LETTER OF INTENT FOR STATE LICENSURE and/or MEDICARE CERTIFICATION

COMPLETE INFORMATION AND RETURN ALONG WITH POLICY MANUAL AND MEDICARE FORMS, IF APPLICABLE. MAIL TO: MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES, BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS, P.O. BOX 570, JEFFERSON CITY, MO 65102.

<table>
<thead>
<tr>
<th>NAME OF AGENCY</th>
<th>TELEPHONE NO.</th>
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<tbody>
<tr>
<td>ADDRESS (STREET, CITY, STATE, ZIP)</td>
<td>COUNTY</td>
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<tr>
<td>CONTACT PERSON</td>
<td>EMAIL ADDRESS</td>
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**TYPE OF AGENCY**

- ☐ HOME HEALTH AGENCY
- ☐ HOSPICE
- ☐ MEDICARE CERTIFICATION
- ☐ STATE LICENSURE

**OWNERSHIP AND MANAGEMENT**

- Hospital Based
- SNF/ICF Based Agency
- Rehabilitation Facility Based Agency
- Subunit
- Free Standing Agency
- Other

Provider Base Entity:

- ____________________________
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**GEOGRAPHIC AREA** - A new agency may only serve counties that are contiguous with the county you are located in.

LIST COUNTY(IES):

**SERVICES PROVIDED** (Home Health Agencies Check Two or More – Hospices Must Provide All Core Services)

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy

Provider Number: ____________________________

Fiscal Year Ending Date: ____________________________

List Direct Service (PT, ST or Nursing): ____________________________

**IFOR OFFICE USE ONLY**

**Initial Forms Received**

- ☐ HHA-30
- ☐ CMS-417
- ☐ HHS-690
- ☐ 855 Appr: __________
- ☐ SOS Registration

- ☐ CMS-1561
- ☐ Lic. App
- ☐ Lic. Fee
- ☐ OASIS Transmission __________
- ☐ FI Additional Info __________

Assigned Surveyor: ____________________________

Policy Manual Received: __________

*Surveyor Checked Out Manual: __________

1561 Copies to RO: ________________

*Manual Approved: ________________

*Administrator Qualifications Approved: ________________

*Geographic Area Reviewed: ________________

*Permission Given to Agency to Start Caseload and: ________________

Confirmation Letter (90): ________________

Complete OASIS Test Transmission

*Dates of Additional Contact: ________________

Agency Called Bureau - Ready for Survey: ________________

*Initial Survey Date: ________________

MO 580-2072 (08/06)

* Surveyor’s Responsibility

HHA-27