicant certify that it shall not provide health care personnel to any health care facility until the applicant provides the required documentation listed above to the Department's satisfaction? **_ Yes** **_ No**

If Yes: In addition to this completed application form, the applicant shall provide the following required documents to the Department for review:

- Medical malpractice insurance of not less than $500,000 to insure against loss, damages or expenses incident to a claim arising out of the death or injury of any individual as the result of negligence or malpractice in the provision of health care services by the temporary health care services agency or an employee, agent or contractor of the temporary health care services agency.
- Carry for each employee a dishonesty bond in the amount of $10,000. (Commercial Crime Insurance not accepted. See Interpretive Guidelines link)
- Maintain insurance coverage for workers' compensation for all health care personnel provided or procured by the temporary health care services agency.
- If the owner is a corporation, copies of the articles of incorporation or articles of association and current bylaws, together with the names and addresses of officers and directors.

CERTIFICATION BY APPLICANT

Application is made to operate a Temporary Health Care Service Agency (THCSA) in accordance with the applicable sections of the Health Care Facilities Act (HCFA) (35 P.S. §448.101- 448.904).

By submitting this application, said THCSA acknowledges and agrees that the records it is required to maintain pursuant to HCFA and any applicable regulations promulgated therefrom shall be immediately available at all times to the Department for inspection upon request, except for those records subject to confidentiality protection under Federal and State law.

Incomplete or inaccurate information is reason for denial or non-renewal of registration. I further agree to conduct said THCSA in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Department of Health.

The undersigned hereby affirms that the foregoing information is true and correct to the best of my knowledge, information and belief and this affirmation is made subject to the penalties prescribed by 18 Pa.C.S § 4904 (relating to unsworn falsification to authorities).

Name of Applicant *(Print)*	Title
Signature of Applicant	Date