MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS

APPLICATION FOR HOME HEALTH AGENCY LICENSE

ANNUAL LICENSE RENEWAL
CHANGE OF OWNERSHIP

In accordance with the requirements of the Missouri Home Health Agency Licensing Law (Chapter 197, RSMo Cumulative Supp. 1983) Regulations and Codes, application is hereby made for a license to conduct and maintain a Home Health Agency (See Missouri Home Health Agency Licensing Law "Definitions", Section 197.400.)

THIS INFORMATION, WITHOUT FURTHER VERIFICATION, WILL BE PROVIDED TO BOTH MEDICARE AND MEDICAID OFFICES AND TO UPDATE THE STATE HOME HEALTH DIRECTORY.

LEGAL NAME OF AGENCY

DOING BUSINESS AS NAME (IF APPLICABLE)	TELEPHONE NO.
ADDRESS (STREET, CITY, STATE, ZIP)	COUNTY

HOME HEALTH AGENCY ADMINISTRATOR	ADMINISTRATOR'S EMAIL ADDRESS	PRE-DESIGNATED ALTERNATE ADMINISTRATOR

OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)

GOVERNMENTAL

- ☐ COUNTY
- ☐ CITY-COUNTY
- ☐ CITY
- ☐ DISTRICT

NON-GOVERNMENTAL

NON-PROFIT

- ☐ CORPORATION
- ☐ OTHER (EXPLAIN)

PROPRIETARY

- ☐ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ CORPORATION

☐ FREESTANDING AGENCY ☐ HOSPITAL-BASED AGENCY ☐ SNF/ICF BASED AGENCY ☐ REHABILITATION FACILITY-BASED AGENCY

CHIEF OFFICER OF GOVERNING BODY

LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

GEOGRAPHIC AREA COVERED BY AGENCY OPERATION

LIST COUNTY(IES).

PROFESSIONAL SERVICES (Indicate ALL services offered by agency)

Place a "1" in the block for each service provided by **AGENCY STAFF** or by contract with an individual. If services are provided **UNDER ARRANGEMENT** with another agency, **place a "2"** in the block.

- ☐ NURSING CARE
- ☐ PHYSICAL THERAPY
- ☐ OCCUPATIONAL THERAPY
- ☐ SPEECH THERAPY
- ☐ MEDICAL SOCIAL SERVICES
- ☐ HOME HEALTH AIDE SERVICE
- ☐ OTHER (SPECIFY)

DIRECT PROFESSIONAL SERVICE (Indicate your agency's direct service) **(Choose only one)**

- ☐ NURSING CARE
- ☐ PHYSICAL THERAPY
- ☐ OCCUPATIONAL THERAPY
- ☐ SPEECH THERAPY
- ☐ MEDICAL SOCIAL SERVICES
- ☐ HOME HEALTH AIDE SERVICE
- ☐ OTHER (SPECIFY) ____________________

MEDICARE/MEDICAID PARTICIPATION

Is this agency Medicare certified? ☐ Yes ☐ No

If yes, list Medicare provider number____________________

Is this agency Medicaid certified? ☐ Yes ☐ No

If yes, list Medicaid provider number____________________

DEEMED STATUS (IF APPLICABLE) **(Choose only one)**

COMMUNITY HEALTH ACCREDITATION PARTNER (CHAP) ACCREDITATION COMMISSION FOR HEALTH CARE THE JOINT COMMISSION

BRANCH LOCATIONS (Identify each approved branch location. All branches must operate under the parent name. Continue on bottom of page if addtional room is needed.)

Address:	***Address:***	***Address:***
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Telephone No. ______________	Telephone No. ______________	Telephone No. ______________

CERTIFICATION

____ and ______________________________

PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP — HOME HEALTH AGENCY ADMINISTRATOR

being duly sworn by me on their oath, deposes and says that they have read the foregoing application and that the statements contained therein are correct and true and of their knowledge; and further gives assurance of the ability and intention of the

____ Home Health Agency to comply with the

EXACT LEGAL NAME

regulations promulgated under the Missouri Home Health Agency Licensing Law (Chapter 197, RsMo. Cumulative 1983).

It is further certified that the ______________________________________ will comply with all recommendations

OPERATING NAME OF AGENCY

for correction and/or improvements as contained in the most recent Licensing Survey Report prepared by the Department of Health and Senior Services and submitted to said Home Health Agency.

SIGNATURES

PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP

HOME HEALTH AGENCY ADMINISTRATOR