

Ohio Department of Health
Home Health Agency or Non-Agency Provider

Non-Medical Home Health Services License Application

General Information and Instructions

The Ohio Administrative Code requires all home health agencies or nonagency providers who provide non-medical health services to be licensed.

You may visit our website at www.odh.ohio.gov to review and print rules 3701-60-01

To be considered for a license to provide skilled home health services either as a home health agency or a nonagency provider, you must submit a completed application and a non-refundable application fee in the amount of \$250.00. The application must be mailed to the address below. The check or money order is made payable to **Treasurer, State of Ohio**. A complete application includes the following:

1. Non-Medical Home Health Services Application.
2. Non-Refundable fee of \$250.00.
3. A document showing a list of all non-medical home health services that are provided or will be provided by the agency or nonagency provider.
4. Copies of all documents filed and recorded with the Ohio Secretary of State.
5. If the applicant is a nonagency provider – a notarized affidavit verifying the identity of the nonagency provider.
6. If the applicant is a home health agency – a copy of the home health agency's written criminal record check policy.
7. Fingerprint impressions of the primary owner of the home health agency or nonagency provider.
8. A document providing a description of the geographic area in which the home health agency or nonagency provider provides or will provide services.

If the home health agency or nonagency provider is certified by the Ohio Department of Aging under section 173.391 of the Revised Code to provide community-based long-term care services; then the facility needs only to submit proof of certification from the Ohio Department of Aging instead of supplying items 3 thru 8 above.

Ohio Department of Health
Revenue Processing #3506
PO Box 15278
Columbus, OH 43215

Submission of an incomplete application may delay the processing of your application.

To obtain online information regarding the licensure process, e.g. forms, rules (Ohio Administrative Code (OAC) and regulations (Ohio Revised Code (ORC)), visit the Ohio Department of Health web site at <http://www.odh.ohio.gov>.

Questions regarding the licensure process may be directed to our e-mail address, liccert@odh.ohio.gov or by calling our office at (614) 466-7713.

Non-Medical Home Health Services Licensure Application

As defined in Section 3740.01 of the Ohio Revised Code and 3701-60-01 of the Ohio Administrative Code.

<p>ODH Use Only</p> <p>ID # _____</p> <p>OHL # _____</p>

Please Print Legibly in Ink or Type

<p>1. Application Type</p> <p>Initial Renewal Change of Ownership</p>	<p>2. Date of operation: projected opening date or date of change of ownership.</p>
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<p>3. Agency or nonagency provider name (DBA)</p>	<p>4. Telephone number ()</p>	
<p>5. Previous facility name, if applicable</p>		
<p>6. Address</p>		
<p>City</p>	<p>ZIP Code</p>	<p>County</p>
<p>7. E-mail address</p>		
<p>8. Administrator name</p>	<p>9. Administrator email address</p>	

10. Mailing address, if different from above

<p>Name</p>		
<p>Address</p>		
<p>City</p>	<p>State</p>	<p>ZIP Code</p>

11. Days and hours of operation for this agency

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M.							
P.M.							

<p>12. Was the home health agency or nonagency provider providing non-medical home health services on or immediately prior to September 30, 2021? No Yes</p> <ul style="list-style-type: none"> If yes, please provide evidence to support this response. If no, please provide a copy of the surety bond issued by a company licensed to do business in Ohio in the amount of twenty thousand dollars (\$20,000).

<p>13. This business is a/an Individual Partnership Limited Liability Company</p> <p> Corporation Association Other: _____</p>

Individual owner: skip questions 16 through 19 only.

14. Owner's name		
Address		
City	State	ZIP Code
Phone number	Owner's occupation	

15. Owner's business address, if different from question #6.

Address			
City	State	ZIP Code	Phone Number ()

Multiple owners, partnership, limited liability company, corporation, association, other skip questions 14 & 15 only.

16. Business entity name			
Address			
City	State	Zip	Phone Number ()

17. This business is a	18. Date of incorporated or registration	19. Charter/registration number
For profit Not for Profit Government	/ /	#

20. List the **name of each person** who has an ownership interest of 5% or more in the business (attach additional sheets if necessary).

Name	Name
Name	Name
Name	Name

21. Officers names, titles, addresses and phone numbers

Title	Name	Address	Phone number
			()
			()
			()
			()

22. Statutory agent's name	Address	Phone Number ()
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23. Has the owner(s) or administrator been affiliated through ownership or employment with any of other home health agency or nonagency provider as defined in rule 3701-60 of the OAC within five years prior to the date of this application?		
No	Yes	<i>If "yes", provide in writing the individual name(s) and address(es) of the facilities.</i>
24. Has the owner(s) or administrator been convicted of any criminal conviction, civil judgment or administrative adjudication related to the provision of care or bearing a direct or substantial relationship to the job responsibilities he/she is to carry out?		
No	Yes	<i>If "yes", provide in writing the individual's name, full explanation stating the charge(s), date(s) and disposition(s).</i>

I affirm that to the best of my knowledge and belief, the answers provided herein, and all accompanying materials are true and correct. I understand that section 3740.03 of the Ohio Revised Code and 3701-60-03 of the Ohio Administrative Code require the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership set forth in the initial application and any change in accreditation status, no later than 10 days after the occurrence of the change.

Any owner named herein may sign the application. That owner's name must appear in question #14, 20 or 21. If the signature is not an owner, attach a notarized affidavit that the individual is the authorized representative of the owner.

Print/Type owner's/representative's name & title	Signature	Date
Print/Type owner's/representative's name & title	Signature	Date

Ohio Department of Health ~ Bureau of Regulatory Operations – Licensure Program ~ 246 N. High St., Columbus, OH 43215.

SUBMIT