

CHANGE OF OWNERSHIP APPLICATION FOR LICENSE TO OPERATE A HOME HEALTH AGENCY

Dear Applicant:

This letter instructs the applicant on how to obtain a license to operate a Home Health Agency. Prior to operating a Home Health Agency in Indiana, a license must be obtained from the Indiana Department of Health ("Department"). To obtain a license, the applicant must submit to the Department a completed application on the designated form, supporting documentation and \$250.00 licensure fee and must be able to show compliance with the licensure statute, IC 16-27.

The Application for License to Operate a Home Health Agency (SF 4008) must be completed in its entirety and submitted to the Department, along with supporting documents and/or information and the required \$250.00 **non-refundable license application fee**. Mail the entire application packet to the Indiana Department of Health addressed as follows:

**Indiana State Department of Health
2 North Meridian Street
Attention: Cashier's Office
Indianapolis, IN 46204**

A home health agency's license to operate expires one (1) year after the date of issuance of initial license and the license must be renewed annually. The home health agency must complete a "Renewal Application for License to Operate a Home Health Agency" application (SF 48851), applicant documentation and a non-refundable licensure fee of \$250.00 for renewal of license. The documentation and licensure fee must be submitted at least 60 days, but not sooner than 90 days before the expiration date of the current license.

If the application is submitted for a Change of Ownership (CHOW) of an existing Home Health Agency, the application packet, documentation, and non-refundable license fee of \$250.00. The application, documentation and licensure fee must be submitted **at least 30 days** prior to the effective date of the CHOW. Submit the applicable purchase agreement with buyer/seller signatures, letters of intent from both the buyer/seller on their agency letterhead, identity of corporation and DBA, and effective date of transaction.

Submission of the application form and supporting documents within the time frames set out above will avoid expiration of licensure and/or unnecessary delays in obtaining authority to operate a new Home Health Agency, or to assume control of an existing Home Health Agency.

Included on this website is a list of required documentation to be submitted with the initial or CHOW licensure application.

Review all the Home Health Agencies State Statute (Law) IC-16-27, Home Health Agencies State Rules (Administrative Code) 410 IAC 17, “Application for License to Operate a Home Health Agency” (State Form 4008) and information packet prior to completing and submitting application to the Department.

If the provider cannot interpret the State Statute IC-16-27 or Rules 410 IAC 17, the provider may obtain an attorney or consultant for interpretation of the State Statute (Law) IC-16-27 and/or Rules 410 IAC 17. The provider may contact the Indiana Association for Home & Hospice Care (IAHHC), 6320-G Rucker Road, Indianapolis, IN 46220, telephone number 317/775-6675 to attend a home health 101 training class for home health agencies. The Indiana Association for Home & Hospice Care (IAHHC) web address is located at www.iahhc.org.

Please include a cover letter with the application to include:

- Contact name
- Telephone number
- Mailing address

In the event additional information is requested the Department needs reliable contact information.

The application will be reviewed in order received at the Department and as the priority is dictated by the Division of Acute Care. The review process will be as follows:

- The Department **will not accept** providers walking in the Department and requesting immediate review and approval of application and licensure due to provider’s timelines.
- The Department **will not accept** providers calling the Department and requesting immediate review and approval of application and licensure due to provider’s timelines.
- The Department **will not accept** providers emailing the Department and requesting immediate review and approval of initial/revised application and licensure due to provider’s timelines.
- The Department **will review** applications in order received by U.S. mail.
- The provider **may call** to request the status of the application.
- All documentation **must** be received and approved prior to issuing a license.

- For faster processing, **do not** return the application in a binder or enclosed in sheet protectors. You may use colored sheets of paper to separate documents. The colored pages may be identified by topic. **Do not** use tabs.

If you have any questions regarding the application process contact the program coordinator at 317/233-7302.

Enclosures

LICENSURE APPLICATION (State Form 4008)

The Department is requesting the following information to be included with the initial licensure “Application for License to Operate a Home Health Agency” (State Form 4008) to facilitate the approval and to process the application.

Licensure Application

- ◆ Submit all documentation requested on the licensure application and in this letter. The “Application for License to Operate a Home Health Agency” (State Form 4008) is available on the Indiana State Department of Health’s website at <http://www.in.gov/isdh/20125.htm> for the provider to complete the form online, print, sign and submit with required documentation. Complete the application and return with the required documentation.

Licensure Fee

- ◆ A non-refundable \$250.00 licensure fee made payable to the Indiana State Department of Health.

Secretary of State (SOS)

- ◆ Submit applicable document from the Indiana Secretary of State (SOS).
 - If a limited Partnership, submit a copy of the “Application for Registration” and “Certificate of Registration” signed by the Indiana Secretary of State.
 - If a Corporation, submit a copy of the “Articles of Incorporation” and “Certificate of Incorporation” signed by the Indiana Secretary of State.
 - If applicant is an out of state corporation (foreign corporation), submit a copy of the “Certificate of Authority” to do business in the State of Indiana signed by the Indiana Secretary of State.
 - If a Limited Liability Company, submit a copy of the “Articles of Organization” and the “Certificate of Organization” signed by the Indiana Secretary of State.
 - If the “doing business as” (d/b/a) name is different from the corporation’s (direct owner) name submit “Certificate of Assumed Business Name” or “Articles of

Incorporation” that list the owner and d/b/a name signed by the Indiana Secretary of State.

Internal Revenue Service

- ◆ Submit a document from the Internal Revenue Service (IRS) that reflects the legal entity’s name and EIN number. **Do not** send a request form that the provider completed requesting an EIN number. **The document must be from the Internal Revenue Service (IRS) that reflects legal name and EIN number.**

Criminal History Checks

- ◆ Submit current copies of a national criminal history or an expanded criminal history check for the administrator, alternate administrator, nursing supervisor, alternate nursing supervisor, and owners/officers.
- ◆ Ensure that the agency conducts a national criminal history or an expanded criminal history check on all employees. Review IC 16-27-2 on criminal history checks for the requirements to operate a home health agency in Indiana.
- ◆ The expanded criminal history check and the national criminal history checks are defined as:
 - **IC 16-27-2-0.5—Expanded Criminal History Check Defined**
Sec.0.5. Expanded Criminal History Check means a criminal history c heck of an individual, obtained through a private agency that includes the following:
 - (1) A search of the records maintained by all counties in Indiana in which the individual who is the subject of the background check resided.
 - (2) A search of the records maintained by all counties or similar governmental units in another state, if the individual who is the subject of the background check resided in another state.
 - **IC 16-27-2-2.1—National Criminal History Background Check Defined**
Sec.2.1. National Criminal History Background Check means the determination provided by the State Police Department under IC 10-13-3-39(i).

Licensure Application (State Form 4008) helpful hints:

- ◆ **Section I—Type of Application**

- Please check the appropriate box for the type of application the agency is submitting.
- **Medicare**
 - ✓ **Please note that the State cannot conduct your survey for Medicare and that you will have to go through an accrediting organization for Medicare.**
 - ✓ If you plan to apply for Medicare in addition to state licensure, you must check the box for Medicare at the top of the application, return all applicable forms and submit a statement in writing to this office along with your application. The note should read as follows – example: *“ABC Healthcare facility plans to apply for Medicare through an accrediting organization, but would like the State to conduct my survey for state license only **OR** for state license and Medicaid”*.
- Check the appropriate box for Medicaid too, if applicable. The state can conduct the Medicaid survey along with the state license survey, or you have the option to have the accrediting organization conduct the Medicaid survey along with the Medicare. **Your note should be specific in regard to who you would like to have conduct the Medicaid survey, if you plan for Medicaid as well.**

◆ **Section II—Identifying Information**

- If the “doing business name” (d/b/a) is different from the direct owner/entity the d/b/a must be registered with the State of Indiana Office of the Secretary of State. Submit “Certificate of Doing Business Name” document signed by the State of Indiana, Office of the Secretary of State that list owner/entity name and d/b/a.
- **Email Address:** Please make this address a generic facility address, versus a person specific email address.
- **Mailing Address:** This is the address for current and future mailings; if this is a temporary address please indicate. It is the agency’s responsibility to notify the Department when the address changes.
- **Types of Home Services to be provided:** Check only the services that you plan to provide at the time of your survey; **DO NOT** check off services that you plan to offer in the future.

◆ **Section III—Staffing**

- Please note the qualifications for each position shown on the application. It is the provider’s responsibility to ensure that all candidates meet the qualifications,

as stated on the application, and as required by state and/or federal guidelines before submitting the application. If the applicant does not meet the stated qualifications, specifically supervisory and management experience in healthcare, the application will be returned. The provider will be asked to submit another candidate for the position. Please be sure that each resume includes job titles, description of supervisory responsibility, number and type of employees supervised, and length of time served in supervisory experience. **Do not** submit experience that is not relevant to healthcare.

◆ **Section IV—Ownership and Controlling Interest**

- **Type of Entity:** How the agency is registered with the Secretary of State

◆ **Section VII—Certification of Application**

- If signed by any individual (e.g. the administrator) other than indicated in section IV.A or V.A of the application, an affidavit must be submitted with the application, affirming that said persons has been given the power to bind the applicant/licensee.