DEPARTMENT OF HEALTH

Home Health Agency (HHA) – Adding or Changing a Service Area

Complete all the following information.

Health Facility Identification Number (HFID): _____

CMS Certification Number (CCN): _____

HHA parent Doing Business As (DBA) name: _____

HHA parent address: _____

Branch office(s), if applicable: _____

Counties in current service area: _____

Proposed counties to add to the service area: _____

Effective date of change: _____

Please submit the following:

1. **Service Area Map**
   - Using the blank Minnesota county map provided, outline the total proposed service area by county. Note: The geographic area must be contiguous (State Operations Manual (SOM), chapter 2, section 2180).
   - Clearly indicate which counties will be served by the parent HHA and which, if applicable, will be served by a branch office.

2. **Distance Calculations**
   - Calculate the driving distance between the HHA parent office and the three most distant points in the proposed service area.
   - For example, the distance between Ramsey and St. Louis counties (the furthest point) is 300 miles. Provide the results of your calculations.
   - County Name: _____ Distance (miles): _____
   - County Name: _____ Distance (miles): _____
   - County Name: _____ Distance (miles): _____

3. **Administrative and Clinical Oversight**

   Provide written responses on a separate sheet of paper describing how the administrator, clinical manager, and supervising physician or registered nurse (RN) will manage the additional responsibilities if the service area is expanded. Include details for the following:
   - Supervision of staff
   - Orientation and training
   - Recruitment, hiring, and termination of employees
   - Implementation and monitoring of care plans

- Oversite by the administrator and supervising registered nurse or physician
- Coordination of care
- Coverage for staff absenteeism

Next Steps for HHA

- Complete this form and attach the required documents and email all items to health.hrd-fedlcr@state.mn.us.
- If deemed status, notify the accrediting organization.

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

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

Service Area Map