DEPARTMENT OF HEALTH

Home Health Agency (HHA) – Adding a Branch Office

Complete all the following information.

Health Facility Identification Number (HFID): _____

CMS Certification Number (CCN): _____

HHA parent Doing Business As (DBA) name: _____

HHA parent address: _____

Phone number: _____

Approved Branch Office(s)

Complete the table in Appendix A: Approved Branch Office(s) with the addresses and telephone numbers.

Proposed Branch Office

Address: _____

City, State & Zip _____

Telephone number: _____

Proposed start date: _____

Geographic Service Area

Before completing this section, verify that the geographic service area you are reporting on has already been approved by the Minnesota Department of Health (MDH).

If the proposed service area has not been approved by MDH, you must complete the **Adding or Changing a Service Area** process before submitting this questionnaire.

Complete the Service Area Map

Attach a county-level map that clearly identifies:

- The current MDH-approved service area (counties) for the HHA parent.
- The current MDH-approved service areas (counties) of any existing approved branch offices.
- The proposed service area for the new branch office.

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): _____

Services

- State Operations Manual (SOM), chapter 2, sections 2180D and 2182.4A
- 42 CFR 484.105

Provided by the HHA Parent

Check the services that are provided by the parent and indicate whether the services are provided directly, through a contract or both.

Service Provided by Parent	Service Provided Directly	Service Provided by Contract
Skilled Nursing		
Physical Therapy		
Speech-language Pathology		
Occupational Therapy		
Medical Social Services		
Home Health Aide services		

Provided by Proposed Branch

Check the services that will be provided by the proposed branch and indicate whether the services will be provided directly, through a contract or both.

Service Provided by Parent	Service Provided Directly	Service Provided by Contract
Skilled Nursing		
Physical Therapy		
Speech-language Pathology		
Occupational Therapy		
Medical Social Services		
Home Health Aide services		

Administrator

- 42 CFR 484.105(b)
- State Operations Manual (SOM), chapter 2, section 2180D

Name: _____

Title: _____

- Attach a copy of the position description.

Administrator Pre-Designed Person

- 42 CFR 484.105(b)(2)

Name: _____

Title: _____

- Attach a signed authorization form confirming acceptance of responsibility.

Clinical Manager

- 42 CFR 484.105(c)

Name: _____

Title: _____

- Attach a copy of the position description.

Supervising Physician or RN

- State Operations Manual (SOM), chapter 2, section 2182.4B

Name: _____

Title: _____

Credential/License #: _____

- Attach a copy of the job description.

Branch Supervisor or Manager

- State Operations Manual (SOM), chapter 2, section 2182.2

Name: _____

Title: _____

- Attach a copy of the position description.

Administration of Services

- State Operations Manual (SOM), chapter 2, section 2182.4A

Describe how the HHA Parent will provide oversight and operational support for the proposed branch office by addressing the following:

1) Explanation of how supervision by the HHA parent will occur: _____

2) Identification of the person who will resolve patient care issues at the branch: _____

3) Explanation of how staff will coordinate care and services: _____

4) Describe plans for addressing staff absenteeism: _____

5) Attach an organizational chart delineating lines of authority, professional and administrative control for the HHA, including the approved and proposed branch office(s). The organizational chart should include all HHA parent and branch staff.

6) Attach the policies for addressing clinical and other emergency situations.

Next Steps for HHA

- Complete this form and attach the required documents and email all items to health.hrd-fedlcr@state.mn.us.
- Submit CMS 855A to the Medicare Administrator Contractor (MAC).
- 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

07/17/2026

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

Service Area Map

Appendix A: Approved Branch Office(s)

Complete the table with the addresses and telephone numbers.

Address: _____

City, State & Zip _____

Telephone number: _____

Address: _____

City, State & Zip _____

Telephone number: _____

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