# Rules of
# Department of Health
## Division 30—Division of Health Standards and Licensure
## Chapter 26—Home Health Agencies

**Title** **Page**

**19 CSR 30-26.010** Home Health Licensure Rule ..............................................................3

**Title 19—DEPARTMENT OF HEALTH**
**Division 30—Division of Health Standards and Licensure**
**Chapter 26—Home Health Agencies**

**19 CSR 30-26.010 Home Health Licensure Rule**

*PURPOSE: This rule defines the minimum requirements for the provision of home health services by state licensed home health programs.*

*PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.*

(1) State Licensure Requirements.

(A) In all Missouri licensed home health agencies which only provide physical therapy and/or speech therapy and/or occupational therapy and/or medical social work services and which do not have Medicare certification as a provider, the agency shall—

1. Not be required to provide skilled nursing services; and

2. Provide the initial evaluation visit be made by a physician, registered nurse, physical therapist or speech therapist.

(B) In all Missouri licensed home health agencies which only provide physical therapy and/or speech therapy and/or occupational therapy and/or medical social work services and which do not have Medicare certification as a provider, the professional staff shall—

1. Be supervised by a physician, registered nurse, physical therapist or speech therapist;

2. Include all client medications and changes in client medications on the plan of care or plan of treatment to be reviewed by the physician; and

3. Include all client diet information and changes in client diet information on the plan of care or plan of treatment to be reviewed by the physician.

(C) Except as specifically provided above, this rule incorporates by reference 42 CFR 484, *Medicare Conditions of Participation: Home Health Agencies,* for Missouri licensed home health agencies. Missouri licensed home health agencies shall strictly meet the currently applicable *Medicare Conditions of Participation* and surveys performed for state licensure will be conducted per Medicare standards.

(2) State Licensure Management.

(A) All licensed home health agencies shall be licensed and shall conduct all their business in their legal name or in their doing business as (d/b/a) name as properly registered with the secretary of state.

(B) Initial Application Procedure for Home Health Agencies.

1. Upon initial request the Department of Health (DOH) will determine which type of entity the applicant is requesting application for and mail the appropriate licensure application packet.

2. The applicant shall provide the DOH with a completed application for home health license, copy of registration with secretary of state and sufficient evidence that the home health agency has established appropriate policies and procedures for providing home health services according to sections 197.400 to 197.477, RSMo. The licensure fee must accompany the application and is nonrefundable. An on-site licensure survey will be conducted prior to issuing a license.

A. An out-of-state home health agency wishing to see Missouri residents must make an application for licensure to the Department of Health (DOH) and establish a branch office in Missouri. The completed application must be submitted with the license fee. A copy of their home health agency license in their home state, a copy (if Medicare certified) of their history with Medicare which can be supplied as a letter or copy of previous certification survey, notification of home state licensure agency of expansion into Missouri and proof of registration with secretary of state in all applicable states. The area served in Missouri by a bordering state agency must be contiguous to the area served by the agency in the bordering state.

(C) Annual Renewal Process.

1. A license shall be renewed annually upon approval of the department when the following conditions have been met:

A. The application for renewal is accompanied by a six hundred dollar ($600) nonrefundable license fee;

B. The home health agency is in compliance with the requirements established under the provisions of sections 197.400 to 197.477, RSMo as evidenced by a survey inspection by the department. In lieu of department survey, such survey as provided in section 197.415.4, RSMo; and

C. The application is accompanied by a statement of any changes in the information previously filed with the department under section 497.410, RSMo and the effective date for that change from the information previously filed.

D. Proof of registration with secretary of state's office in Missouri.

2. The agency shall submit the Application for Home Health Agency License and licensure fee prior to the license expiration date. If the license fee is not paid by the expiration date the department may begin the revocation process.

(D) Change of Ownership. A license shall not be transferable or assignable.

1. When a home health agency is sold or ownership or management is transferred, or the corporate legal organization status is substantially changed, the license of the agency shall be voided and new license obtained.

2. The owner shall apply for a new license at least ninety (90) calendar days prior to the effective date of sale, transfer, or change in corporate status.

3. The department may issue a temporary operating permit for the continuation of the operation of the home health agency for a period of not more than ninety (90) days pending the survey inspection and the final disposition of the application.

(E) Inspection Process.

1. The home health agency management shall allow representatives of the Department of Health (DOH) to survey the home health agency to determine eligibility for licensing and/or renewal of license. On-site surveys may be unannounced.

2. A branch office of an out-of-state agency shall be subject to an unannounced on-site licensure survey.

3. After completion of each department survey, a written report of the findings with respect to compliance or noncompliance with the provisions of sections 197.400 to 197.477, RSMo and the standards established thereunder as well as a list of deficiencies found shall be prepared.

A. A copy of the deficiency list shall be sent to the home health agency within fifteen (15) business days following the survey inspection.

B. The agency management or designee shall have ten (10) calendar days following receipt of the written survey report to provide the DOH with a written plan for correcting the cited deficiencies.

C. Upon receipt of the required plan of correction for achieving license compliance, the DOH shall review the plan to determine the appropriateness of the corrective action and respond to the agency. If the plan is not acceptable, the DOH shall notify the

management or designee and indicate the reasons why the plan was not acceptable. A revised plan of correction shall be provided to the DOH.

D. If an agency does not acknowledge the deficiencies the agency must, within ten (10) calendar days, request in writing a resurvey by the DOH. If, after the resurvey, the home health agency still does not agree with the findings of the department, it may seek a review of the findings of the department by the Administrative Hearing Commission. A copy of the letter requesting the review must be sent to the DOH.

E. Upon expiration of the completion date for correction of deficiencies specified in the approved plan of correction, the DOH shall determine if the required corrective measures have been acceptably accomplished. The DOH shall document that the corrective action has been satisfactorily completed. If the DOH finds the home health agency still fails to comply with sections of 197.400 to 197.477, RSMo, the DOH may rewrite the deficiencies and request another plan of correction or may take action to suspend or revoke the license.

(F) Refusal to Issue/Suspension/Revocation of License. The department shall refuse to issue or shall suspend or shall revoke the license of any home health agency for failure to comply with any provision of sections 197.400 to 197.477, RSMo or with any rule or standard of the department adopted under the provisions of sections 197.400 to 197.477, RSMo or for obtaining the license by means of fraud, misrepresentation, or concealment of material facts.

1. Any home health agency which has been refused a license or which has had its license revoked or suspended by the department may seek a review of the department's action by the Administrative Hearing Commission. A copy of the letter requesting the review must be sent to the DOH.

2. The Department of Health will not consider application for home health licensure for a period of six (6) months after revocation or denial of the agency's license.

(G) Voluntary Termination.

1. To voluntarily terminate a home health agency license, the agency must submit to the DOH, in writing, on agency letterhead the following information:

A. A request for termination of their state license (include license number);

B. State the effective date of termination;

C. State disposition of active caseload; and

D. Location of medical record storage.

2. The agency must enclose the original voided license with the voluntary termination letter.

(H) Complaint Procedure. The DOH may accept complaints by phone or in writing.

1. Any person wishing to make a complaint against a home health agency licensed under the provisions of sections 197.400 to 197.477, RSMo may file the complaint in writing with the department setting forth the details and facts supporting the complaints.

2. The DOH may also accept complaints regarding a licensed home health agency by phone and may document that the complaint was received.

3. The nature of the complaint will determine if an investigation is appropriate or if referral of the complaint to another agency is needed.

4. An on-site visit may be made by a DOH representative and deficiencies may be written.

5. The process for documentation of complaints will be determined by the DOH.

6. The agency must comply with paragraph (2)(E)3. in response to deficiencies written as a result of a complaint investigation.

*AUTHORITY: section 197.445, RSMo 1997.* Original rule filed Aug. 17, 1998, effective Jan. 30, 1999.*

**Original authority RSMo 1983, amended 1993, 1995, 1997.*

MISSOURI DEPARTMENT OF HEALTH
BUREAU OF HOME HEALTH LICENSING AND CERTIFICATION

# APPLICATION FOR HOME HEALTH AGENCY LICENSE

In accordance with the requirements of the Missouri Home Health Agency Licensing Law (Chapter 197, RSMo Cumulative Supp. 1983) Regulations and Codes, application is hereby made for a license to conduct and maintain a Home Health Agency (See Missouri Home Health Agency Licensing Law "Definitions", Section 197.400.)

**THIS INFORMATION, WITHOUT FURTHER VERIFICATION, WILL BE PROVIDED TO BOTH MEDICARE AND MEDICAID OFFICES AND TO UPDATE THE STATE HOME HEALTH DIRECTORY.**

| NAME OF AGENCY | TELEPHONE NO. |
|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP) | COUNTY |
| HOME HEALTH AGENCY ADMINISTRATOR | SUPERVISORY NURSE |

**OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)**

GOVERNMENTAL
- ☐ COUNTY
- ☐ CITY-COUNTY
- ☐ CITY
- ☐ DISTRICT

NON-GOVERNMENTAL

NON-PROFIT
- ☐ CORPORATION
- ☐ OTHER (EXPLAIN) ____________

PROPRIETARY
- ☐ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ CORPORATION

☐ FREESTANDING AGENCY ☐ HOSPITAL-BASED AGENCY ☐ SNF/ICF BASED AGENCY ☐ REHABILITATION FACILITY-BASED AGENCY

CHIEF OFFICER OF GOVERNING BODY

LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

**GEOGRAPHIC AREA COVERED BY AGENCY OPERATION**

LIST COUNTY(IES).

**PROFESSIONAL SERVICES**

Place a "1" in the block for each service provided by AGENCY STAFF or by contract with an individual. If services are provided UNDER ARRANGEMENT with another agency, place a "2" in the block.

- ☐ NURSING CARE
- ☐ PHYSICAL THERAPY
- ☐ OCCUPATIONAL THERAPY
- ☐ SPEECH THERAPY
- ☐ MEDICAL SOCIAL SERVICES
- ☐ HOME HEALTH AIDE SERVICE
- ☐ OTHER (SPECIFY) ____________

ADDING SERVICE(IES)? LIST.

EFFECTIVE DATE ____________

DELETING SERVICE(IES)? LIST.

EFFECTIVE DATE ____________

Number of Employees on the Agency Staff (Full-Time Equivalents). If service is provided by non-employees enter "BY MANAGEMENT."

| A. REGISTERED PROFESSIONAL NURSES | C. QUALIFIED PHYSICAL THERAPISTS | E. QUALIFIED SPEECH PATHOLOGIST OR AUDIOLOGIST | |
|---|---|---|---|
| B. LPN/LICENSED VOCATIONAL NURSES | D. QUALIFIED OCCUPATIONAL THERAPISTS | F. HOME HEALTH AIDES | G. ALL OTHERS |

MO 580-0437 (8-96) HHA-10

**BRANCH LOCATIONS** (Identify each approved branch location. All branches must operate under the parent name.)

*Address:* ______________________
______________________
______________________
Telephone No. ______________________
Supervising Nurse: ______________________

*Address:* ______________________
______________________
______________________
Telephone No. ______________________
Supervising Nurse: ______________________

*Address:* ______________________
______________________
______________________
Telephone No. ______________________
Supervising Nurse: ______________________

*Address:* ______________________
______________________
______________________
Telephone No. ______________________
Supervising Nurse: ______________________

*Address:* ______________________
______________________
______________________
Telephone No. ______________________
Supervising Nurse: ______________________

*Address:* ______________________
______________________
______________________
Telephone No. ______________________
Supervising Nurse: ______________________

**CERTIFICATION**

______________________________________ and ______________________
PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP — HOME HEALTH AGENCY ADMINISTRATOR

being duly sworn by me on their oath, deposes and says that they have read the foregoing application and that the statements contained therein are correct and true and of their knowledge; and further gives assurance of the ability

and intention of the ______________________________ Home Health Agency to comply with the
EXACT LEGAL NAME

regulations promulgated under the Missouri Home Health Agency Licensing Law (Chapter 197; RsMo. Cumulative 1983).

It is further certified that the ______________________________ will comply with all recommendations
NAME OF AGENCY

for correction and/or improvements as contained in the most recent Licensing Survey Report prepared by the Department of Health and submitted to said Home Health Agency.

**SIGNATURES**

PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP

HOME HEALTH AGENCY ADMINISTRATOR

MO 580-0417 (8-96)

MISSOURI DEPARTMENT OF HEALTH — BUREAU OF HOME HEALTH AND HOSPICE STANDARDS

## STATE DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

| Name of Entity | D/B/A | Provider No. | Telephone No. |
|---|---|---|---|
| | | | |

| Street Address | City, State, County | Zip Code |
|---|---|---|
| | | |

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX? ☐ Yes ☐ No

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX? ☐ Yes ☐ No

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. List any additional names and addresses under "Remarks". If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

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

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

(d) Are any owners of the disclosing entity also owners of other facilites? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers. ☐ Yes ☐ No

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

IV. (a) Has there been a change in ownership or control within the last year? ☐ Yes ☐ No
If yes, give date ____________

(b) Do you anticipate any change of ownership or control within the year? ☐ Yes ☐ No
If yes, give date ____________

(c) Do you anticipate filing for bankruptcy within the year? ☐ Yes ☐ No
If yes, give date ____________

V. Is this facility operated by a management company, or leased in whole or part by another organizations? ☐ Yes ☐ No
If yes, give date of change in operations ____________

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? ☐ Yes ☐ No

VII. (a) Is this facility chain affiliated? (if yes, list name, address of Corporation, and EIN) ☐ Yes ☐ No

Name EIN#

Address

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 STATE AGENCY, OR SECRETARY, AS APPROPRIATE.

| Name of Authorized Representative (Typed) | Title |
|---|---|
| | |

| Signature | Date |
|---|---|
| | |

Remarks

MO 580-2145 (8-96) HHA-30