DEPARTMENT OF HEALTH

Home Health Agency (HHA) – Initial Medicare Certification

A home care agency seeking Medicare certification must first be licensed as a comprehensive home care provider. See State Licensed Home Care Providers (HCP) website. Temporary comprehensive home care nor basic home care licenses are not eligible to become Medicare certified.

All HHAs must provide skilled nursing services and at least one of the following other therapeutic services: physical therapy, speech language pathology or occupational therapy, medical social services, or home health aide services in a place of residence used as a patient's home. HHA must provide at least one of these services directly and in its entirety by employees of the HHA. See State Operations Manual (SOM), chapter 2, section 2180.

Complete all the following information.

Health Facility Identification Number (HFID): _____

CMS Certification Number (CCN): _____

HHA Doing Business As (DBA) name: _____

HHA address: _____

Branch office(s), if applicable: _____

Effective date of CHOW: _____

Complete the following:

- Home Health Agency Survey Report (CMS-1572)
- Health Insurance Benefit Agreement (CMS-1561)
- U.S. Department of Health and Human Services, Office for Civil Rights, Assurance of Compliance

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).

Onsite Initial Medicare Survey

- This survey can be conducted by an approved accrediting organization.
- MDH follows the CMS Mission & Priority Document (MPD) regarding workload priorities. See CMS Mission & Priority Information website for the latest MPD.

Decision Notification

- The Minnesota Department of Health (MDH) will review all submitted documentation and survey findings and provide a recommendation to the Medicare Administrative Contractor (MAC) regarding the initial Medicare certification. The Centers for Medicare & Medicaid Services (CMS) retains final authority to approve or deny the initial Medicare certification and will issue written notification of the decision.

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.