OREGON HEALTH AUTHORITY

IN-HOME CARE AGENCY

License Application
Health Facility Licensure and Certification

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

Type of Action

* Fee Payment Required (See back of this form for amount) **Requires Public Health Division pre-approval		
New Agency*:	☐ Parent	☐ Subunit (provide name of parent agency and city where located. In addition, attach separate document identifying all subunits associated with the parent agency): _____
License Renewal* :	☐ License #: _____ Renewal application must be submitted at least 30 days prior to license expiration date (OAR 333-536-0025).	

Change Request	Eff. Date of Change	Change Request	Eff. Date of Change
☐ Name/Address		☐ Service Area**	
☐ Ownership*		☐ Administrator**	
☐ Add/Remove Branch**		☐ Classification**	
☐ Other (specify): _____			

Agency Information

Agency Legal Name:		
Agency DBA Name (if applicable):		
Agency Physical Address, City, State & ZIP:		
Phone:	Fax:	County:
Agency Mailing Address (if different from above):		

Name of Administrator:	Phone:	
Administrator E-mail:	Agency E-mail:	
Does the administrator have direct contact with any client as defined in OAR 333-536-0093? *(If yes, attach 'Owner/Administrator Background Check Request' form)*		☐ Yes ☐ No

Name of Owner(s):		
Address, City, State & ZIP of Owner(s) – attach additional pages if necessary.		
Phone:	FAX:	County:
Does any owner have direct contact with any client as defined in OAR 333-536-0093? *(If yes, attach 'Owner/Administrator Background Check Request' form for each owner having direct contact.)*		☐ Yes ☐ No

Emergency Contact Name:	Phone:

Describe the geographic service area for this parent agency or subunit agency:

Agency physically located within:	☐ Commercial Business Building	☐ Private Home/Residence
☐ Independent Living Retirement Facility or Community	☐ Registered Continuing Care Retirement Community	☐ Other Licensed Facility or Agency – Type:_____

Office Hours:	Su	M	T	W	T	F	Sa

Classification Levels:	**New agency:** (check one)	**License renewal:** Current Class (check one)	**Change Request:**	
			Current:	Change to:
Limited: An agency that provides personal care services that may include medication reminding but does not provide medication assistance, medication administration, or nursing services.	○	○	☐	☐
Basic: An agency that provides personal care services that may include medication reminding and medication assistance but does not provide medication administration or nursing services.	○	○	☐	☐
Intermediate: An agency that provides personal care services that may include medication reminding, medication assistance and medication administration but does not provide nursing services.	○	○	☐	☐
Comprehensive: An agency that provides personal care services that may include medication reminding, medication assistance, medication administration and nursing services.	○	○	☐	☐

Renewal Licensure Applicants Only

Name and title for Administrator Designee (All classification types, OAR 333-536-0050(7)):

Name: _____ Title: _____

Name and title for Qualified Individual [providing medication training and return demonstration competency evaluations] (Basic/Intermediate/Comprehensive only, OAR 333-536-0005(23) & 333-536-0007(2)):

Name: _____ Title: _____

Name and license number for Registered Nurse (Intermediate/Comprehensive only, OAR 333-536-0075(9) & 333-536-0080(1)):

Name: _____ License Number: _____

Description of Branch Operations

- **List address and telephone numbers of each branch**
- **If this is a change, indicate (A) if adding, (R) if removing, or (N) if no change**

Please enter (A), (R), or (N)	Address	Phone

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 Regulation and Quality Improvement Section, in writing, of any changes in this information as required.

_____ _____

Administrator's Signature ***Print Name***

_____ _____

Print Title ***Date (mm/dd/yyyy)***

HCRQI Office Use Only					
Initial licensure:	Eff. Date:	Class:		Initials:	Date:
Renewal licensure/change:	☐ Approved	☐ Denied	☐ Withdrawn	Initials:	Date:

CASH OFFICE:	QC **659**	Initial/QC **660**	Renewal **50320 50455**

ALL APPLICATION FEES ARE NON-REFUNDABLE per OAR 333-536-0031(4)

Fee Requirements (as of 1/1/2018)		
Initial Parent Licensure:		
	Limited	$2,000.00
	Basic	$2,250.00
	Intermediate	$2,500.00
	Comprehensive	$3,000.00
Initial Subunit Licensure:	All classification types	$1,250.00
Yearly Parent Renewal:		
	Limited	$1,000.00
	Basic	$1,000.00
	Intermediate	$1,250.00
	Comprehensive	$1,500.00
Yearly Subunit Renewal:	All classification types	$1,000.00
Ownership Change	All classification types	$350.00
Subunit Ownership Change:	All classification types	$350.00

Make check payable to Oregon Health Authority and mail to:
Health Care Regulation and Quality Improvement
PO Box 14260
Portland, OR 97293-0260

NEW AGENCIES APPLYING FOR INITIAL LICENSURE MUST COMPLETE CHECKLIST BELOW AND SUBMIT WITH APPLICATION PACKET

Initial (new agency) Licensure Application Checklist

New agencies must fill out this checklist and include it with their initial packet, along with the application, fee, administrator resume, and outlined policies and procedures:

Completely fill out an in-home care application, found online www.healthoregon.org/hcrqi.

☐ **Include a check or money order payable to the "Oregon Health Authority".**

☐ **Include a resume for your administrator: Please ensure that your administrator resume meets the following requirements:**

- **Must be current**

- **Must show evidence of at least two years of professional or management experience in a health related field or program (Please include the employer's name and location, the dates of employment including month and year, the title of the position held, and the duties performed)**
- **Must show evidence of high school diploma or equivalent**

☐ **Develop agency specific policies and procedures (including associated forms such as the initial assessment form, disclosure form, etc.), and include the following sampling of those policies and procedures with your application:**

- **Organizational operations policies and procedures (OAR 333-536-0050)**
- **Disclosure policies and procedures (OAR 333-536-0055)**
- **Service plan policies and procedures (OAR 333-536-0065)**

You may use the survey preparation checklist for the development of your policies and procedures (including associated forms). The checklist is available online at www.healthoregon.org/hcrqi

☐ **Send everything listed above to: HCRQI, PO Box 14260, Portland, OR 97293. Please do not send in partial applications or incomplete documentation.**

Oregon Health Authority

In-Home Care/Home Health Agency
Owner/Administrator Background Check Request

Name (last, first, middle):	DOB:	Gender: ◯ M ◯ F	Social Security # (SSN)*
All other names used (Include maiden name):		ODL or ID card #:	State:
Mailing address (Street/Apt#):		Home or message phone:	
City:	State:	ZIP:	

Street address (If different than mailing address):	City:	State:	ZIP:

Email address:

Agency name: **Agency city:**

☐	**In Home Care Agency**	☐	**Home Health Agency (please check the box that applies)**
☐	**Owner**	☐	**Administrator information (Please check the box that applies)**

During the past 5 years, have you been outside Oregon 60 days or more in a row?

◯ **Yes** ◯ **No** **If yes, list the locations and dates:**

City/state/country:	From (month/year):	Until (month/year):

Have you ever been charged, arrested and/or convicted of a crime?

◯ Yes ◯ No If yes, list all charges, arrests and/or convictions and the outcome regardless of how long ago. **(Attach additional pages if needed.)**

	Date (or estimate):	List each charge, arrest or conviction:	County:	State:	Outcome:
1.					
2.					
3.					
4.					
5.					

Provide a detailed explanation for each charge, arrest and conviction noted above. If you have criminal history, the Health Care Regulation & Quality Improvement (HCRQI) program will weigh several factors to decide if you are fit for the license/position for which you are applying. Respond to the following questions for each charge, arrest and conviction and attach documentation to support your responses.

- What happened leading up to the charge, arrest, conviction or other history?
- What was your age at the time of charge, arrest, conviction or other history?
- List any requirements resulting from each charge, arrest or conviction.
- Describe any treatment, education and training specifically related to your history.
- How is your history relevant to your position?
- How has your life changed since your history?
- List other information you believe would be helpful to the HCRQI program in making a decision in this case.

1.	
2.	
3.	
4.	
5.	

I hereby certify that I am the above named individual and that the information provided is true and correct. I understand that a criminal records and abuse check will be completed on me. My signature authorizes the Health Care Regulation & Quality Improvement program to request and receive any juvenile, police, court or investigation reports needed to complete this background check. In the event potentially disqualifying abuse or other information is discovered, I may be notified at the address listed above and asked to provide additional information. I certify the information I have provided is correct and complete. I understand that if I provide false or incomplete information, my application may be closed or I may be denied the license/position. I understand the check may be repeated during the time I hold this license/position.

Signature:_____	Date:_____

* As part of your application you are required to provide your Social Security Number pursuant to ORS 25.785