# Nonmedical Home Health Services License Application

## General Information and Instructions

Ohio Revised Code Chapter 3740 requires all home health agencies or nonagency providers who provide skilled home health services to be licensed by the Ohio Department of Health.

**For Initial and Change of Ownership Applications:** Submit a completed application that includes the following:

- ☐ Nonmedical Home Health Services Application.
- ☐ Non-Refundable $250 fee.
- ☐ Proof of Operations prior to Sept. 30, 2021.
  - If you do not have proof, a surety bond in the amount of $20,000.

AND PROOF OF EITHER OF THE FOLLOWING:

- ☐ Certification by the Ohio Department of Aging.

OR

- ☐ A list of all nonmedical home health services that are provided or will be provided by the agency or nonagency provider.
- ☐ Copies of all documents filed and recorded with the Ohio Secretary of State.
- ☐ Fingerprint impressions of the primary owner.
- ☐ A description of the geographic area in which the home health services are provided.
- ☐ **Nonagency provider only** – a notarized affidavit verifying the identity of the nonagency provider.
- ☐ **Home health agency only** – a copy of the home health agency's written criminal record check policy.

The application, $250 check or money order made payable to **Treasurer, State of Ohio**, and supporting documentation must be mailed to:

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.

**For renewal applications**, please complete boxes 1 and 2 on the next page and then only provide information that has changed before completing boxes 24 and 25 and signing your application. Your application and fee may be mailed to the above address.

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

# Nonmedical Home Health Services Licensure Application

| 1. Application | 1a. For Renewal | 2. For Initial and Change of Owner Applications: |
|---|---|---|
| ☐ Initial<br>☐ Change of Ownership<br>☐ Renewal | State ID _____<br>Has any of the below information changed since your last application? ☐ Yes ☐ No | Opening Date or Date of Change of Ownership<br>_____ |

| 3. Agency or Nonagency Provider Name (DBA) | | 4. Telephone Number |
|---|---|---|
| 5. Previous Facility Name, if Applicable | | |
| 6. Address | | |
| City | ZIP | County |
| 7. E-mail Address | | |
| 8. Administrator Name | 9. Administrator Email Address | |

10. Mailing Address, if different from above

| Name | | |
|---|---|---|
| Address | | |
| City | State | ZIP |

11. Days and Hours of Operation for This Agency or Nonagency Provider

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

12. Is this home health agency or nonagency provider certified by the Ohio Department of Aging under ORC 173.91 to provide community-based long-term care services? ☐ Yes ☐ No

- If yes, please attach evidence of certification.
- If no, attach all additional required documentation.

13. Was the home health agency or nonagency provider providing nonmedical home health services on or immediately prior to Sept. 30, 2021? ☐ Yes ☐ No

- 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).

14. This business is a/an:

☐ Individual ☐ Partnership ☐ Limited Liability Company ☐ Corporation ☐ Association ☐ Other: _____

**Individual Owner: Skip Questions 17 Through 22 Only**

| 15. Owner's Name | | |
|---|---|---|
| Address | | |
| City | State | ZIP |
| Phone Number | Owner's Occupation | |

| 16. Owner's Business Address, *if different from question 6* | | | |
|---|---|---|---|
| City | State | ZIP | Phone Number |

**Multiple Owners, Partnership, Limited Liability Company, Corporation, Association, Other: Skip Questions 15 & 16 Only**

| 17. Business Entity Name | | | |
|---|---|---|---|
| Address | | | |
| City | State | ZIP | Phone Number |
| 18. This business is a/an:<br>☐ For Profit ☐ Not for Profit ☐ Government | 19. Date of Incorporated or Registration | | 20. Charter/Registration Number<br># |

21. 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 |

22. Members, Officers, Trustee, or Board of Directors Names, Titles, Addresses and Phone Numbers

| **Title** | **Name** | **Address** | **Phone Number** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| 23. Statutory Agent's Name | Address | Phone Number |
|---|---|---|
| | | |

24. Has the owner(s) or administrator been affiliated through ownership or employment with any 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?

☐ Yes ☐ No *If "yes", provide in writing the individual name(s) and address(es) of the facilities.*

25. Has the owner(s) or administrator been the subject of any criminal conviction, civil judgment or administrative adjudication related to the provision of care or to the job responsibilities he/she is to carry out?

☐ Yes ☐ No *If "yes", provide in writing the individual's name, full explanation stating the charge(s), date(s) and disposition(s).*

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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 15, 21 or 22. 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 |



Department of Health