Reset Form

BRANCH QUESTIONNAIRE FOR A HOME HEALTH AGENCY

State Form 53209 (R / 9-17)
Indiana State Department of Health-Division of Acute Care

INSTRUCTIONS: *1. Answer all questions on this questionnaire and submit requested documentation.*
2. Read pages 13 and 14 prior to completing the application.
3. If the branch questionnaire is incomplete or not legible it will be returned to facility without processing.

Basic Information

1. Ownership – Identify the owning entity, address, city, state, ZIP code and Employer Identification Number (EIN). Indicate whether or not the parent and the new location are owned by the same entity, and name the owning entity below. *If they are not commonly owned, the new location **cannot** be determined to be a branch; in this case, discontinue completion of this questionnaire.*

Name of Owning Entity		EIN number
Street address *(number and street)*		
City	State	ZIP Code

2. Parent Location – Indicate Medicare provider number, name, street address, city, state, county, ZIP code, and telephone number, including area code.

Parent's name		
Street address *(number and street)*		County
City	State	ZIP Code
Telephone number ( )	Medicare number	Facility number

3. Existing Branch – Include names, address, and telephone numbers.

Branch name		Telephone number ( )	
Street address *(number and street)*	City	State	ZIP Code
Branch name		Telephone number ( )	
Street address *(number and street)*	City	State	ZIP Code

Branch name		Telephone number ( )	
Street address *(number and street)*	City	State	ZIP Code
Branch name		Telephone number ( )	
Street address *(number and street)*	City	State	ZIP Code
Branch name		Telephone number ( )	
Street address *(number and street)*	City	State	ZIP Code
Branch name		Telephone number ( )	
Street address *(number and street)*	City	State	ZIP Code
Branch name		Telephone number ( )	
Street address *(number and street)*	City	State	ZIP Code
Branch name		Telephone number ( )	
Street address *(number and street)*	City	State	ZIP Code
Branch name		Telephone number ( )	
Street address *(number and street)*	City	State	ZIP Code

4. New Location – Indicate name, street address, city, state, ZIP code, county, and telephone number, including area code.

Branch name		Telephone number ( )
Street address *(number and street)*		County
City	State	ZIP Code

5. New Location Effective Date

Effective Date *(month, day, year)*

6. Business Hours, Parent Location – Indicate hours and days of the week the parent location provides services.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
P.M.	P.M.	P.M.	P.M.	P.M.	P.M.	P.M.

7. Business Hours, New Branch Location – Indicate hours and days of the week the new branch location provides services.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
P.M.	P.M.	P.M.	P.M.	P.M.	P.M.	P.M.

8. Service Area, Parent Location – Indicate geographic area served by the parent (*include copy of map from MapQuest, etc.*).

Complete the attached geographic area served form and map.

9. Service Area, New Branch Location - Indicate geographic area served by the new location (*include copy of a map from MapQuest, etc.*). The branch must be within the HHA's geographic service area and close enough to the HHA to share supervision. If the branch is extending geographic service area, the new geographic area must be contiguous.

Complete the attached geographic area served form and map.

10. Proximity - Indicate the mileage and approximate travel time between the parent office and the new location (*include copy of the map that indicates the mileage*). Note any unusual conditions (urban congestion, travel by non-interstate, etc.) that could affect travel time. A branch office must be located within one hundred and twenty (120) minutes driving time of the parent. ***Provide a map that reflects the distance from the parent to the branch.***

Indicate the mileage and approximate travel between parent and branch.

11. Services, Parent Location – List the services (*skilled nursing, home health aide, physical therapy, occupational therapy, speech pathology, medical social services*) provided by the parent location, indicating whether the service is provided directly or is contracted.

Services Provided	Yes or No	Provided Directly	Provided by Contract
Skilled Nursing	☐ Yes ☐ No	☐	☐
Home Health Aide	☐ Yes ☐ No	☐	☐
Occupational Therapy	☐ Yes ☐ No	☐	☐
Physical Therapy	☐ Yes ☐ No	☐	☐
Speech Pathology	☐ Yes ☐ No	☐	☐
Medical Social Services	☐ Yes ☐ No	☐	☐

12. Services, New Branch Location – List the services (*skilled nursing, home health aide, physical therapy, occupational therapy, speech pathology, medical social services*) provided by the new location, indicating whether the service is provided directly or is contracted. Services offered by the parent must offered by the branch.

Services Provided	Yes or No	Provided Directly	Provided by Contract
Skilled Nursing	☐ Yes ☐ No	☐	☐
Home Health Aide	☐ Yes ☐ No	☐	☐
Occupational Therapy	☐ Yes ☐ No	☐	☐
Physical Therapy	☐ Yes ☐ No	☐	☐
Speech Pathology	☐ Yes ☐ No	☐	☐
Medical Social Services	☐ Yes ☐ No	☐	☐

13. Staff, Parent Location – List the number and types of employees, including contracted staff. (*Your list should include, but is not limited to: administrator; area managers; RN or MD supervisor; RN's; LPN's; aides; therapists – PT, OT, SP; social worker; quality assurance staff; etc.*)

Types of Employees	Number of Employees	Types of Employees	Number of Employees

14. Staff, New Branch Location –
    - List the number and type of employees, including contracted staff. (*Your list should include, but is not limited to: administrator; area managers; RN or MD supervisor; RN's; LPN's; aides; therapists – PT, OT, SP; social worker; quality assurance staff; etc.*)

Types of Employees	Number of Employees	Types of Employees	Number of Employees

Supervision
Before responding to the following questions, please refer to the regulatory definition of supervision on page 14 of this questionnaire (*supervision entails the physical presence of a qualified person during the provision of services to a patient on the patient's premises*).

15. Branch Supervision - Describe how the HHA will be able to adequately supervise the branch to assure that the quality and scope of items and services provided to all patients is of the highest practicable functional capacity for the patient so to meet their medical, nursing, social, and rehabilitative needs.

16. Supervising RN or MD – Identify the supervising nurse or physician (42 CFR 484.14). The supervising nurse or physician must be available by phone or other means of communication during operating hours.

Supervising nurse or physician
How does this individual supervise and direct the skilled nursing and other therapeutic services of the agency for all locations of the agency?
How is this person or a qualified alternate made available during all of the agency's operating hours?

17. Please indicate the name and title of any parent or branch personnel who perform supervisory activities (*as defined by regulations*) at the new location. Indicate whether these supervisory personnel are assigned to the parent, the new location, or both. Spell out the exact nature of the supervisory function and the frequency of the supervisory activity.

18. Describe the ways by which the parent exercises the supervisory control over the new location, such as on-site observation of staff with patients, use of clinical supervisors, use of care coordinators, use of quality improvement staff, on-site visits by the administrator, chart reviews, surveys of or interviews with patients to determine if needs are being met, etc. Describe these activities by type and frequency and by the parent staff performing them. If some of the new location staff are contracted, describe specifically how the services performed by contracted staff are overseen by the parent.

Services

19. Identify which staff, if any, routinely provide home health agency services (*skilled nursing, home health aide, physical therapy, occupational therapy, speech pathology, medical social services*) to patients at both the parent and the new location. Identify the services, under what circumstances, and how often this sharing of services occurs.

20. Explain how the parent provides services in the event of the temporary or prolonged absence of any new location staff due to emergency, illness, vacation, or resignation.

Administration

21. To aid review of your answers to the following questions, please enclose an organizational chart, annotating it, if necessary, to show where specific personnel (*indicate by name*) are based. The organizational chart must show both the parent and the new location.

22. How are agency policies and procedures disseminated to the new location?

Communication

23. Explain how the HHA is able to maintain a system of communication and integration of services throughout the agency, whether provided directly or under arrangement, that ensures the identification of patient needs, an ongoing liaison between all disciplines providing care, and physician availability when necessary for relevant medical issues.

24. **Patient Care**

- Within your organizational structure, how does your agency ensure the quality of care and appropriate delivery of services at the new location?

- Identify the person who will resolve patient care issues at the branch, and explain how supervision by the HHA parent will occur.

- Explain how the Administrator of the HHA is able to maintain an ongoing liaison with the branch to ensure that staff is competent and able to provide appropriate, adequate, effective and efficient patient care so as to ensure that any clinical and/or other emergencies are immediately addressed and resolved.

- Explain how staff will coordinate care and services.

- Describe how the new location will address clinical and other emergency situations.

Describe how the parent exercises administrative control over the new location. Describe any activities performed by type and frequency along with the parent staff performing them.

If the new location utilizes contracted staff, describe specifically how the services are performed by the contracted staff are overseen by the parent.

25. Provide documentation on the HHA's governing body that is responsible for the overall operation of the parent and branch. ***Identify documentation submitted to ISDH by corresponding number.***

PLEASE ATTACH THIS PAGE TO THE SEPARATE SHEETS CONTAINING YOUR RESPONSES TO THE QUESTIONNAIRE.

THE FOLLOWING MUST BE SIGNED AND DATED BY THE ADMINISTRATOR OF THE HOME HEALTH AGENCY.

I certify that the responses to this Home Health Agency Branch Questionnaire are true, correct, and complete.

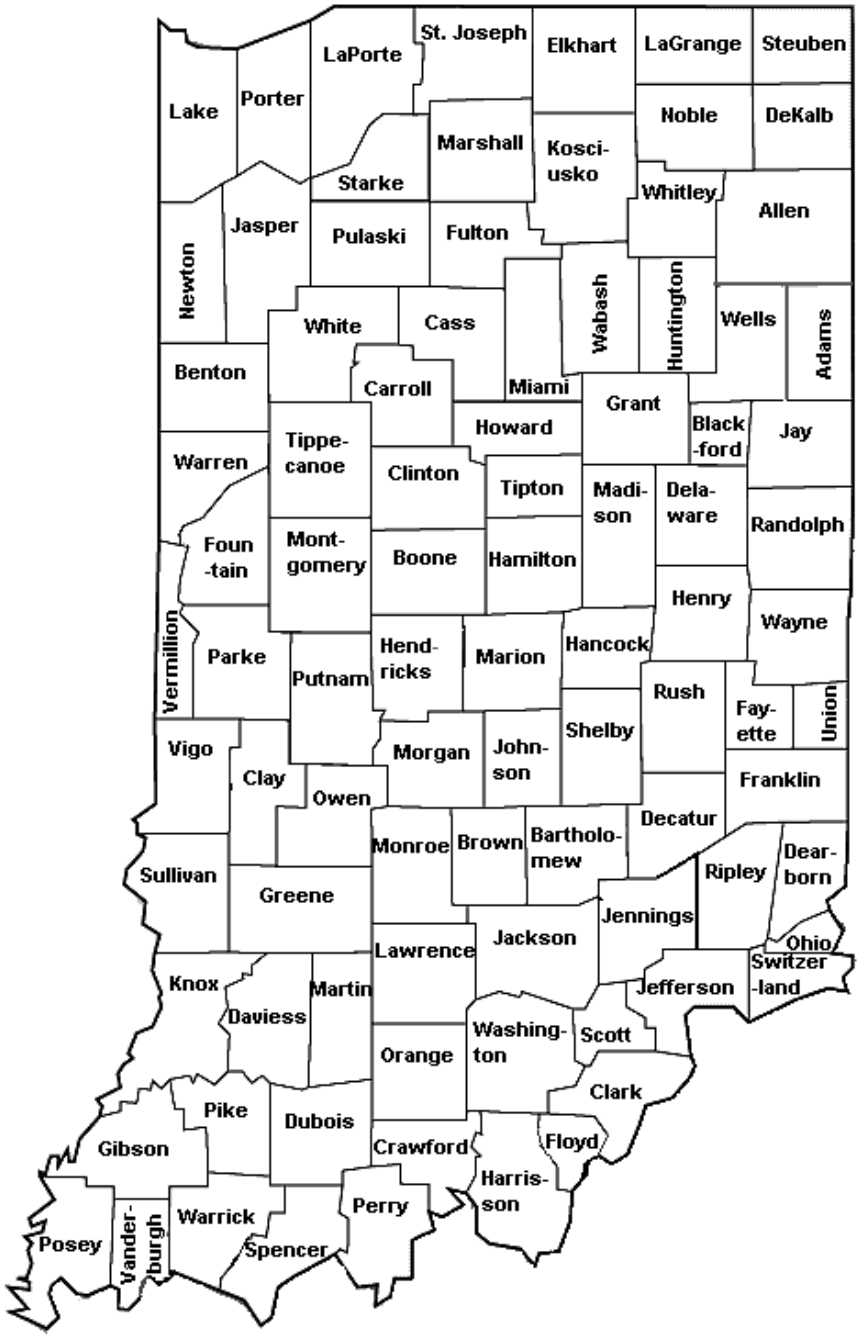
Signature	
Printed Name	Date *(month, day, year)*

GEOGRAPHIC AREA SERVED

PLEASE CHECK THE COUNTIES SERVED BY THE PARENTAND BRANCH IDENTIFY WHICH IS THE PARENT AND THE BRANCH.

Adams ☐	Franklin ☐	Lawrence ☐	Rush ☐
Allen ☐	Fulton ☐	Madison ☐	St. Joseph ☐
Bartholomew ☐	Gibson ☐	Marion ☐	Scott ☐
Benton ☐	Grant ☐	Marshall ☐	Shelby ☐
Blackford ☐	Greene ☐	Martin ☐	Spencer ☐
Boone ☐	Hamilton ☐	Miami ☐	Starke ☐
Brown ☐	Hancock ☐	Monroe ☐	Steuben ☐
Carroll ☐	Harrison ☐	Montgomery ☐	Sullivan ☐
Cass ☐	Hendricks ☐	Morgan ☐	Switzerland ☐
Clark ☐	Henry ☐	Newton ☐	Tippecanoe ☐
Clay ☐	Howard ☐	Noble ☐	Tipton ☐
Clinton ☐	Huntington ☐	Ohio ☐	Union ☐
Crawford ☐	Jackson ☐	Orange ☐	Vanderburgh ☐
Daviess ☐	Jasper ☐	Owen ☐	Vermillion ☐
Dearborn ☐	Jay ☐	Parke ☐	Vigo ☐
Decatur ☐	Jefferson ☐	Perry ☐	Wabash ☐
DeKalb ☐	Jennings ☐	Pike ☐	Warren ☐
Delaware ☐	Johnson ☐	Porter ☐	Warrick ☐
Dubois ☐	Knox ☐	Posey ☐	Washington ☐
Elkhart ☐	Kosciusko ☐	Pulaski ☐	Wayne ☐
Fayette ☐	LaGrange ☐	Putnam ☐	Wells ☐
Floyd ☐	Lake ☐	Randolph ☐	White ☐
Fountain ☐	LaPorte ☐	Ripley ☐	Whitley ☐

IDENTIFY THE COUNTIES SERVED BY THE PARENT AND BRANCH.



HOME HEALTH AGENCY BRANCH QUESTIONNAIRE
REVIEW QUESTIONNAIRE PRIOR TO COMPLETING THE APPLICATION
CMS Region V, Chicago (*05/10/02)*

The Division of Acute Care, Indiana State Department of Health, must receive the branch questionnaire completed in its entirety and all requested documentation in order to process the request to add a branch. If the branch questionnaire is incomplete or not legible the questionnaire will be returned to the facility without processing.

Purpose
The purpose of this questionnaire is to gather information so that a determination can be made as to whether a new location should be classified as a branch office, or parent agency. A branch may or may not be surveyed immediately.

Definition
A determination will be made based on the following home health agency definitions located at 42 CFR 484.2:
Parent home health agency means the agency that develops and maintains administrative controls of subunits and/or branch offices.
Branch office means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch to independently meet the Conditions of Participation as a home health agency.

Processing and Determinations
The State Agency (SA) mails this questionnaire, reviews the responses and supporting documentation, and makes a recommendation to the Chicago Regional Office (RO) of the Centers of Medicare and Medicaid Services (CMS). The RO has the authority to make the final determination. The RO sends the applicant a determination letter, either approving the location as a branch or denying the request for branch status and listing the reasons for denial.

An agency who has been denied branch status can request to apply for licensure to become a home health agency.

All locations in a multi-site home health agency receive some degree of oversight from the top of the organization, regardless of the number of locations or geographic dispersion (proximity of the other location to the parent location) of the organization. It is the extent to which administration, supervision, and services are shared on a daily basis that is the focus of this questionnaire.

Who Should Complete the Questionnaire
Refer to the regulatory definitions above. If it is clear that the new location will be operated independently of a parent location except for administrative oversight, and the new location could independently meet the HHA Conditions of Participation, do not complete this

questionnaire. Instead, contact the Indiana State Department of Health for a home health application for licensure.

Approval by RO
The provider may not provide service from the new location until approval by CMS- Regional Office is received.

Supervision
References to supervision are found at 42 CFR 484.2, 484.14(d), 484.30(a) & (b), 484.34 and 484.36(d). Supervision requires, unless it is otherwise specified in the regulations, that a qualified person be physically present during the provision of services by any individual who does not meet the qualifications specified in 42 CFR 484.4. A major aspect of supervision is supervision of the CMS's personnel in the furnishing of services to a patient on the patient's premises.

How to Complete this Questionnaire
Answer all questions do not skip any of the numbered questions. If you use additional sheets of paper identify number sheets of paper according to the question. Submit the requested documentation and number according to the questions. **If any requested information is not present in your response, the questionnaire and your responses may be returned to you for completion, and processing will not proceed until all requested information is received**. **All documentation must be legible.**

Contact for Assistance
If you have any questions, please contact the **Program Coordinator at the Indiana State Department of Health Division of Acute Care at 317-233-7302,** or mail branch application to:

PHNSS-Program Director
Indiana State Department of Health
2 N Meridian St
Acute Care Division - 4A 07
Indianapolis, IN 46204