pennsylvania
DEPARTMENT OF HEALTH

**Please type all responses in the application materials.
Handwritten submissions will not be accepted.
Hand delivery of the application is not accepted.
Applications must be mailed in.**

Dear Applicant:

The following series of documents contain the application materials for a Home Health Agency.

Please note that all questions must be answered, and all requested supporting documentation must be provided. Please label all the exhibits.

If you fail to submit all of the requested information, the application materials will be mailed back to you.

If you submit a complete application, to include all the required supporting documentation, an email will be sent to the contact email listed on the application. Do not include information not specifically requested.

If your application is in accordance with Pennsylvania Home Health Agency rules and regulations, the Division of Home Health will issue you a license. Please keep in mind the length of time for the licensure process depends upon the accuracy of information provided.

If it is determined that corrections need made to the information you submitted, an email will be sent to the email address you provide in the application materials. You will be given 30 days from the date of the email to resubmit revisions to your policies. Failure to resubmit in a timely fashion will result in your application being withdrawn from consideration.

Sincerely,

Division of Home Health

Identifying Information for Home Health Agency License

Name of Entity: ______________________________

Doing Business As/Fictitious Name: ______________________________

Mailing Address: ______________________________
Street *City* *State* *Zip Code*

Physical Site Address: ______________________________
(No PO Boxes) *Street* *City* *State* *Zip Code*

County: ______________________________

Telephone: ____________________ Fax: ____________________

Email Address: ______________________________
(Must be an active email address)

Contact Person: ______________________________

Days and Hours of Operation: *(Physically present in office)*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

<u>NOTE</u>: An on-site inspection by surveyors will occur during the business hours submitted.

List of Geographic Service Area by County:
Must be adjoining counties from physical location of agency

☐ Please indicate if the agency will have 24-hour on-call system.

Payment

A Check or Money Order Payable to "Commonwealth of Pennsylvania" for the amount of the fee must accompany this application. Currency is not acceptable. The regular fee per license is $250.

Mail the completed and signed original application with a check or money order to:

Pennsylvania Department of Health
Division of Home Health
2525 N. 7th Street
Harrisburg, PA 17110

IMPORTANT: Please retain a copy of your entire packet for your records.

Agreement

Application is made to operate a Home Health Agency in accordance with Chapter 8 of the Health Care Facility Act (35 P.S. §448.101 et. seq.). Application includes Initial Application Form with payment, Civil Rights Survey, Information requested of Health Care Providers applying for a license, Documentation Required for Initial Home Health License, and Password Agreement form.

I agree that all of the identifying information on this form and information furnished on the aforementioned attached documents and all other materials submitted are complete and true. I understand that incomplete or inaccurate information **IS REASON FOR DENYING THE ISSUANCE OF A LICENSE**. I further agree to conduct said facility in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Department of Health.

Affirmation

The undersigned hereby affirms that the foregoing information is true and correct to the best of said persons knowledge, information and belief; said affirmation being made subject to the penalties prescribed by 18 Pa. C.S.A. §4904 (unsworn falsifications to authorities).

Authorized Representative's Signature*	Date
Print Name of Authorized Representative's	Date

**Authorized Representative – the individual within the Applicant organization with the legal authority to give assurances, make commitments, enter into contracts, and execute documents on behalf of the Applicant, including this Application. The signature of the Authorized Representative certifies that commitments made on this Application will be honored and ensures that the Applicant agrees to conform to applicable law and regulations.*

pennsylvania
DEPARTMENT OF HEALTH

Provider/License Number: ________________
Initial Applicants: This section is for Dept. use Only

Password Agreement

I, ______________________ **(Name)** hereby certify that effective ____________ **(date became administrator)**, I am the Administrator/Director/Chief Executive Officer for ______________________________________ **(Facility Name)** and that I am responsible for submitting a Plan of Correction in response to deficiencies cited by the Pennsylvania Department of Health on CMS Form 2567.

1. I acknowledge receipt of the facility identification number and my individual password (which will be provided after receipt of this agreement) from the Pennsylvania Department of Health.

2. I agree to main the confidentiality of both the facility identification number and my password.

3. I recognize and acknowledge that the use of my password to electronically submit a Plan of Correction, in response to deficiencies cited on the CMS Form 2567, identifies me as the signer of the Plan of Correction.

4. I further recognize and acknowledge that the use of my password, in conjunction with the submission of a Plan of Correction, authorizes the Pennsylvania Department of Health to conclusively accept that electronic Plan of Correction as my authorized submission.

I have had the opportunity to review this Agreement and hereby agree to the above statements.

____
Email Address

____
Signature of Administrator/Director/CEO

____
Signature of Witness

____
Date

Already Licensed Facilities ---
Return to: ra-dhhomehealth@pa.gov
With the required supporting documentation

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DEPARTMENT OF HEALTH

Civil Rights Survey

Extra pages may be attached if more space is needed. Please label accordingly, and place directly behind the Civil Rights Survey form.

Agency Name: ____

Note: The word "discrimination" shall be understood to mean "discrimination on the basis of race, color, national origin, religious creed, ancestry, sex, age, or handicap" as used in the Pennsylvania Human Relations Act of 1955, as amended.

1. Is a non-discrimination policy, which states services are provided, referrals are made, and employment actions are made without regard to race, sex, color, national origin, ancestry, religious creed, handicap, or age?

   ☐ **Provide a copy** and indicate where postings are located.

   ____

   Note: When any change in policy, a signed and dated copy of the revised policy shall be submitted to the State Survey Agency within 30 days of the effective change.

2. Does the agency include the non-discrimination policy in brochures, media notices, and posters?
   ☐ Yes – If yes, identify publications and media communications means used.
   ☐ No – If no, state what corrective steps will be taken.

   ____

3. Describe methods and materials used to orient patients and staff to civil rights compliance requirements.

   ____

4. Are patients/consumers and staff informed that complaints of discrimination may be filed with the Office of Equal Opportunity, Pennsylvania Department of Health, and/or the Pennsylvania Human Relations Commission?
   ☐ Yes – If yes, explain the contents of the information and how it is disseminated.
   ☐ No – If no, state what corrective steps will be taken.

   ____

5. Describe methods used to assure communication with non-English speaking, limited English proficient and speech impaired persons who you may provide services to (even if you do not currently serve these consumers).

____

6. Describe methods used to assure communication with the hearing and visually impaired person who you may provide services to (even if you do not currently serve these consumers).

____

7. Does the non-discrimination policy statement include that reasonable accommodation is to be provided for handicapped employees?
   ☐ Yes – If yes, explain the contents of the information and how it is disseminated.
   ☐ No – If no, specify reasons or corrective actions to be taken.

____

8. Within the past 12 months, have there been any complaints of discrimination filed against this agency?
   ☐ Yes
   ☐ No
   If yes, for each complaint registered, please show date of the complaint; the sex and race/national origin of the complainant; major allegations made in the complaint; agency with which the complaint was registered; and the finding of either cause or no cause by the investigating agency.

____

Employment

Be sure to include yourself and/or all owners, along with anyone hired.

	Black		Hispanic		White		American Indian		Asian		Alaskan Native		Pacific Islander	
Job Title	M	F	M	F	M	F	M	F	M	F	M	F	M	F

DOCUMENTATION **REQUIRED** FOR
HOME HEALTH CARE AGENCY LICENSURE APPROVAL

The following materials **must** be submitted with your licensure application. This documentation will be reviewed by the Division of Home Health for substantial compliance with the regulations at 28 Pa. Code, Chapter 601, Subpart F, Home Health Care Agencies. The agency cannot admit or treat any patients until approval is received from the Department of Health.

GOVERNANCE AND MANAGEMENT

Organization, Services, and Administration – See Section 601.21
Please send the following:

1. Organizational chart
2. Description of services to be provided
3. Members of governing body
4. Appointment of administrator by governing body
   a. Administrator's qualifications
   b. Administrator's criminal history clearance results (either through PA State Police or FBI fingerprints)
   c. Qualified alternate
5. Arrangement for professional advice
6. Budget policies
7. Supervising Registered Nurse or physician
   a. Copy of professional license
   b. State PATCH (background check results through PA State Police - Purpose must be "Employment")
   c. Copy of orientation
   d. Similarly qualified alternate
8. Outline of personnel policies
9. Policies for coordination of patient services

Agency Evaluation and Review – See Section 601.22
Please send the following:

1. Individual's responsible for professional advice
   a. Name, professional background and State PATCH (background check results through PA State Police - Purpose must be "Employment")
2. Policies relating to advisory and evaluation responsibilities of the Group of Professional Personnel
3. Polices for annual program evaluation
4. Policies for quarterly clinical record reviews
5. Policies for collection of statistical data
   a. Data to be collected

Acceptance of Patients, Plan of Treatment, and Medical Supervision – See Section 601.31
Please send the following:

1. Policies for acceptance of patients
2. Policies for development of the plan of treatment
   a. Sample plan of care
3. Polices for review of the plan of treatment
4. Policies for conformance with physician's orders
   a. Verbal order policy

Skilled Nursing Service – See Section 601.32
Please send the following:

1. Copies of professional licenses
2. Job description
3. State PATCH (background check results through PA State Police - Purpose must be "Employment")

Therapy Services – See Section 601.33
Please send the following: (if providing therapy services)

1. Copies of professional licenses
2. Job description
3. State PATCH (background check results through PA State Police - Purpose must be "Employment")

Medical Social Services – See Section 601.34
Please send the following: (if providing medical social services)

1. Copy of resume and professional license
2. Job description
3. State PATCH (background check results through PA State Police - Purpose must be "Employment")

Home Health Aid Services- See Section 601.6 Definitions and Section 601.35
Please send the following: (if providing home health aide services)

1. If providing home health aide services
   a. Copy of home health aide training program - Please make sure the training program clearly defines each topic and how many hours/minutes per topic. Hours must total the minimum requirements of the Home Health regulations.
   b. Policies for assignment of home health aides
   c. Policies for supervision of home health aides
   d. Home Health Aide job description

Clinical Records – See Section 601.36
Please send the following:

1. Policies on maintenance of clinical records
2. Policies on retention of clinical records
3. Policies of protection of clinical records

**The passage of Act 169 of 1996 requires applicants who seek employment at home health agencies obtain a criminal history background check. The provision of the Act takes effect July 1, 1998. A request for a background check can be initiated by obtaining the "Request for Criminal Background Check" (form SP-4 – 164) from the State Police. Documentation that criminal background checks have been completed for all employees must also be submitted.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

INFORMATION REQUESTED OF HEALTH CARE PROVIDERS APPLYING FOR A LICENSE TO OPERATE A HEALTH CARE FACILITY

You must physically answer the following 10 questions, along with including the requested supporting documentation. Should you need further clarification, directions are located at the end of this document.

BUSINESS STRUCTURE

1. A description of the business structure of the health care provider ("Applicant") applying for a license to operate a health care facility, as defined in the Health Care Facilities Act, Act of July 19, 1979, P.L. 130, as amended, 35 P.S. §§448.101 - 448.904b.

OWNERSHIP AND/OR CONTROLLING INTEREST

2. (a) Identify the persons and entities with 5% or greater direct or indirect ownership or controlling interest in the Applicant (see attached definitions).

   (b) Provide the information requested in questions 1, 4, 5 and 8 with respect to all persons and entities identified in (a).

DOCUMENTATION

3. (a) A copy of the Applicant's articles of incorporation, certificate of registration, certificate of incorporation, charter, certificate of organization, or other articles, statements or documents establishing the legal existence of the business entity that will hold the license. This submission shall include applicable Pennsylvania Department of State filings and approvals. For foreign entities, provide a copy of the applicable Pennsylvania Department of State filings and approvals to conduct business in Pennsylvania.

   (b) A copy of the applicant's by-laws, operating agreement, partnership agreement, or other rules adopted for the regulation or management of the business entity applying for licensure, regardless of the name used to describe those rules.

IDENTIFICATION OF INDIVIDUALS WITH MANAGEMENT AND OPERATIONAL AUTHORITY

4. (a) A list of the names, addresses and health care experience of the individuals who are responsible for the overall business direction of the Applicant

   (b) A list of the names, addresses and health care experience of the individual[s] to be appointed by the Applicant to act on its behalf in the overall management and operation of the health care facility regardless of form of ownership.

(c) The names, addresses and health care experience of the individual[s] who will have responsibility for day-to-day operations and who will provide immediate direction and control over the manner of delivery of health care services to individuals served by the health care facility.

LOCATION OF APPLICANT

5. Address of the Applicant's headquarters. If the Applicant has out-of-state headquarters, the Applicant also shall supply the address where the Applicant may be served with legal documents within Pennsylvania.

HEALTH CARE SERVICES TO BE PROVIDED BY APPLICANT

6. (a) A description of the health care services the Applicant intends to offer through the health care facility.

   (b) If the application for licensure is the result of a change of ownership, the health care provider should provide a description of
   i. any actual or anticipated change from the health care services currently offered,
   ii. any actual or anticipated change in the present staff, or in the composition of the staff, and
   iii. a description of any anticipated innovations in the manner of delivery of health care services.

BACKGROUND OF APPLICANT

7. The Applicant's previous experience in operating health care facilities inside or outside Pennsylvania, including:
   (a) the type of health care facilities currently or previously owned, managed or operated by Applicant

   (b) the names and addresses of facilities currently or previously owned, managed or operated by Applicant and persons and entities identified in 2(a)

   (c) a description of any adverse action taken by any state or federal agency against any of the facilities identified in 7(b), and any documentation regarding the action taken and its resolution.

8. Have any of the facilities identified in 7(b) or any of the individuals identified in 4(a), (b) or (c):
   (a) Been subject to criminal or civil fraud charges; or

   (b) Ordered to pay a civil monetary penalty (other than those listed in response to 7(c); or

   (c) Convicted of Medicare or Medicaid fraud and abuse?

   If yes, please provide documentation regarding the action taken and its resolution.

9. Are there any ongoing fraud and abuse investigations at any facility identified in 7(b)?

INTENTIONS WITH RESPECT TO CHARITY CARE

10. A description of the Applicant's intentions with respect to the level of charity and uncompensated care to be provided.

Special Instructions:

Under the Commonwealth of Pennsylvania's Right-to-Know Law, ("RTKL"), 65 P.S. §§ 67.101-67.3104, any information submitted in response to this form may be considered a public record, which will be provided by the Department in response to request for copies of such records.

Records that constitute or reveal a trade secret or confidential proprietary information are exempt from disclosure under the RTKL. 65 P.S. § 67.708(b)(11).

"Trade secret" is defined as "information, including a formula, drawing, patter, compilation, including a customer list, program, device, method, technique, or process that (1) derives independent economic value, actual, or potential, from not being generally known to and not being readily ascertainable by proper means by other persons who can obtain economic value from its disclosure and/or use; and (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy. The term includes data processing software obtained by an agency under a licensing agreement prohibiting disclosure."

"Confidential Proprietary Information" is defined as "commercial or financial information received by an agency: (1) which is privileged and confidential; and (2) the disclosure of which would cause substantial harm to the competitive position of the person that submitted the information."

If you believe that any of the information that is bring provided in response to this form meets the definition of either "trade secret" or "confidential proprietary information," you must so assert at the time of submission. The written response to each question must state whether any of the answers given are or contain either "trade secrets" or "confidential proprietary information." The written response must also state the basis on which you are asserting that the information provided constitutes either "trade secrets" or "confidential proprietary information" and should not be re-disclosed. This is necessary as the Department's response to a RTKL requester must include the basis on which the information is considered to be a "trade secret" or the reason the information is considered "confidential proprietary information." Without the basis for your assertion, the Department is unable to assert this exception to disclosure under the RTKL on your behalf.

Further, you must indicate on **each page** of additional documentation submitted that the page contains "trade secret" or "confidential proprietary information" which should not be released. If only some of the information on a page is "trade secret" or "confidential proprietary information," please identify the **confidential** text. A blanket statement that all information being submitted falls within one of these two categories is **not** acceptable.

Failure to raise a claim of "trade secret" or "confidential proprietary information" will result in a waiver of any future claim(s) that this information should not be provided by the Department of a third party requestor because it falls within one of these classifications.

DIRECTIONS AND DEFINITIONS FOR PROVIDING THE
INFORMATION REQUESTED OF HEALTH CARE PROVIDERS APPLYING FOR
A LICENSE TO OPERATE A HEALTH CARE FACILITY

BUSINESS STRUCTURE

1. Please provide as much information as necessary to provide a complete description of the business structure of the Applicant. While you may choose to provide an organizational chart outlining chain of command or lines of decision-making authority for the Applicant, that is not the primary purpose of this question. The purpose of this question is to obtain a detailed explanation of the business entity that is seeking a license to operate a health care facility. The business entity may be a business corporation, professional corporation, nonprofit corporation, limited liability company, general partnership, limited partnership, limited liability partnership, restricted professional company, unincorporated association, professional association, sole proprietorship, trust, estate, joint stock company, insurance company, the Commonwealth or political subdivision or instrumentality (including a municipal corporation or authority) or other government entity. The description of the business structure of the entity applying for a license should include information about those entities or persons that have an ownership interest in the Applicant. The explanation of the business structure should include information about a parent corporation, a holding company, or the corporate or individual members of a limited liability company.

OWNERSHIP AND/OR CONTROLLING INTEREST

2. Please see the definitions to determine the direct/indirect ownership/control of the Applicant. Please include "parent" corporations, sole members or any entities that have a relationship with the Applicant that results in ownership or control as defined below.

DOCUMENTATION

3 (a) Please provide the documentation that demonstrates the legal existence of business entity that is seeking a license to operate a health care facility. The technical form of that documentation may vary. If the Applicant is a corporation, the documentation will be the Articles of Incorporation. If the Applicant is a limited liability company, the documentation will be a Certificate of Authority. If the Applicant is a Partnership, the documentation will be the Partnership Agreement. If the business entity that will operate the health care facility is a sole proprietorship, there will be no documentation to supply. A foreign corporation shall supply a copy of the corporation's application for a Certificate of Authority to do business in Pennsylvania.

(b) Please provide the documentation necessary to describe the rules for the regulation, management and operation of the Applicant as a business entity. The form of that documentation may vary. If the Applicant is a corporation, the documentation may be titled "by-laws." If the Applicant is a limited liability company, the operating agreement will include the rules for operation of the company. If the Applicant is a partnership, the partnership agreement will include the operating rules for the partnership. If the business entity that will operate the health care facility is a sole proprietorship, there is no requirement for documentation setting forth the rules for running the business.

IDENTIFICATION OF INDIVIDUALS WITH MANAGEMENT AND OPERATION AUTHORITY

4. (a) The names included in the response to this question should include any and all persons who have overall responsibility for business direction of the Applicant. The title of these persons may vary depending upon the form of business entity that will operate the health care facility. In a corporation, these persons often are referred to as "directors." In a limited liability company, these persons often are referred to as "members."

(b) The names included in the response to this question should include any and all persons appointed by the health care provider to act on its behalf in the overall management and operation of the health care facility. The title assigned to these persons may vary depending upon the form of the business entity that will operate the health care facility. In a corporation, these persons often are referred to as "officers." In a limited liability company, the members may fill the roles described in (a) and (b), or the members may appoint an individual to manage the company, and may be referred to as "manager." This person or persons also may be referred to as the "general partners," "managing partners," "chief executive officer," or "chief operating officer."

(c) The name provided in the response to this question should be, for example, the individual who is licensed as a nursing home administrator, or the individual named as the administrator, director of nursing, medical director, or executive director for the health care facility.

It is possible that the same persons will have responsibility for the business direction of the health care facility, for the overall management and operation of the facility, and for direction and control over the manner of delivery of health care services. In the event of repetition of names in response to (a), (b), and (c) above, simply supply all names in response to this question 4 and list the responsibilities of each.

LOCATION OF APPLICANT

5. An applicant with an out-of-state address must supply an in-state address to which the Department or one of its divisions may deliver correspondence including notice of an adverse action or other legal documentation.

HEALTH CARE SERVICES TO BE PROVIDED BY APPLICANT

6. Self-explanatory.

BACKGROUND OF APPLICANT

7. The term "adverse action" refers to an adverse licensure or certification action by a state or federal agency, including civil monetary penalties.

8, 9. Self-explanatory.

INTENTIONS WITH RESPECT TO CHARITY CARE

10. A response to this question is solicited merely as a means of collecting information. An answer indicating an unwillingness to provide charity care will not affect the Department's decision with regard to the application for licensure.

DEFINITIONS

“Direct Ownership” means an interest through the possession of stock, equity in capital or any interest in the profits of the Applicant.

“Indirect Ownership” means an interest in an entity that has direct or indirect ownership interest in the Applicant. The amount of indirect ownership in the Applicant that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the Applicant.

“Control” means the ability to control operational direction or management of the Applicant which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (e.g. joint venture agreement, unincorporated business status) of the Applicant; the ability or authority to nominate or name members of the Board of Directors or Trustees of the Applicant; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management rules of the Applicant; the right to control any or all of the assets or other property of the Applicant upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the Applicant, or to arrange for the sale or transfer of the Applicant to new ownership or control.