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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-01710 (12/2016) | **STATE OF WISCONSIN**Page 1 of 2 |
| **HOME HEALTH AGENCY INITIAL LICENSURE CHECKLIST** |
| All information in this checklist, *except the CMS-855 form which should be sent to your MAC*, should be sent to:Department of Health ServicesDQA / BHSATTN: Home Health Agency LicensurePO Box 2969Madison WI 53701-2969 |
| **GENERAL HHA APPLICATION REQUIREMENTS** |
| [ ]  | Letter of intent / detailed statement of proposed home health agency (HHA) on business letterhead |
| [ ]  | *Home Health Agency License Application* (DQA form F-62674), completed in its entirety*Incomplete applications will not be considered.* |
| [ ]  | HHA application fee ($300 non-refundable) |
| [ ]  | Entity Caregiver Background Checks (CBC) + $10 per individual (See: <https://www.dhs.wisconsin.gov/caregiver/enitity.htm>)*A CBC must be completed for each owner, administrator, substitute administrator, and other required individuals as described on the CBC webpage. A background check completed via any other means does not satisfy this requirement.* |
| [ ]  | Business plan and operational by-laws of the agency |
| [ ]  | HHA Administrator — Copy of resume and professional license (if applicable) |
| [ ]  | HHA Substitute Administrator — Copy of resume and professional license (if applicable) |
| [ ]  | Nurse Supervisor — Copy of resume and professional license |
| [ ]  | Job descriptions for all of staff that the agency will employ (administrator, RN supervisor, registered nurses, personal care workers, physical therapists, etc.) |
| [ ]  | Copies of any contracts for services that will be contracted |
| [ ]  | Copies of agency policies and procedures:  *All procedures and materials as indicated in the Home Health Agency Prelicensure Desk Review Checklist (DQA form F-62536) must be provided.* |
| [ ]  | Type of organization: *As indicated in the application, provide documentation (Corporation* — *copy of Articles of Incorporation, LLC - copy of articles of organization and operation agreement, LLP* — *copy of partnership agreement).* |
| [ ]  | Interested parties / other providers *(Refer to application.)* |
| [ ]  | Subsidiary / parent company information / chain organization information provided *(Refer to application.)* |
| [ ]  | Organizational chart *(Identify any other entities or the parent company related to the applicant.)* |
| [ ]  | If the applicant has health care facilities in other states, a statement from each state’s licensing agency verifying each facility’s current licensure and certification status |
| [ ]  | Fit and Qualified: Review application and provide supporting documentation if required. |
| [ ]  | Financial Reference — Organization must provide: |
|  | [ ]  | Financial reference(s) from financial institution(s) |
|  | [ ]  | A proposed operating budget for the first 90 days of operation*A “Model Balance Sheet” (DQA form F-62674A) is enclosed to assist with this budget development.* |
|  | [ ]  | Proof of ability to provide 90 days’ worth of finances for operations which may include the following documentation: |
|  |  | [ ]  | Bank statements for checking / savings accounts |
|  |  | [ ]  | Evidence verifying stock / bond / certificate of deposit ownership |
|  |  | [ ]  | Verification of outside employment and salary |
|  |  | [ ]  | Verification of income from another business |
|  |  | [ ]  | Credit reports |
| [ ]  | Copy of Internal Revenue Service (IRS) Employer Identification Number (EIN) document |
| [ ]  | Notify Wisconsin Medicaid (Forward Health) to begin the Medicaid certification process. |
| [ ]  | “Contact Person” and “Attestation” sections are completed on the HHA Licensure Application on page 10, signed, and dated. |
| **MEDICARE CERTIFICATION** |
| **If your agency seeks Medicare certification, the following federal documents are required and must be requested from the state agency when you are ready to begin that process. The Medicare certification process does not begin until an agency has successfully passed an unannounced state licensure survey and is granted a regular non-expiring state license.** |
| [ ]  | CMS-855, *Medicare Enrollment Application**Contact your Medicare Administrative Contractor (MAC); MAC will send documentation to state agency and hospital upon approval.* |
| [ ]  | CMS-1572, *HHA Survey and Deficiencies Report* (from the Medicare certification survey) |
| [ ]  | CMS 1561, *Health Insurance Benefits Agreements* — two original signed copies |
| [ ]  | HHS-690, *Office of Civil Rights (OCR) Assurance of Compliance* — two original signed copies |
| [ ]  | OCR Document — one original signed copy |
| [ ]  | Accreditation Organization (AO) — *Specify:*  |