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

Oregon Health Authority

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	Effective Date of Change	Change Request	Effective Date of Change
☐ Name/ ☐ Address		☐ Service Area**	
☐ Ownership*		☐ Administrator**	
☐ Add/Remove branch**		☐ Add/remove services**	
☐ 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 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 ◯
Name of Owner(s):		
Address, City, State & ZIP of Owner(s) – attach additional pages if necessary.		
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

		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

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

FEE SCHEDULE	
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
Portland, OR 97293

Questions about this application?
Phone:971-673-0540
Email: mailbox.hclc@odhsoha.oregon.gov

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 333-027-0060 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.

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