Home Health Agency License Application

TYPE OF ACTION

* Fee payment required (See fee schedule)	**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).
Related information:	CMS Certification Number (CCN) #: _____
	Is HHA accredited? ☐ Yes ☐ No
	Accrediting agency _____ Effective date _____
	Is HHA deemed? ☐ Yes ☐ No

Change request	Eff. date of change	Change request	Eff. date of change
☐ Name Address		☐ Service area**	
☐ Ownership*		☐ Administrator**	
☐ Add/remove branch**		☐ Add/remove services**	
☐ 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 email:	Agency email:
Does administrator have direct/face-to-face contact with any client as defined in OAR 333-027-0064? (If yes, attach completed '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/face-to-face contact with any client as defined in OAR 333-027-0064? (If yes, attach completed '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:	

SERVICES AND STAFFING

- Indicate 'A' if adding, 'R' if removing, or 'N' if no change
- Place checkmark in one of columns 5, 6, or 7 as appropriate

Services	Check if provides	Enter A, R, or N	Staffing	Employees provide	Provided by contract or under arrangement	Combination of employee & contract
Skilled Nursing (SN)	☐	choose	Registered Nurses (RNs)	☐	☐	☐
	☐	choose	Licensed Practical Nurses (LPNs)	☐	☐	☐
Home Health Aide (HHA)	☐	choose	Home Health Aides (HHAs)	☐	☐	☐
Physical Therapy (PT)	☐	choose	Licensed Physical Therapists (LPTs)	☐	☐	☐
	☐	choose	Licensed Phys. Ther. Assistants (LPTAs)	☐	☐	☐
Occupational Therapy (OT)	☐	choose	Licensed Occupations Therapists (OTs)	☐	☐	☐
	☐	choose	Licensed Occ. Ther. Assistants (COTAs)	☐	☐	☐
Speech Therapy (ST)	☐	choose	Licensed Speech Pathologist (SLPs)	☐	☐	☐
Medical Social Services (MSS)	☐	choose	Masters prepared Social Worker (MSW)	☐	☐	☐
	☐	choose	Bachelors prepared SW Assistant (BSW)	☐	☐	☐
In-Home Care Services provided under HHA license	☐	choose	(If provides under HHA license, attach attestation form: 'Home Health Agency (HHA) attestation for provision of In-Home Care (IHC) Services'.)			

BRANCH OPERATIONS

- List all required information for each branch; List additional locations on a separate page; Indicate 'A' if adding, 'R' if removing, or 'N' if no change

Enter A, R, or N	Address	Phone	Distance from parent agency
choose			
choose			

I declare, under penalty of perjury, that I have examined this application and all attachments, and that this information is true, correct and complete. I will notify Health Care Regulation and Quality Improvement in writing of any change in this information as required.

_____ _____

Administrator's signature ***Name (please print)***

_____ _____

Title (please print) ***Date (mm/dd/yyyy)***

Health Care Regulation and Quality Improvement
Phone: 971-673-0540 Fax: 971-673-0556 www.healthoregon.org/hcrqi

HCRQI Office Use Only

Initial licensure: ☐ Eff. Date: Services: Initials: Date:

Renewal licensure/change: ☐ ☐ Approved ☐ Denied ☐ Withdrawn Initials: Date:

CASH OFFICE:	QC Initial - **409**	QC Renewal - **405**	Index - **50202**	PCA - **51040**

The HHA Oregon Administrative Rules, forms, and other related information may be found on the HCRQI website at: www.healthoregon.org/hcrqi

ALL APPLICATION FEES ARE NON-REFUNDABLE per OAR 333-027-0025(5)

FEE SCHEDULE	PARENT AGENCY	SUBUNIT AGENY
New	$1600 for parent	$1600 for each Subunit
Annual renewal	$850 for parent	$850 for each Subunit
Change of ownership	$500 for parent	$500 for each Subunit

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 REMAINDER OF PAGE AND SUBMIT WITH APPLICATION PACKET

Initial (new agency) Licensure Application Checklist

- ☐ **Complete the Home Health Agency License Application form.**
- ☐ **Complete the 'Owner/Administrator Background Check Request' form(s) if applicable.**
- ☐ **If IHC services provided under HHA license, complete the 'Home Health Agency (HHA) attestation for provision of In-Home Care (IHC) Services' form.**
- ☐ **Include a check or money order for $1600.00 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 include employer names and locations, dates of employment including month and year, title of positions held, and duties performed.
  - Must reflect that the administrator is a physician or registered nurse, currently licensed in Oregon, who has education, experience, and knowledge in community health service systems appropriate to the fulfillment of his/her responsibilities; or
  - Is an individual who has education, experience, and knowledge in a related community health service systems and at least one year overall administrative experience in home health care or related community health program appropriate to the fulfillment of his/her responsibilities.
- ☐ **Develop agency specific policies and procedures, forms, curriculums to address and ensure compliance with the HHA OARs, Division 27. Include a sampling of those policies and procedures that demonstrate compliance with the following requirements:**
  - OAR 333-027-0060 Administration of Home Health Agency
  - OAR 333-027-0080 Patients' Rights
  - OAR 333-027-0090 Plan of Treatment
- ☐ **Send all documents above to: HCRQI, PO Box 14260, Portland, OR 97293 to attention of the HHA Program. 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.					

CONFIDENTIAL

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