

QC-409-Initial
QC-405-Renew/CHOW

HOME HEALTH AGENCY

License Application\Renewal Form

Department of Human Services

Health Care Licensure and Certification Section

Phone: 971-673-0540 Fax: 971-673-0556

License # _____

If you need this document in an alternate format please contact this office.

AGENCY TYPE ____ Parent Agency ____ Sub Unit		AGENCY AFFILIATION ____ Oregon Hospital Based** ____ Out of State Hospital Based ____ Non-Hospital Based		TYPE OF ACTION ____ New Agency* ____ License Renewal* ____ Other (specify _____)		Effective date of Action/Change _____ ____ Name/Address Change ____ Ownership Change* *Fee payment required per schedule below		____ Change in Service(s) ____ Branch Office Change	
AGENCY NAME						TELEPHONE NUMBER			
AGENCY STREET ADDRESS						FAX NUMBER			
AGENCY MAILING ADDRESS (If different than above)						E-MAIL ADDRESS:			
CITY				STATE		ZIP CODE		COUNTY	
ASSUMED BUSINESS NAME		(IF ANY)				FISCAL YEAR END			
OWNERSHIP CATEGORY: <input type="checkbox"/> Individual <input type="checkbox"/> City <input type="checkbox"/> Church <input type="checkbox"/> State <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> County <input type="checkbox"/> Health District						OWNERSHIP TYPE: <input type="checkbox"/> Non-Profit <input type="checkbox"/> For-Profit			
NAME OF OWNER (S) (attach additional sheets if necessary)									
STREET ADDRESS OF OWNER (S) (not P.O. Box)									
CITY				STATE		ZIP CODE		PHONE NUMBER	
NAME OF ADMINISTRATOR:						NAME OF DIRECTOR OF PROFESSIONAL SERVICES:			
DESCRIBE GEOGRAPHIC SERVICE AREA FOR THIS PARENT AGENCY OR SUB-UNIT:									

*FEE SCHEDULE: Make checks payable to the "DHS" and mail to Public Health Division, Fiscal Services
P. O. Box 14260, Portland, OR 97293-0260.

New Facility: \$1,000.00 – Fee is required when initial application is submitted.

Yearly Renewal: \$600.00 – Fee will be requested prior to the end of each calendar year. Submit fee with the renewal notice and this application.

Change of Ownership: \$500.00 – Submit the fee with this application.

**Hospital-based agencies licensed in Oregon are exempt from license fee.

DESCRIPTION OF SERVICES (If this is a change, indicate if adding or deleting service(s))	NUMBER OF EMPLOYEES and/or CONTRACTEES
Nursing _____	Registered Nurses _____
Home Health Aide (HHA) _____	Licensed Practical Nurses _____
Physical Therapy (PT) _____	Home Health Aides _____
Occupational Therapy (OT) _____	Licensed Physical Therapists _____
Speech Therapy (ST) _____	Licensed Physical Therapists Assistants _____
Medical Social Services (MSS) _____	Licensed Occupational Therapists _____
Other (Specify): _____	Licensed Occupational Therapy Assistants _____
	Speech Pathologists _____
	Masters Prepared Social Workers _____
	Bachelors Prepared Social Work Assistants _____

DESCRIPTION OF BRANCH OPERATIONS - (if this is a change, indicate if adding or deleting branch office.-List Address and telephone number of Each Branch Office (list additional on separate page)

I attest that this agency intends to provide home health agency services to patients in this and the next calendar year, and if this agency is already licensed, I attest that home health agency services have, in fact, been provided to patients in this last calendar year. I declare, under penalties of perjury, that I have examined this application and all attachments and that to the best of my knowledge and belief, this information is true, correct and complete. I will notify the Health Care Licensure and Certification Section, in writing, of any changes in this information within 30 days of any such change.

Signature of Administrator _____

Date: _____

Name and Title (printed or typed) _____

HCLC OFFICE USE ONLY ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓

Initial Licensure: Approved _____ Nursing HHA PT OT ST MSS

Effective Date _____ Check box (es) Denied _____ Withdrawn _____ Reason: _____

Change in Service(s): Addition of HHA PT OT ST MSS Approval Effect. Date _____

Deletion of HHA PT OT ST MSS Approval Effect. Date _____

Branch Office Change(s):

Addition of Branch At _____ Address _____ Approval Effect. Date _____

Deletion of Branch At _____ Address _____ Effective Date _____

Other (specify): _____

Surveyor Signature: _____ Date: _____

Section Manager Signature: _____ Date: _____