DEPARTMENT OF HEALTH
AND HOSPITALS

# Health Standards Section
# Change of Ownership
# HOME HEALTH

Federal and State regulations require that copies of all documents relating to the change of ownership be submitted along with a description of the change of ownership (lease, purchase of assets, etc.), the effective date and the name and address of the old owner and the new owner. The change of ownership **must be filed within five working days of the effective date** per state licensing standards. An agency with a provisional license may not undergo a change of ownership.

**The Home Health license is not transferable, therefore, another licensing application, licensing fee and documentation that the new ownership meets the qualifications set forth in the standards must be submitted.** The fee of $600.00 plus $300 per branch/satellite office must be in the form of a company check, certified check, or money order payable to the Department of Health and Hospitals. The new owner is responsible for notifying all other licensing authorities for which it may be licensed, of the change of ownership (i.e. CLIA).

**For participation in the Medicare program, all providers/suppliers must complete the CMS 855 form, Medicare Federal Health Care Provider/Supplier Application for Health Care Providers or Suppliers. The application must be obtained from the provider/supplier's chosen fiscal intermediary or carrier. The Centers for Medicare and Medicaid Services (CMS) website located @ http://www.cms.hhs.gov/MedicareProviderSupEnroll/, contains a list of FIs and carriers by state and specialty. The FI/Carrier will answer any inquiries concerning completion of the enrollment application.**

The forms applicable to the change of ownership are enclosed. Please note that if more than one copy of the same form is included, we must have these completed with original signatures.

**FORMS INCLUDED:**

| | |
|---|---|
| HSS-HH-01 (HH License Application) | (1) |
| CMS 1572 (omit items 7, 8, 21, & 23) | (1) |
| CMS 1561 | (2) |
| HSS-1513L | (1) |
| Office for Civil Rights Forms Memo | (1) |
| Agreement between HHA & DHH | (1) |

(The agreement must be signed by the provider's authorized representative and the attestation notarized.)

**In addition to the forms listed above you must include a bill of sale and articles of incorporation (certified copy).** If you have any questions, please contact the program manager at (225) 3426446.

At the direction of the Dallas Regional office of the CMS, the Louisiana State Agency will no longer be making recommendations or inquiring about provider-based designation status. Prospective providers and/or suppliers that have questions as to whether they meet the criteria for provider-based designation are instructed to contact: Patty Rawlings with the CMS at (214) 7674423.

**NOTE: If the new owner rejects assignment of the current Medicare Provider agreement, but intends to apply for Initial Certification with Medicare, an Initial Medicare Certification packet must be submitted.**



Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5292 • http://new.dhh.louisiana.gov/

DEPARTMENT OF HEALTH
AND HOSPITALS

# Health Standards Section
# License Application
# HOME HEALTH AGENCY

☐ *INITIAL* ☐ *RENEWAL* ☐ *OTHER* (Specify) _____

*LICENSE NUMBER* _____ *EXPIRATION DATE* _____

*TOTAL FEE AMOUNT INCLUDED* _____ *CHECK / MONEY ORDER #* _____

☐ check if any change has occurred since last application STATE ID #HH__ __ __ __ __ __ __ __

I. *FACILITY (DBA) NAME* _____

*GEOGRAPHICAL ADDRESS* _____

*CITY / STATE / ZIP* _____ *PARISH* _____

*TELEPHONE NUMBER* (____) _____ *FAX NUMBER* (____) _____ *EMAIL ADDRESS* _____

II. MAILING. ADDRESS *(IF DIFFERENT FROM ABOVE)* _____

*CITY / STATE / ZIP* _____ *PARISH* _____

III. *ADMINISTRATOR* _____ *DIRECTOR OF NURSING* _____

IV. TYPE OF OWNERSHIP:

| NON- PROFIT | FOR – PROFIT | GOVERNMENT |
|---|---|---|
| ☐ *INDIVIDUAL/SOLE PROPRIETOR* | ☐ *INDIVIDUAL/SOLE PROPRIETOR* | ☐ *FEDERAL* |
| ☐ *CORPORATION* | ☐ *CORPORATION* | ☐ *STATE* |
| ☐ *PARTNERSHIP* | ☐ *PARTNERSHIP* | ☐ *PARISH* |
| *(Specify):* _____ | ☐ *GROUP PRACTICE* | ☐ *CITY/PARISH* |
| ☐ *RELIGIOUS AFFILIATION* | ☐ *OTHER (Specify):* _____ | ☐ *CITY* |
| ☐ *UNINCORPORATED ASSOCIATION* | | ☐ *COMBINATION GOV-N-PROFIT* |
| ☐ *OTHER (Specify):* _____ | | ☐ *HOSPITAL DISTRICT* |
| | | ☐ *OTHER* |

V. *ENTITY / CORPORATION NAME* _____

*MAILING ADDRESS (IF DIFFERENT)* _____

*CITY / STATE / ZIP* _____

*TELEPHONE NUMBER* (____) _____ *FAX NUMBER* (____) _____ *EIN#* _____

**VI.** List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity *(ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).*

| OWNER NAME | ADDRESS | TELEPHONE # |
|---|---|---|
| | | |
| | | |



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Phone #: 225/342-0138 • Fax #: 225/342-0157 • http://new.dhh.louisiana.gov/

# HOME HEALTH AGENCY LICENSE APPLICATION

*VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.*

| NAME | ADDRESS | TELEPHONE NUMBER |
|---|---|---|
| | | |

*VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities?* ☐ *Yes* ☐ *No*
*(Proprietorship, Partnership or Board Member) If yes, list names, addresses of individuals and other provider numbers.*

| NAME | ADDRESS | PROVIDER NUMBER |
|---|---|---|
| | | |
| | | |

*IX. Has there been a change of ownership or control within the last year?* ☐ *Yes* ☐ *No*
*If yes, give date:* _____

*X. PROGRAM OPERATIONAL INFORMATION* (IF ADDITIONAL SPACE IS NEEDED PLEASE ATTACH SUPPLEMENTAL PAGE)

*NUMBER OF CURRENT ACTIVE PATIENTS* _____ *NUMBER OF LICENSED BEDS (If applicable)* _____

*NUMBER OF SATELLITE, BRANCH OR OFFSITE OFFICES (If applicable)* _____

*BRANCH / SATELLITE / OFFSITE OFFICES*

| BRANCH/SATELLITE/OFFSITE NAME | STREET ADDRESS | CITY/PARISH/ZIP | PHONE NUMBER | FAX NUMBER |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

☐ *check if any change has occurred since last application*

*XI. SERVICES PROVIDED*
*Place a "1" in the blank for services provided by Direct Staff. Place a "2" in the blank if services are provided under arrangement. NOTE: Administration, Skilled Nursing and one (1) other service must be provided directly by the agency at all times.*

_____ *SKILLED NURSING* _____ *APPLIANCE AND EQUIPMENT SERVICES* _____ *PHYSICAL THERAPY*

_____ *SPEECH THERAPY* _____ *PHARMACEUTICAL SERVICES* _____ *MEDICAL SOCIAL SERVICES*

_____ *OCCUPATIONAL THERAPY* _____ *VOCATIONAL SERVICES* _____ *HOME HEALTH AIDE*

_____ *NUTRITIONAL GUIDANCE* _____ *OTHER (Specify)*_____

*XII. HOURS OF OPERATION:* _____ *24 HOUR TELEPHONE NUMBER:* _____

*XIII. ACCREDITATION: (check all that apply):*

☐ *JCAHO* ☐ *CHAP* ☐ *Other (specify* _____ *)* *Status of Accreditation:* ☐ *Accredited* ☐ *Deemed*

*ATTESTATION: I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.*

_____
*AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)*

_____ _____
*AUTHORIZED REPRESENTATIVE SIGNATURE* *DATE*

FORM APPROVED
OMB NO. 0938-0355

# HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

1. Name of Facility:

11. Provider No.:

2. Street Address:

12. Type of Survey:

☐ Initial (G2) ☐ Resurvey (G3)

1 = Standard
2 = Partial Extended
3 = Extended
4 = 1 and 2
5 = 1 and 3
6 = 1, 2 and 3

3. City and/or County:

4. State:

5. Zip Code:

6. Telephone No. (G4)

7. State/County Code: (G5)

8. State/Region Code: (G6)

9. Name of Administrator:

13. Eligibility: (G7)

☐
1 = Medicare
2 = Medicaid
3 = Both

10. Discipline of Administrator: (G8)

☐
1 = RN/LPN
2 = Physician
3 = PT/OT
4 = Speech Path/Audiologist
5 = Medical/License Social Worker
6 = Pub Adm/MBA/ACCT
7 = Lawyer
8 = Proprietor
9 = Other

14. Has there been a change of ownership since last survey? (G9)

☐ Yes ☐ No

15. A. Is this home health agency also a Medicare certified hospice? (G10)

☐ Yes ☐ No

If yes, give the hospice Medicare provider number: (G11)

B. Does this home health agency operate sub-units? (G12)

☐ Yes ☐ No

If yes, how many: (G13)

C. Is this home health agency a sub-unit? (G14)

☐ Yes ☐ No

If yes, parent agency provider number: (G15)

D. Does this home health agency or sub-unit operate branch(es)? (G16)

☐ Yes ☐ No

If yes, how many: (G17)

If yes, give official name and mailing address of each branch (include street, state and zip code):

☐ If more space is needed, check here, use a separate page and attach.

16. Type of Agency: (G18)

☐
01 = VNA
02 = Combination Government Voluntary
03 = Official Health Agency
04 = Rehab based program*
05 = Hospital based program*
06 = Skilled Nursing Facility/Nursing Facility based program*
07 = Other

*If Medicare/Medicaid certified give the provider number: (G19)

17. Type of Control: (G20)

☐
**Voluntary Non-Profit**
01 = Religious Affiliation
02 = Private
03 = Other
**For Profit**
04 = Proprietary
**Government**
05 = State/County
06 = Combination Govt. and Voluntary
07 = Local Government

## HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

*(continued)*

18. Services Offered: (G21)

1 = Provided by Agency Staff
2 = Under Arrangement
3 = Combination

- [ ] 01 = Nursing Care
- [ ] 02 = Physical Therapy
- [ ] 03 = Occupational Therapy
- [ ] 04 = Speech Therapy
- [ ] 05 = Medical Social Worker
- [ ] 06 = Home Health Aide
- [ ] 07 = Intern/Resident
- [ ] 08 = Nutritional Guidance
- [ ] 09 = Pharmaceutical Services
- [ ] 10 = Appliance and Equipment Service
- [ ] 11 = Vocational Guidance
- [ ] 12 = Laboratory Services
- [ ] 13 = Other

19. Staffing (List full-time equivalent):

| | | |
|---|---|---|
| Registered Nurse (G22) | | |
| Licensed Practical Nurse (G23) | | |
| Physical Therapist (G24) | | |
| Occupational Therapist (G25) | | |
| Speech Pathologist/Audiologist (G26) | | |
| Social Worker (G27) | | |
| Home Health Aide (G28) | | |
| Pharmacist (G29) | | |
| Dietitian (G30) | | |
| All Others (G31) | | |

20. Home Health Agency provides directly: (G32)

- [ ] 1 = Home Health aide training program
- [ ] 2 = Home Health aide competency evaluation program
- [ ] 3 = Both
- [ ] 4 = Neither

21. Number records reviewed with home visits (G33)

Number records reviewed, no home visits (G34)

Number of home visits with no records review (G35)

Total records reviewed (G36)

Total home visits (G37)

22. Patient census since last standard survey:

**Admissions:**

(G38) _____ Unduplicated admissions

(G39) _____ Readmissions

**Discharges**

(G40) _____ Hospital discharges

(G41) _____ Nursing home discharges

(G42) _____ Goals met discharges

(G43) _____ Death discharges

(G44) _____ Total discharges

23. Surveyor summary: Based on the reviews of the patients from this home health agency including all information surveyed in the standard survey and using the Functional Assessment Instrument (FAI), this home health agency: (G45)

- [ ] 1. Provides care that promotes a high potential for reaching the highest attainable levels of functioning for its patients. There is no evidence of need for a partial extended or extended survey.

- [ ] 2. Provides care that promotes a moderate potential for reaching the highest level of functioning for some but not all of its patients. There are standard level deficiencies and need for a partial extended survey. If no conditions are out of compliance, a Plan of Correction will be requested for the standard level deficiencies.

- [ ] 3. Provides substandard care. There are condition level deficiencies in one or more Conditions of Participation. There is an immediate need for an extended survey.

FORM APPROVED
OMB No. 0938-0832

# HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

## AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act, _____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

| TITLE | DATE |
|---|---|
| | |

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

| TITLE | DATE |
|---|---|
| | |

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

| TITLE | DATE |
|---|---|
| | |

Louisiana Department of Health and Hospitals
Health Standards Section

# Disclosure of Ownership & Controlling Interest Statement

**I. Identifying Information**

| | |
|---|---|
| Legal Entity/Corp. Name: | |
| D/B/A Name: | |
| Employer ID Number (EIN): | |
| Street Address: | |
| City: | State : |
| Parish/County: | Zip Code: |
| Phone Number: | Email : |

**II. (a)** List names, addresses and phone numbers for persons or group of persons, or the Employer Identification Number (EIN) for organizations having direct or indirect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity.

| Name | Address | EIN # |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**II. (b) Type of Entity:**

| For-Profit Entity | Non-Profit Entity | Government Entity |
|---|---|---|
| ☐ Individual/Sole Proprietorship | ☐ Individual/Sole Proprietorship | ☐ Federal |
| ☐ Corporation | ☐ Corporation | ☐ State |
| ☐ Partnership | ☐ Partnership | ☐ Parish |
| ☐ Group Practice | ☐ Religious Affiliate | ☐ City/Parish |
| ☐ Religious Affiliate | ☐ Unincorporated Association | ☐ City |
| ☐ Unincorporated Association | ☐ Limited Liability Corporation | ☐ Hospital District |
| ☐ Limited Liability Corporation | ☐ Other : | ☐ Combination Gov/Non-Profit |
| ☐ Other : | | ☐ Human Services District |
| | | ☐ Other : |

**II. (c) If the disclosing entity is a corporation, list names, addresses, and phone numbers of the Directors and attach.**

**II. (d) Are any owners of the disclosing entity also owners of other licensed health care facilities?** ☐ **Yes** ☐ **No**
**(proprietorship, partnership, or Board Members). If yes, list names, addresses, and phone numbers of individuals and facility provider numbers.**

| Name | Address | Provider Number |
|---|---|---|
| | | |
| | | |
| | | |

**III. Has there been a change in ownership or control within the last year?**

| | |
|---|---|
| ☐ **NO** change of ownership. | ☐ **YES**, ownership has changed. **Date** of Ownership Change: |

**WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS, IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE LOUISIANA STATE AGENCY**

| | |
|---|---|
| **Print Name and Title of Authorized Representative:** | |
| **Signature:** | **Date:** |
| **Notes/Remarks:** | |



Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
*Phone #: 225/342-0138 • Fax #: 225/342-5073 • http://dhh.louisiana.gov/*

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

# CHECKLIST FOR
# HOME HEALTH APPLICATION &/ OR CHANGE OF OWNERSHIP ( CHOW )

___ $600 Licensing Fee ( plus $300 for each branch location )

___ Home Health License Application

___ *Form CMS-1572 Home Health Agency Survey & Deficiencies Report

___ *Form CMS-1561 Health Insurance Benefit Agreement (three with original signatures- for a Change of ownership, sign in the 3rd section as the successor)

___ Fiscal Year End Date Form

___ Agreement with HHA & DHH (3rd page must be signed by authorized representative)

___ Qualifications for Administrator & Director of Nursing

___ Line of Credit ( $75,000) from a federally insured lending agency

___ Proof of Insurance (General & Professional including worker's compensation ) DHH must be listed as certificate holder-must be in the amount of $300,000

___ Criminal Background Check ( on all owners & the administrator-if a corporation, include the Board of directors & principal owners)

___ Proof of Citizenship ( on all owners & administrative personnel )

___ Form 1513-L Disclosure of Ownership & Control Interest Statement

___ Articles of Incorporation

___ CHOW-in addition to the above information; submit a copy of the Bill of sale .

___ OCR forms ( Office of Civil Rights)

*Only required if requesting Initial Medicare Certification or a CHOW of a Medicare Certified Agency.

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF HEALTH SERVICES FINANCING • HEALTH STANDARDS SECTION
500 LAUREL ST. - FIRST FLOOR (70801) • P.O. BOX 3767 • BATON ROUGE, LOUISIANA 70821-3767
PHONE • VOICE (225) 342-0138 • FAX (225) 342-5292

# CRIMINAL HISTORY CHECKS

## Nursing Homes, Intermediate Care Facilities for Developmentally Disabled, Home Health Agencies, Hospices, and Ambulance services (Emergency Medical Transportation)

In accordance with Louisiana Revised Statute 40:1300.51 through 40:1300.56, prior to any employer making an offer to employ or to contract with a non-licensed person or any licensed ambulance personnel to provide nursing care, health-related services, medic services or supportive assistance to any individual, the employer shall request a criminal history check be conducted on the non-licensed person or any licensed ambulance personnel. The office of State Police or authorized agency, as defined in LA R.S.40:1300.51, will perform criminal history checks on non-licensed personnel of health care facilities and licensed ambulance personnel. The employer shall provide the office or authorized agency any relevant information and fee required to conduct the criminal history check. It is the responsibility of your facility/agency to contact the office of State Police to obtain the required forms and fee information.

**For further information regarding criminal history checks, please contact the Office of State Police – Criminal Records Applicant Section at (225)925-1886.**

*(revised 05/07/2010; 01/2012; 02/2012)*

DEPARTMENT OF HEALTH
AND HOSPITALS

**HEALTH STANDARDS SECTION**

**Fiscal Year End Date**

In order to be assured that your Fiscal Year End Date is currently and correctly recorded, please complete the information in the space provided below. Be sure to sign this form and return it along with any other requested documents.

Name of Provider: _____

Address: _____

_____

_____

_____

_____
Fiscal Year Ending Date

_____
Signature

*HSS-ALL-21 (revised 07/24/09; 8/11; 02/12)*

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DEPARTMENT OF HEALTH AND HOSPITALS

**Health Standards Section**

# KEY PERSONNEL CHANGE FORM

**Please do not submit personnel's SSN or professional license number**

| **Agency Name:** | **Provider License #:** |
|---|---|
| **Address:**<br>**City, State, Zip:** | **Provider CMS ID if applies#:** |
| **Telephone Number:**<br>**Fax :** | **Email Address:** |

**Circle the Position that is changing:** Director of Nurses Alternate Director of Nurses Administrator Alternate Administrator Director Other:_____

**Previous employee in this position:** _____

**Proposed employee for this position:** _____

**Date of the proposed change:** ____/____/____

## EDUCATIONAL QUALIFICATIONS OF EMPLOYEE

| COLLEGE/SCHOOL | GRADUATION DATES | DEGREE OBTAINED |
|---|---|---|
| | | |
| | | |
| | | |

**Current LA Licensure Verification Date:** ____/____/____

## EMPLOYMENT HISTORY

This section may not apply to all providers; Please refer to the licensing standards for your program and submit information as required. *DON of Psych Hospital - a copy of the employee resume and CEUs are required with this form.

| Start Date | End Date | Facility Name Address | List of job duties performed & Number of personnel supervised |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Signature/Title of person verifying the above information:** _____

## DO NOT WRITE BELOW THIS LINE (FOR STATE OFFICE USE ONLY)

**Position:** _____ **Approved ( ) Disapproved ( )**

**Remarks:** _____

_____

**Signature/Title:** _____ **Date:** ____/____/____



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DEPARTMENT OF HEALTH
AND HOSPITALS

**HEALTH STANDARDS SECTION**

**Office of Civil Rights Forms**

# Instructions

Required Office of Civil Rights (OCR) information must be completed and submitted with each Change of Ownership (CHOW) and/or Initial Provider Certification Packet. This provider completed information is needed by the OCR to process clearance for the facilities undergoing CHOWS and Initial Certification. The role of this agency (Health Standards Section of the Louisiana Department of Health and Hospitals) is limited to verifying submission via portal **OR** collecting and forwarding the printed civil rights data to the Center for Medicare and Medicaid Services (CMS), who will then forward to the OCR. The OCR Civil Rights Information Request for Medicare Certification Form (OMB No. 0990-0243), and the Form HHS-690 for Assurance of Compliance are included as a part of the state agency packet.
Alternatively you may choose to complete the information via the OCR Portal using the web site to enter and complete the process.

Information required by OCR must be submitted. Guidance regarding each method of completion can be accessed using the following website:

http://www.hhs.gov/ocr/civilrights/clearance/index.html

Carefully read the information on this website regarding Civil Rights Certification for Medicare Provider Applicants (that is located on the above website) for a complete listing of instructions and for the documents required for submission by OCR.

Any questions concerning the forms must be directed to the regional HHS Office for Civil Rights http://www.hhs.gov/ocr/office/faq/ .

Please be aware that completed CHOW or Initial Certification packets will not be forwarded to the CMS for processing until all completed OCR forms or e-mail verification from OCR have been submitted to this agency.



628 N. Fourth Street• Baton Rouge, Louisiana 70802 • P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 • *WWW.DHH.LA.GOV*
"An Equal Opportunity Employer"

Form Approved
OMB No. 0945-0006
Exp. Date 04/30/2017

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office for Civil Rights (OCR)

# Civil Rights Information Request For Medicare Certification

**Instructions:** Healthcare providers applying for participation in the Medicare Part A program must receive a civil rights clearance from OCR. Complete all fields and return this form, with the required policies and procedures, to your State Health Department, along with your other Medicare application materials.

## I. Healthcare Provider Information

CMS Medicare Provider Number: _____

Name of Facility: _____

Address: _____
*Street Number and Name*

_____
*City or Town* *State or Province* *Zip Code*

Administrator's Name: _____ Contact Person: _____

Telephone: _____ TDD: _____

FAX: _____ E-mail: _____

Type of Facility: _____ Number of employees: _____

Reason for Application: Circle One

Corporate Affiliation: _____ Initial Certification or Change of Ownership

**You can complete this form and submit your policies electronically via the OCR Portal at** https://ocrportal.hhs.gov/ocr/pgportal/index.jsf.

*(Please note, if using the electronic Civil Rights Information Request for Medicare Certification Package via the Portal, you do not have to submit any hard copies. Your State Health Department will be informed that you have completed this Package and submitted it to OCR. No further action will be needed by you. The Portal will guide you through completing the Package, and help you develop and submit your policies that meet your civil rights requirements.)*

## II. Documents Required for Submission

For guidance or to obtain sample policies and procedures, please visit the OCR Technical Assistance for Medicare Providers and Applicants web page at http://www.hhs.gov/ocr/civilrights/clearance/index.html. *(When submitting hard copies to your State Health Department.)*

| | |
|---|---|
| 1. | **Assurance of Compliance Form,** HHS-690 *(completed, signed and dated).* |
| 2. | **Nondiscrimination Policy that provides for admission and services without regard to race, color, national origin, disability, or age, as required by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.** (Click to see sample policy) Learn more about the regulatory requirements |
| 3. | **Description of methods used to disseminate your nondiscrimination policies/notices:**<br>**a) Describe where you post your Nondiscrimination Policy;**<br>**b) Include brochures, websites, pamphlets, postings, or ads with general information about your services.** |
| 4. | **Facility admissions policy that describes eligibility requirements for your services.** |
| 5. | **A description/explanation of any policies or practices restricting or limiting your facility's admissions or services on the basis of age. In certain narrowly defined circumstances, age restrictions are permitted.**<br>Learn more about the regulatory requirements |
| 6 | **For healthcare providers with 15 or more employees: copy of your procedures used for handling disability discrimination grievances along with the name/title and telephone number of the Section 504 coordinator.**<br>(Click to see sample policy) Learn more about the regulatory requirements |

Form Approved
OMB No. 0945-0006
Exp. Date 04/30/2017

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office for Civil Rights (OCR)

# Civil Rights Information Request For Medicare Certification

| **II. Documents Required for Submission** *(Continued)* | |
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| For guidance or to obtain sample policies and procedures, please visit the OCR Technical Assistance for Medicare Providers and Applicants web page at http://www.hhs.gov/ocr/civilrights/clearance/index.html. *(When submitting hard copies to your State Health Department.)* | |
| 7. | **Procedures to effectively communicate with persons who are limited English proficient (LEP), including:**<br>**a) Process for how you identify individuals who need language assistance;**<br>**b) Procedures to provide services (interpreters, written translations, bilingual staff, etc.). Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);**<br>**c) Methods to inform LEP persons that language assistance services are available at no cost to the person being served;**<br>**d) Appropriate restrictions on the use of family and friends as LEP interpreters;**<br>**e) A list of all written materials in other languages, if applicable. Examples may include consent and complaint forms, intake forms, written notices of eligibility criteria, nondiscrimination notices, etc.** (Click to see sample policy) Learn more about the regulatory requirements |
| 8. | **Procedures used to communicate effectively with individuals who are deaf, hard of hearing, blind, have low vision, or who have other impaired sensory, manual or speaking skills, including:**<br>**a) Process to identify individuals who need sign language interpreters or other assistive services;**<br>**b) Procedures to provide interpreters and other auxiliary aids and services. Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);**<br>**c) Procedures used to communicate with deaf or hard of hearing persons over the telephone, including the telephone number of your TTY/TDD or State Relay System;**<br>**d) A list of available auxiliary aids and services;**<br>**e) Methods to inform persons that interpreter or other assistive services are available at no cost to the person being served;**<br>**f) Appropriate restrictions on the use of family and friends as sign language interpreters.** (Click to see sample policy) Learn more about the regulatory requirements |
| 9. | **Notice of Program Accessibility and methods used to disseminate information to patients/clients about the existence and location of services and facilities that are accessible to persons with disabilities.** (Click to see sample policy) Learn more about the regulatory requirements |

**III. Certification**

I certify that the information provided to the Office for Civil Rights is true, complete, and correct to the best of my knowledge.

| Name and Title of Authorized Official | Signature | Date |
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# ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. **Title VI of the Civil Rights Act of 1964** (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. **Section 504 of the Rehabilitation Act of 1973** (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. **Title IX of the Education Amendments of 1972** (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. **The Age Discrimination Act of 1975** (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

Date

Signature of Authorized Official

Name and Title of Authorized Official (please print or type)

Please mail form to:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201

Name of Healthcare Facility Receiving/Requesting Funding

Street Address

City, State, Zip Code

Form HHS-690
3/2011

## AGREEMENT BETWEEN HHA AND DHH

This agreement is entered into by and between:

The **STATE OF LOUISIANA,** by through the Department of Health and Hospitals, Health Standards Section, hereinafter referred to as the Agency,

**AND**

_____

d/b/a _____

located at _____

hereinafter referred to as the Provider.

**THE PROVIDER AGREES:**

To provide only necessary home health services to ill, disabled, or infirmed persons in their homes.

To meet or exceed the requirements of the Minimum Standards in the provisions of services.

To provide services in compliance with the Civil Rights information and agreement.

To serve the elderly population and to protect that population from neglect, abuse, extortion, harassment, and solicitation.

To remain fully operational and in compliance with Minimum Standards, as well as all federal, state, and local laws at all times.

To allow each recipient free choice of agencies.

To accept patients only as referred by a physician or his authorized agent.
To provide home health services only to those persons who qualify for the criteria of their own payor source and only in the home.

To operate the above agency in a cost-effective manner and to contain costs to the payor source whenever possible.

To avoid over-utilization of services being paid by payor source, and to notify payor source within ten (10) days of discovery of any billing errors.

To inform patient or their guardian of all charges being billed to their payor source.

To maintain necessary communication with the patient's attending physician and to submit to him/her a written summary at least every 60 days.

To immediately notify the patient's attending physician and responsible party of any emergency involving the patient.

**THE AGENCY AGREES:**

To act as fairly and impartially as possible to maintain the highest quality of care to all patients being treated in their home.

To notify the agency of any violations and to allow agency to take corrective action unless the agency has intentionally violated the standards.

**THE AGENCY AND THE PROVIDER MUTUALLY AGREE:**

That this contract shall be valid for one (1) year and may be renewed and extended by the Agency provided compliance is maintained by the provider with licensing standards for Home Health Agencies and all other rules and regulations.

That this agreement shall not be transferable.

That breach or violation of any provision of this agreement shall make this entire contract subject to immediate cancellation.

The effective date of this agreement shall be _____
DATE

_____
NAME OF HOME HEALTH AGENCY

_____
ADDRESS OF HOME HEALTH AGENCY

_____
AUTHORIZED REPRESENTATIVE NAME
(typed or printed)

_____
AUTHORIZED REPRESENTATIVE SIGNATURE

_____
Cecile Castello, RN
DIRECTOR, HEALTH STANDARDS SECTION