

**Application for Registration as a
Temporary Health Care Services Agency or Health Care Technology Platform
(NYS Public Health Law Article 29-k)**

Form Version 2026-04-15

This application should be accompanied by the payment of the \$1000 annual fee (check or money order) and mailed to:

New York State Department of Health
Office of Health Care Workforce Innovation
Room 1695 Corning Tower, Empire State Plaza
Albany, NY 12237

A. This is an application for (select one): New Registration
 Agency Information Change TA ID# _____

B. Submitted for registration year August 1st 2025 through July 31st 2026

C. Agency Information

In which State is the agency organized or incorporated? _____

Agency Legal Name _____ Agency FEIN _____

Address _____

City _____ State _____ ZIP _____

D. Identify the Controlling Person(s) for the Agency.

1. Name _____ Title _____

Home Address _____

Email _____ Phone _____

2. Name _____ Title _____

Home Address _____

Email _____ Phone _____

(Note: If the agency has more than 2 controlling persons, identify additional controlling persons on a separate sheet.)

E. Does any Agency Owner or Controlling Person from Item D, or any of their family members, have an ownership relationship or direct the management or policies of a NYS Health Care Entity, such as a hospital or a nursing home?

- No (move on to Item F)
- Yes (identify each health care entity owned or managed by the Temporary Health Care Staffing Agency's controlling persons or their family members. **Use additional sheets if necessary.**)

Entity Name _____ PFI _____

Entity Address _____

Name of Controlling Person _____ or Family Member _____

The relationship between the Agency Controlling Person/Family Member and the Health Care Entity is (select one)

- Ownership
- Management

F. Payment of Annual Fee. Submission of this application requires the payment of a \$1000 annual processing fee via check or money order. To ensure each payment can be matched to the appropriate application, please:

Identify the name of the check remitter _____ Identify check # _____

G. Eligibility: Listed below are the requirements for registration as a Temporary Health Care Services Agency under Article 29-K of the New York State Public Health Law. Applicants must agree to each requirement by selecting each check box:

1. The Agency shall document that each health care personnel referred to, provided to, or contracted with health care entities currently meets the minimum licensing, training, and continuing education standards for the position in which the health care personnel will be working.	
2. Agency does not restrict employment opportunities of personnel and does not require the payment of liquidated damages, employment fees, or other compensation should personnel be hired as a permanent employee.	
3. Agency shall retain all records related to health care personnel for six calendar years and make them available to the Department upon request.	
4. Agency will comply with any request made by Department to examine records of the Agency, subpoena witnesses and documents, and make other investigations as is necessary.	
5. Agency shall appoint an administrator qualified by training, experience, or education to operate the Agency. Each separate Agency location shall have its own administrator.	
6. Agency shall maintain a written agreement or contract with each health care entity and the rates to be charged by the temporary health care services agency will be included in the agreement/contract.	
7. Contracts shall identify the minimum licensing, training, and continuing education requirements for each assigned health care personnel.	
8. Any requirement for minimum advance notice to ensure prompt arrival of assigned health care personnel will be included in the contract.	
9. The maximum rates that can be billed or charged by the temporary health care services agency will be included in the contract.	
10. Procedures for notice from health care entities of failure of medical personnel to report to assignments will be included in the contract.	
11. Procedures for the investigation and resolution of complaints about the performance of the temporary health care services agency personnel will be included in the contract.	
12. Procedures for notice of actual or suspected abuse, theft, tampering or other diversion of controlled substances by medical personnel will be included in the contract.	
13. The types and qualifications of health care personnel available for assignment through the temporary health care services agency will be included in the contract.	

H. Attestation: To be signed by one of the Controlling Persons identified in Item D above.

Consistent with Article 29-K of the Public Health Law (“Registration of Temporary Health Care Services Agencies and Health Care Technology Platforms”), the individual authorized by the above-named Agency to submit this form attests that the information submitted is true, accurate, and complete to the best of their knowledge. The information collected will be used to register the agency as a temporary health care services agency in New York State. I understand that any falsification, omission, or concealment of information may subject the above-named agency and/or its controlling person(s) to administrative, civil, or criminal liability, penalties, and/or fines.

Name (printed) _____

Signature _____ Dated _____

Instructions for Completing the Registration Application Form:

Temporary Health Care Services Agencies and Health Care Technology Platforms (collectively, "Agencies" or "THCSA") that procure or place temporary health care workers in New York State Health Care Entities must register as a THCSA using this form. Complete and print pages 1 and 2 (double-sided, please) then mail them, along with a check or money order for \$1,000 payable to "New York State Department of Health," to:

New York State Department of Health
Office of Health Care Workforce Innovation
Room 1695 Corning Tower, Empire State Plaza
Albany, NY 12237

In addition to this **mail-in** application form and payment, applicants are required to electronically submit a compendium of appendices (using the SendVault tool) to complete their initial registration. The appendices, along with their instructions and instructions for SendVault, are on the Department's website: https://www.health.ny.gov/facilities/staffing_agency/.

Timetable for Applications:

The Registration Year begins each August 1st and goes through the following July 31st. **The Department of Health shall notify via email Controlling Person #1 of the result of each application (acceptance or denial) within 4 weeks of application receipt.** If the application is accepted, a Certificate of Registration will be sent via email to Controlling Person #1.

Item A "Application Status." (select one response):

If you are a first-time applicant as a New York State Temporary Health Care Services Agency or Health Care Technology Platform, select "**New Registration.**" If you are ALREADY registered and your agency has updated information (e.g., Address, Phone Number, etc.) please select "**Agency Information Change,**" and provide your assigned Agency TA ID number. Change of Information does NOT require payment of another \$1000 fee. However, when ownership interest of ten percent or more, or management is sold or transferred, the registration of the agency may be transferred to the new owner or operator **for thirty days, or until the new owner or operator applies, including the \$1000 fee, and is granted or denied a new registration, whichever is sooner.**

Item B "Application Year." (select one response):

Select the registration year for which you are applying.

Item C "Agency Information."

Identify the State where your agency is organized or incorporated. Identify your Agency's Legal Name (including DBA if applicable.) Provide the Federal Employer Identification Number (FEIN), and address of the Agency's headquarters.

Item D "Controlling Person(s)."

Identify all persons, officers, program administrators, or directors whose responsibilities include the direction of the management or policies of your agency. "Controlling Person" also means an individual who owns at least ten percent voting interest in a corporation, partnership, or other business entity that controls the management or policies of your agency. Use additional sheets of paper if your agency has more than two Controlling Persons. For each Controlling Person, provide their full name, title within the agency, home address, email address, and phone number for contact purposes.

Item E "Relationships with NYS Health Care Entities."

Identify all NYS Health Care Entities for which an Agency Owner or Controlling Person, or any of their family members, either:

- has an ownership relationship with the Health Care Entity, or
- directs the management or policies of the Health Care Entity.

Health Care Entity means **an agency, corporation, facility, or individual providing medical or health care services** and can include, but is not limited to, a hospital or a nursing home. If there are no Health Care Entities to identify, select "No," and move to Item F. If there *are* Health Care Entities to identify, provide their Entity Name, Address, NYS Permanent

Facility Identifier (PFI), and the name of the Owner or Controlling Person or Family Member with the relationship with the Entity. Use additional sheets if there is more than one Health Care Entity to identify.

Item F “Payment of Annual Fee.”

Each application requires a \$1000 payment via check or money order. Identify the name of the check remitter and the check number submitted with this application. The check remitter is typically printed in the check’s upper left-hand corner and, for example, could be the agency’s legal name, a Doing-Business-As name, or even an individual person’s name.

Item G “Eligibility.”

The registration requirements are listed as check boxes. Applicants must agree to each requirement by marking each check box with an “X”. A registration application cannot be approved when an applicant does not agree to the minimum requirements set forth by the statute.

Item H “Attestation.”

This item seeks the agency’s attestation that the information submitted in the registration application is true, accurate, and complete. This attestation needs to be **signed by one of the Controlling Persons identified in Item D above**. Along with their signature, please provide the signatory’s **printed name** and the **date signed**.