Home Health Agency (HHA) – Change of Location

Complete all the following information.

Health Facility Identification Number (HFID): _____

CMS Certification Number (CCN): _____

HHA Doing Business As (DBA) name: _____

Select which location is changing: ☐ Parent location ☐ Branch location

Previous location Address: _____

New Location Address: _____

☐ Check here if mailing address is the same as the parent location.

Complete if different: _____

Distance between previous and new location: _____

Will there be changes to the following: services provided, staffing, clients, or service area? ☐ Yes ☐ No

If yes, explain: _____

_____

Effective date of change: _____

Next Steps

- Email form to health.hrd-fedlcr@state.mn.us.
- Submit the CMS 855A to the Medicare Administrator Contractor (MAC). See CMS 855A Medicare Enrollment Application (PDF) (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf).
- 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.