PUBLIC HEALTH DIVISION
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
healthoregon.org/hflc

Oregon Health Authority

In-Home Care Agency License Application Form

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**	
☐ Add/Remove Branch**		☐ Classification* **	
☐ 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 E-mail:
Does the administrator have direct contact with any client as defined in OAR 333-536-0093? *(If yes, attach 'IHC Background Check Request' form for each administrator having direct contact.)*		☐Yes ☐No
Name of Owner(s) (attach additional pages if necessary):		
Owner(s) Email:		Tax ID#:
Address, City, State & ZIP of Owner(s):		
Phone:	FAX:	County:
Does any owner have direct contact with any client as defined in OAR 333-536-0093? *(If yes, attach 'IHC Background Check Request' form for each owner having direct contact.)*		☐Yes ☐No
Emergency Contact Name:	Emergency Contact Phone:	Emergency Contact Email:

Geographic Service Area:		
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:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Classification Levels:	**New agency**	**License renewal/current classification**	**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.	☐	☐	☐

Administrator Designee, Qualified Individual/Entity/Trainer, &/or RN (all classification types)
Administrator Designee Name:
Administrator Designee Title:
Qualified Trainer(s) Name:
Qualified Entity Name:
Qualified Individual Name:
Qualified Individual Title:
Registered Nurse Name (intermediate/comprehensive only):

Description of Branch Operations – use separate sheet if necessary

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

Please check A or R		**Address**	**Phone**
☐ **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)***

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

In-Home Care Fees (as of January 1, 2018)		
Initial Parent Licensure	Limited	$2,000
	Basic	$2,250
	Intermediate	$2,500
	Comprehensive	$3,000
Initial Subunit Licensure	All classification types	$1,250
Yearly Parent Renewal	Limited	$1,000
	Basic	$1,000
	Intermediate	$1,250
	Comprehensive	$1,500
Yearly Subunit Renewal	All classification types	$1,000
Ownership Change		$350
Subunit Ownership Change		$350

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

Questions about this application?
Phone: 971-673-0540 (Option 3)
Email: mailbox.inhomecare@oha.oregon.gov

HCRQI Office Use Only

Effective date of initial licensure: _____ Class: _____Initials: _____ Date: _____

Renewal Licensure/Change: Approved: _____Denied: _____Withdrawn: _____ Initials: _____ Date:_____

CASH OFFICE: QC **659** initial/QC **660** renewal

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
- ☐ Include a check or money order payable to the “Oregon Health Authority”
- ☐ Complete the Owner/Administrator Background Check Request form(s), include a resume and administrator application form (available at www.healthoregon.org/hflc. Please ensure that your administrator application and resume meets the following requirements:
  - 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); and
  - 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.) to address and ensure compliance with the IHC OAR’s, Division 536. Include the following sampling of those policies, procedures, forms that demonstrate compliance with the following requirements:
  - OAR 333-536-0050 Agency Organization
  - OAR 333-536-0055 Disclosure Statement
  - OAR 333-536-0065 Service Plan
- ☐ Send documents listed above to “HFLC, PO BOX 14260, Portland, OR 97293, Attention: IHC Program”. Partial or incomplete applications will not be processed.