

**INSTRUCTIONS FOR COMPLETING INITIAL APPLICATION/ANNUAL REPORT
FOR HOME HEALTH AGENCY LICENSE**

****for the Initial Application Packet email lwilkins@kdheks.gov****

(Please Read and Follow the Enclosed Instructions Carefully)

- A. Provide the full legal name and address of the agency, **as it should appear on the license**. Include the full 9-digit zip code; telephone number; fax number and the email address.
- B. Identify the person designated by the governing body to be responsible for the daily management of the agency.
- C. Indicate the name and discipline of the person listed as the alternate administrator. If the administrator is a health professional other than an RN, please specify the discipline (e.g. physical therapist). If the administrator is not an appropriate qualified health professional as defined by KAR 28-51-100(c), then check "Other" and include the requested information.
- D. Indicate the actual number of unduplicated home health clients enrolled by the agency during the calendar year prior to the completion of the annual report.
- E. Indicate the actual number of home health visits performed by the agency during the calendar year prior to the completion of the annual report. If services are performed on an hourly basis, compute the number of visits on the basis that four hours represent one visit. County or regional public health departments should not include county home visits that are public health services as determined by the Secretary of Health and Environment.
- F. If the agency is making an initial application for license, check the space preceding "Initial Application" and include payment of the initial license fee of \$100.00. **Please refer to the email address above, to receive the complete Initial Home Health Agency Packet Information.**

If the agency is undergoing a change of ownership, check the appropriate space and include payment of **\$100.00** license fee.

For annual reports; check the number of home visits corresponding the number of home health visits recorded in Section-E, and submit payment for the fee shown to the right of this number.

- G. Indicate the geographic extent of the agency's operation. Indicate whether the agency provides services in less than an entire county (such as a city or a portion of a county), within a single county, or in more than one county by checking the space preceding the appropriate geographic category. Identify all areas in which service is provided by the agency.

If service is less than countywide, list municipalities or sections of the county served. If service is provided to a single or multiple county areas, list the counties in which services are provided and identify any counties, which are in another state. **Please note that agencies can neither serve patients nor establish branch offices beyond 100 miles of the parent location.**

- H. List the complete telephone number, address (including street, city, state, zip and name) for each branch office which is to be included in the license for which the agency is applying.
- I. Indicate all home health services provided by this agency. Please specify which Waiver Programs this home health agency is enrolled and providing services under (ex... FE, TBI, MR/DD or PD waivers). List the services provided (e.g. attendant care, health maintenance activities, homemaker, etc.).
- J. Give the legal name and address of the organization that controls or owns this agency.
- K. Check the boxes preceding the appropriate type of entity status from Item J.
- L. Complete the boxes below with the information about the disclosing entity.
- M. Accrediting Organization and or Clinical Lab Improvement Act, please attach the certificate.

Select one:

- Initial
- Renewal
- Amended

Kansas Department of Health & Environment
 Bureau of Community Health Systems & Health Facilities Program
APPLICATION FOR HOME HEALTH AGENCY LICENSE
 Initial Application, Annual Report or Change of Ownership

A. Name of Agency: _____ email _____

Street Address	City	County	Zip Code	Phone	Fax
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B. Administrator Name: _____ Email _____

Discipline of Administrator: _____ License No. _____ Phone No. _____
 Other Health Professional (Please attach documents of health care education and experience).

C. Alternate Administrator Name: _____ Email _____

Discipline of Alternate Administrator: _____ License No. _____ Phone No. _____
 Other Health Professional (Please attach documents of health care education and experience).

D. * Number of Unduplicated Clients during the previous calendar year: _____

E. Number of Home Visits made during the previous calendar year: _____

F. Fee Schedule: Initial Application \$100.00 Change Ownership \$100.00 Annual Report (see below)

	<u>Visits</u>	<u>Fee</u>		<u>Visits</u>	<u>Fee</u>
0 - 500		\$25.00	5,001 - 6,000		\$330.00
501 - 1,000		\$60.00	6,001 - 7,000		\$380.00
1,001 - 2,000		\$120.00	7,001 - 8,000		\$440.00
2,001 - 3,000		\$170.00	8,001 - 10,000		\$490.00
3,001 - 4,000		\$220.00	10,001 - 20,000		\$550.00
4,001 - 5,000		\$280.00	Over 20,000		\$580.00

G. Geographic Area Covered by Agency Operation: Less than Countywide Single County Multi County

List counties served: _____

H. Branch Offices: Name/Telephone Number Branch Location (Street Address, City, State, Zip)

Do not write below this line

License Effective Date: _____

License ID No.: _____

Annual Renewal Date: _____

Reviewed By: _____

I.

√ **Select the Services that apply and provided through this home health agency:**

- | | |
|---|--|
| <input type="checkbox"/> Nursing Care | <input type="checkbox"/> Medical Social Services |
| <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> HCBS/Medicaid Waiver Programs | <input type="checkbox"/> Physical Therapy |
| <i>Specify Programs:</i> | <input type="checkbox"/> Respiratory Therapy |
| HCBS <input type="checkbox"/> FE <input type="checkbox"/> PD <input type="checkbox"/> TA <input type="checkbox"/> TBI <input type="checkbox"/> MR/DD <input type="checkbox"/> | <input type="checkbox"/> Speech Therapy |
| <i>List Services Provided:</i> | <input type="checkbox"/> Nutritional/Dietetic Consulting |
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Part II

J. Disclosing Entity Name: _____ Address: _____

K. Type of Entity: Sole Proprietorship Partnership Joint Venture Limited Liability Company
 Corporation for profit Corporation nonprofit Government _____

L. Complete the Boxes below with the Information as Follows for the Disclosing Entity Listed on section (K).

- List the name and addresses of each person who has any direct or indirect ownership of **10 percent** or more in entity listed above.
- List each person who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
- If the disclosing entity is organized as a corporation, attach a list showing the names and address of each officer and director.
- If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 10 percent owner, and for all general partners.
- If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

The following is the legal signature and title of the individual authorized to represent the governing body, corporation, partnership, joint venture, individual, or organization in the operation of the agency by the disclosing entity.

Indicate with "X"		Individual Name	Address	City	State
Owner	Mortgagor	3. Limited Liability Company Describe for each Limited Partnership & LLC the Limited for Each 10% Owner and for all General Partners.	4. Directors /Officers	5. Elected Officials	(or provide an attachment listing)

M. Are you an Accredited HHA? _____ Show decision letter of deemed status with expiration date.

If this HHA holds a (CLIA) waiver or a certified provider, enter the CLIA No.: _____

_____	_____	_____
Signature	Title	Print Name
_____	_____	_____
Telephone Number		Date

Return the application & submit the fee to:	Kansas Department of Health and Environment Bureau of Community Health Systems Health Facilities Program 1000 SW Jackson St., Suite 330 Topeka, Kansas 66612
Phone (785) 296-1258	Fax (785) 291-3419