Department of Health

Home Health Agency or Nonagency Provider

Skilled 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:

- ☐ Skilled 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 $50,000.

AND PROOF OF EITHER OF THE FOLLOWING:

- ☐ Certification by the Centers for Medicare and Medicaid Services.
- ☐ Accreditation by a recognized accrediting organization.
- ☐ Certification by the Ohio Department of Aging.

OR

- ☐ An attestation that the agency otherwise meets the Medicare Conditions of Participation.
- ☐ A document showing a list of skilled home health services that are provided or will be provided by the agency.
- ☐ A document providing a description of the geographic area in which the home health agency provides or will provide services.

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 27 and 28 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.

Skilled Home Health Services Licensure Application

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

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.							

*****NOTE: You must select "Yes" to either Question 12, 13, 14, or 15*****

12. Is this home health agency or nonagency provider certified for participation in the Medicare program? ☐ Yes ☐ No

If yes, provide the Medicare provider number for the Home Health Agency: _____

- If yes, skip questions 13, 14 and 15.
- If no, then answer either question 13, 14 or 15.

13. Is this home health agency or nonagency provider accredited or certified? ☐ Yes ☐ No

If yes, type the name of the accrediting organization: _____

- If yes, enclose a copy of the current accreditation inspection report and skip questions 12, 14 and 15.
- If no, then answer either question 12, 14 or 15.

14. 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 provide proof of the certification and skip questions 12, 13 and 15.
- If no, then answer either questions 12, 13 or 15 .

15. Does this home health agency or nonagency provider meet the Medicare conditions of participation, even though it is not certified for participation in the Medicare program? ☐ Yes ☐ No

- If yes, please provide proof that this facility meets the Medicare conditions of participation and skip questions 12,13 and 14.
- If no, then answer either questions 12, 13 or 14.

16. Was the home health agency or nonagency provider providing skilled 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 fifty thousand dollars ($50,000).

17. This business is a/an:

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

Individual owner: Skip Questions 20 through 26 Only

18. Owner's Name		
Address		
City	State	ZIP
Phone Number	Owner's Occupation	

19. 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 18 & 19 Only

20. Business Entity Name			
Address			
City	State	ZIP	Phone Number
21. This business is a/an: ☐ For Profit ☐ Not for Profit ☐ Government	22. Date of Incorporated or Registration		23. Charter/Registration Number #

24. 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

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

Title	Name	Address	Phone Number

26. Statutory Agent's Name	Address	Phone Number

27. 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.*

28. 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).*

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 18, 24 or 25. 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 administrator's name _____ Signature _____ Date _____

Ohio Department of Health