

Home Health Agency License Application

Type of Action			
New agency:	<input type="checkbox"/>		
License renewal: (due 12/1)	<input type="checkbox"/> License #: _____		
	Renewal application must be submitted at least 30 days prior to license expiration date (OAR 333-536-0025).		
	Is HHA accredited? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Accrediting agency: _____ Effective date: _____			
Change Request	Effective Date of Change	Change Request	Effective Date of Change
<input type="checkbox"/> Name/ <input type="checkbox"/> Address		<input type="checkbox"/> Service Area**	
<input type="checkbox"/> Ownership*		<input type="checkbox"/> Administrator**	
<input type="checkbox"/> Add/Remove branch**		<input type="checkbox"/> Add/remove services**	
<input type="checkbox"/> Other (specify): _____			

* Fee Payment Required (See back of this form for amount)

**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 e-mail:		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 for administrator have direct contact.)			Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
Emergency Contact Name:			
Emergency Contact Phone:		Emergency Contact E-mail:	
Geographic Service Area: Geographic service area is limited to within a 60-mile radius of the parent		Yes <input type="checkbox"/> No <input type="checkbox"/>	

location unless a waiver is obtained. Do you have a waiver?

Services and Staffing - Indicate 'A' if adding, 'R' if removing, or 'N' if no change

Services	Check if providing	A, R, or N	Staffing	Employees provide	Provided by contract or under arrangement	Combination of employee and contract
Skilled Nursing (SN)	<input type="checkbox"/>		Registered Nurses (RNs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>		Licensed Practical Nurses (LPNs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Health Aide	<input type="checkbox"/>		Home Health Aides (HHAs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy (PT)	<input type="checkbox"/>		Licensed Physical Therapists (LPTs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>		Licensed Physical Therapy Assistants (LPTAs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy (OT)	<input type="checkbox"/>		Licensed Occupational Therapists (OTs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>		Licensed Occupational Therapist Assistants (COTAs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>		Licensed Speech Pathologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Social Services	<input type="checkbox"/>		Masters prepared Social Worker (MSW)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>		Bachelors prepared SW assistant (BSW)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In home care services provided under HHA license	<input type="checkbox"/>		(If provided under HHA license, attach attestation form: 'Home Health Agency (HHA) attestation for provision of In-Home Care (IHC) Services'.)			
Number of unduplicated admissions for the prior 12 months						

Branch Operations

List all required information for each branch

List additional locations on a separate page

Please check 'A' if adding, 'R' if removing, or leave blank if no change

		Address	Phone	Distance from parent agency
<input type="checkbox"/> A	<input type="checkbox"/> R			
<input type="checkbox"/> A	<input type="checkbox"/> R			
<input type="checkbox"/> A	<input type="checkbox"/> R			
<input type="checkbox"/> A	<input type="checkbox"/> R			

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)**

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	
New	\$1,600
Annual renewal	\$850
Change of ownership	\$500

Make check payable to: Oregon Health Authority**Mail payment to: HFLC****PO Box 14260****Portland, OR 97293****HCRQI Office Use Only**

Effective date of initial licensure: _____ Initials: _____ Date: _____

Renewal Licensure/Change: Approved: _____ Denied: _____ Withdrawn: _____ Initials: _____ Date: _____

CASH OFFICE: QC 617 initial/QC 618 renewal

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 \$1,600.00 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 system, 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 documents listed 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.