Home Health Agency (HHA) – Providing Services Across State Lines

Complete all the following information.

Health Facility Identification Number (HFID): _____

CMS Certification Number (CCN): _____

Previous Doing Business As (DBA) name: _____

New Doing Business As (DBA) name: _____

HHA address: _____

Effective date: _____

Name of State to provide services on an interstate basis: _____

Explain how you meet applicable state licensure, personnel licensure and other state requirements from the respective state (State Operations Manual (SOM), chapter 2, section 2184): _____

_____

_____

_____

_____

_____

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Next Steps for HHA

- Email form to health.hrd-fedlcr@state.mn.us.
- If deemed status, notify the accrediting organization.

MDH and the state agency involved must have a written reciprocity agreement permitting the HHA to provide services in this manner.

Affirmation

☐ I certify that the information provided on this form is accurate and complete.

Signature of Administrator/Authorized Agent: _____

Name (print or type): _____

Title: _____

Date: _____

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4200
Health.HRD-FedLCR@state.mn.us

07/17/2026

If you have questions, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.