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PUBLIC HEALTH DIVISION
Health Care Regulation and Quality Improvement

Oregon Health Authority

In-Home Care Agency License Application

TYPE OF ACTION

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	Effective date of change	Change request	Effective date of change
☐ Name/Address		☐ Service area**	
☐ Ownership*		☐ Administrator** (attach resume and administrator application)	
☐ Add/remove branch**		☐ Classification**	
☐ Other (specify): _____			

* Fee Payment Required (Schedule is on page 3) **Requires Public Health Division pre-approval

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 email:	Agency email:
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:	S	M	T	W	T	F	S

CLASSIFICATION

Classification levels:	New agency: (check one)	License renewal: Current class (check one)	Change request: Current:	Change request: 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.	☐	☐	Choose one	Choose one
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.	☐	☐	Choose one	Choose one
Intermediate: An agency that provides personal care services that may include medication reminding, medication assistance and medication administration but does not provide nursing services.	☐	☐	Choose one	Choose one
Comprehensive: An agency that provides personal care services that may include medication reminding, medication assistance, medication administration and nursing services.	☐	☐	Choose one	Choose one

DESCRIPTION OF BRANCH OPERATIONS

- List address and telephone numbers of each branch
- Select status from drop-down menu: **A (**adding), **R** (removing) for changes; **N** for no change

Status	Address	Phone
Choose one		
Choose one		

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 _____ *Name (please print)* _____

Title (please print) _____ *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**

IF YOU ARE A NEW AGENCY APPLYING FOR YOUR INITIAL LICENSURE, YOU MUST COMPLETE THIS CHECKLIST AND SUBMIT IT WITH YOUR APPLICATION.

Checklist

☐ I have **read and understand** the Initial Agency packet.

☐ I have **read and understand the rules** applicable to In-Home Care (OAR 333-536-0000 through 333-536-0125).

☐ **An administrator application and resume,** ensuring that it 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. 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)

☐ **Background Check Request** for administrator and owners who have direct client contact.

☐ A check or money order for $1500 payable to "Oregon Health Authority".

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

FEE SCHEDULE	PARENT AGENCY	SUBUNIT AGENY
New	$1500 for parent	$750 for each subunit
Annual renewal	$750 for parent	$750 for each subunit
Change of ownership	$350 for parent	$350 for each subunit

Incomplete applications or documentation will not be processed.

Mail to:

State of Oregon
Health Care Regulation and Quality Improvement
PO Box 14260
Portland, OR 97293

Forms and information are available online at www.healthoregon.org/hcrqi

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

PRINT FORM