

## INITIAL 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, 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.

Enclosed is a list of required documentation to be submitted with the initial 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](http://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.

Under Indiana Rule 410 IAC 17-10-1(e), after receiving an acceptable completed application, fee for licensure, disclosure or ownership and management information and any other requested information, this Division may issue a letter of approval to operate a home health agency, **not to exceed 90 days**, pending an on-site inspection (survey) by the Division.

Upon receipt of a letter of approval to operate a home health agency, the applicant should be ready for inspection as soon as possible. Per 410 IAC 17-10-1(e), the agency must provide the service(s) which they have specified on the application prior to the inspection and must have three (3) active patients for record review. Licenses issued by the Department to operate home health agencies will be based upon the results of a survey conducted by Department representatives to determine compliance with the requirements of 410 IAC 17-9 *et seq.* If the Division finds that the applicant is not in compliance with all applicable state and/or federal statutes and rules at the time of the initial licensure survey, **the approval to operate a home health will be terminated.** Upon termination of the approval to operate, the applicant must cease operations. If the applicant chooses to resubmit an application, it may submit a request for reapplication form with the applicable documentation at any time after notification of termination of approval to operate.

If the application is submitted for renewal of license, the application packet and licensure fee must be submitted **at least 60 days prior, 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 HHA, the application packet and license fee must be submitted at least 30 days prior to the effective date of the CHOW.

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 HHA, or to assume control of an existing HHA.



## IMPORTANT!!!!

- ✓ In order to expedite your application make sure the application is accurate and complete. If the application is not completed accurately and/or documentation is missing it hinders and delays the processing of the application.
  
- ✓ Ensure that all forms in this application packet, including duplicate forms, have original signatures. The initial licensure application **cannot** be processed until the Division has received all of the required forms and documentation.
  
- ✓ Review all rules and regulation **BEFORE** submitting your application to the Indiana State Department of Health.

## **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 national criminal history or expanded criminal history background checks on the administrator, alternate administrator, nursing supervisor, alternate nursing supervisor, and owners/officers.
- ◆ Ensure that the agency conducts national criminal history or expanded criminal history checks 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 national criminal history checks are defined below.
  - **IC 16-27-2-0.5—Expanded Criminal History Check Defined**  
Sec.0.5. Expanded Criminal History Check means a criminal history check 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. The selection is either for a ‘new agency’ or a Change of Ownership (CHOW).
- **Medicare Certification Only:**
  - ✓ **Please note that the State CANNOT conduct your survey for Medicare. Medicare certification must be obtained through an accrediting organization approved by the Centers for Medicare and Medicaid Services (CMS).** Contact information is located at:  
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Pro prospective-Clients-.pdf>
  - If you plan to apply for Medicare only in addition to state licensure, you must return all applicable forms and submit a statement in writing to this office along with your application (example: “In addition to State licensure, *ABC Healthcare Agency plans to apply for Medicare certification through an accrediting organization.*”).
- **Medicaid Certification Only:**
  - ✓ **Please note that the agency has two options for obtaining Medicaid certification:**
    - Option one: The State Agency can schedule a Medicaid only certification survey. The certification survey is separate from and not concurrent with the State licensing survey. The State Agency will schedule the Medicaid only certification survey as staff schedules allow. There may be significant delay under this option.
    - Option two: Contact a CMS approved accreditation organization to schedule a Medicaid only accreditation survey. Contact information is located at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Pro prospective-Clients-.pdf>
  - ✓ If you plan to apply for Medicaid only certification, in addition to state licensure, you must return all applicable forms and submit a statement in writing to this office along with your application. Examples:
    - Option one: “In addition to State licensure, *ABC Healthcare Agency plans to apply for Medicaid only certification and requests that the survey be performed by the State Agency.*”

- *Option two: “In addition to State licensure, ABC Healthcare Agency plans to apply for Medicaid only certification and requests that the survey be performed by an accrediting organization.”*
- **Concurrent Medicaid AND Medicare Certification**
  - ✓ CMS approved accreditation organizations can perform both accreditation surveys concurrently.
  - ✓ If you plan to apply for concurrent Medicare and Medicaid certification in addition to state licensure, you must return all applicable forms and submit a statement in writing to this office along with your application (example: “In addition to State licensure, ABC Healthcare Agency plans to apply for Medicare certification and Medicaid certification concurrently through an accrediting organization.”)

#### ◆ **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 agency 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**

- The individual who signs the application form must be either an officer or director of the applicant entity (if corporation), or one of the partners (if partnership). If the application is signed by an individual other than an officer, director, partner, or sole proprietor, then one of the officers, directors, partners, or sole proprietor, as listed in Item IV (D)(1) and IV (D) (2) of the application form, must give that individual written permission, in the form of a notarized affidavit, to sign on his her behalf. A copy of this written permission must be included with the application packet.