Home Health Agency License Application

Type of Action		
New agency:	◯	
License renewal: (Due 12/1)	◯ License #: *Renewal application must be submitted at least 30 days prior to license expiration date (OAR 333-027-0020).*	
	Is HHA accredited? ◯ Yes ◯ No	
	Accrediting agency: Most recent accreditation date:	
Change Request:	☐ Name ☐ Address ☐ Ownership* ☐ Service Area** ☐ Administrator** ☐ Add/remove services** ☐ Add/Remove branch** ☐ Other (specify):	Effective Date of Change: Prior Information:

* 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:
As an employee of the home health agency, Administrators may have contact with patients or access to personal information about patients as defined in OAR 333-027-0064(1)(c). Please complete and attach Home Health Agency Background Check Request to this application.		
Name of Ownership/Non-Profit Entity:		
Address, City, State & ZIP of Owner/Non-Profit:		
Phone:	Fax:	County:
Does any owner have contact with patients or access to personal information about patients as defined in OAR 333-027-0064(1)(c)? (If yes, attach completed Home Health Agency Background Check Request form.)		Yes ◯ No ◯
Emergency Contact Name:		Tax ID#:
Emergency Contact Phone:	Emergency Contact E-mail:	

Geographic Service Area: Geographic service area is limited to within a 60-mile radius of the parent location unless a waiver is obtained.	Does your agency operate within the 60-mile radius? Yes ◯ **No*** ◯
	****If no, does your agency have a waiver?** Yes ◯ No ◯

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)	☐		Registered Nurses (RNs)	☐	☐	☐
	☐		Licensed Practical Nurses (LPNs)	☐	☐	☐
Home Health Aide	☐		Home Health Aides (HHAs)	☐	☐	☐
Physical Therapy (PT)	☐		Licensed Physical Therapists (LPTs)	☐	☐	☐
	☐		Licensed Physical Therapy Assistants (LPTAs)	☐	☐	☐
Occupational Therapy (OT)	☐		Licensed Occupational Therapists (OTs)	☐	☐	☐
	☐		Licensed Occupational Therapist Assistants (COTAs)	☐	☐	☐
Speech Therapy	☐		Licensed Speech Pathologist	☐	☐	☐
Medical Social Services	☐		Licensed Master of Social Work (LMSW)	☐	☐	☐
	☐		Licensed Clinical Social Worker	☐	☐	☐
	☐		Clinical SW Associate (CSWA)	☐	☐	☐
Palliative Care	☐			☐	☐	☐
In home care services provided under HHA license	☐		(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 check nothing if there is no change

Please note: CMS must approve the change of location prior to providing services are the new location. Claims at the new location prior to the CMS approval date are not reimbursable by CMS.

		Address	Phone	Distance from parent agency
◯ A	◯ R			
◯ A	◯ R			
◯ A	◯ R			
◯ A	◯ 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/hflc

Questions about this application?

Email: mailbox.hclc@odhsoha.oregon.gov

Phone: 971-673-0540

FEE SCHEDULE

ALL APPLICATION FEES ARE NON-REFUNDABLE per OAR 333-027-0010(7)

New	$4,000
Annual renewal	$2,125
Change of ownership	$1,250

Make check payable to: Oregon Health Authority
Mail payment to: HFLC
PO Box 14260

HCRQI Office Use Only
Effective date of initial licensure: _____ Initials: _____ Date: _____
Renewal Licensure/Change: Approved: _____Denied: _____Withdrawn: _____ Initials:_____ Date:_____
CASH OFFICE: QC **409** initial/QC **405** renewal

Portland, OR 97293

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 $4,000.00 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 333-027-0001 Compliance with Federal Law
  - OAR 333-027-0060 Administration of Home Health Agency
  - OAR 333-027-0080 Advance Directives to cover Patients' Rights of Treatment
- ☐ Send documents listed above to: HCRQI, PO Box 14260, Portland, OR 97293 to attention of the HHA Program. Partial applications or incomplete documentation cannot be accepted.