HOME HEALTH CARE SERVICES
APPLICATION FORM

ARKANSAS HEALTH SERVICES PERMIT COMMISSION

ARKANSAS HEALTH SERVICES PERMIT AGENCY
906 BROADWAY, SUITE 200
Little Rock, AR 72201
(501) 661-2509

INSTRUCTIONS FOR COMPLETION OF PERMIT OF APPROVAL APPLICATION FORM

General Instructions

In accordance with adopted policies pursuant to Arkansas Act 593 of 1987, as amended, all parties desiring to obtain a Permit of Approval are required to provide the requested information on this application form. Failure to supply adequate information may result in a delay in the review, a return of the application, or a denial of the application. Please refer to the Health Services Permit Commission's Policies and Procedures for Permit of Approval for details of the scope of coverage, projects subject to review, and specific procedures for processing applications.

1. **Please review the Commission's adopted Home Health Care need standards and criteria before starting the application process.**

2. **The Agency recommends that each applicant meet with a staff member of the Health Services Permit Agency (by appointment) for a pre-submission conference.**

3. **Each question must be addressed fully. Contact the staff before a response of "not applicable" is made in order to insure that it is an appropriate response.**

4. **One (1) original and one (1) copy of the completed application along with the appropriate fee must be submitted to the Health Services Permit Agency in accordance with the established batching schedule. The original must be signed in blue ink. Please do not send applications in binders or folders.**

APPLICATION FOR HOME HEALTH AGENCY

I. GENERAL INFORMATION

1. **Name of Proposed Agency: _____**

   _____
   Address

   _____
   City Zip County

   Proposed County to be served_____

2. **This application is for which type of license:**
   Class "A" License _____ Class "B" License _____

3. **Ownership of Agency (Check One):**

   Individual Owner ____ Partnership _____ Corporation:_____

   List names and addresses of all partners:
   _____
   _____
   _____

4. **Parent Organization: _____**

   Address _____

   City_____State_____Zip_____

5. **Project Contact Person: (*This person will be contacted for questions on this application or for progress on your project if a POA is granted).***

   Name_____

   Corporation/Company _____

   Title: _____

   Address:_____

   City: _____Zip Code: _____

Phone: _____Fax: _____

Email: _____

A. Project Description

1. Describe range of services to be provided. Include "core home health services" and any additional services to be provided:

2. If services are to be provided through contract, identify the contractor and document their capability of providing the services.

3. Estimated project-starting date: _____.

- **(*Home Health Projects must be licensed within one year of receiving the POA).***

4. POA transfers are required by law to provide proof of at least $2,500 of assets to be transferred with the Permit. If this application involves transfer of a POA, please list the assets and the value of these assets to be transferred with this Permit.

- **Will you need an extension on the time frames of the original POA? Yes_____ No_____**
  If yes, state and justify the amount of time needed in a separate letter. This will be heard by the Commission as a separate request.

II. COMPLIANCE WITH REVIEW CRITERIA

CRITERION #1 The need that the population served or to be served has for the proposed project. Explain the need for the proposed project by addressing each of the following items.

A. Methodology

1. Standards – The following is the standard to be used in the review of additional or expanded home health agencies. The service area is a county.

County Population Range	Maximum Number of Agencies Allowed
Up to 30,000	2
30,000 to 50,000	3
50,000 to 75,000	4
75,000 to 110,000	5
110,000 to 150,000	6
150,000 to 250,000	7
250,000 to 400,000	8
400,000 and above	1 for every 50,000 in population.

2. **Exception: Approvals may be granted when the methodology does not show a need if the applicant offers documentation to prove that existing agencies are not meeting the needs of the service area population. The application must meet the home health definition as required by the core services, etc.**

3. **Applications for change in licensure category: An agency with a "B" license that applies for a permit of approval to proceed with obtaining an "A" license will have to meet published criteria including the standard of need. Such approvals may not exceed the standard of need unless the applicant has provided evidence to support an exception.**

4. **Unfavorable Review: No application will be approved for a new home health agency or an expanded service area or change in license category if the applicant has suffered a condition level of deficiencies as determined by the ADH in its last two annual surveys.**

B. Explain how the proposed project complies with the adopted standard of need.

County population _____
Number of Home Health Agencies Serving the Entire County _____.
Number of Home Health Agencies Serving Part of the County _____.
Number of Home Health Agencies Allowed in the County _____.

(Please refer to the Bed Need book for this information. If your county Net Need is 0 or below, there is no need for Home Health Services and you will have to apply under the exception.)

C. If you are applying under the "Exception", please explain how the proposed project complies with the exception. (The applicant has the burden of proof to provide documentation that services are not being provided.)

D. Explain how the local community's health care system will benefit from the project.

E. Other indicators of need.

1) **Attach at least one (1) letter of support from a practicing physician in the community who will agree to refer patients.**

2) **Attach other assessments or surveys indicating the need for the proposal.**

3) **If this is an application for home health services to be provided by a rural hospital, please complete the following.**

    a) **Describe your hospital, the number of beds in the hospital and your county population in the last decennial census.**

    b) **If the hospital has operated a home health agency in the past, please describe the circumstances that led to the loss, surrender or transfer of the home health agency and license.**

    c) **If the agency was sold or transferred to another entity, please indicate the date of the transfer, the entity to which it was transferred and any financial gain from the transfer of ownership.**

<u>CRITERION #2</u> "Whether the project can be adequately staffed and operated when completed.

A. Personnel – list the number of personnel by classification and proposed salary. Include a time-phased plan for hiring staff.

B. Describe your plan for recruitment and retention of staff.

CRITERION # 3 **"Whether the proposed project is economically feasible"**

A. Estimated Start Up Cost: **$ _____**

B. Estimated Annual Operating Cost: **$ _____**

C. Source of Funds to implement the project

- **A recent (not more than 90 days old) pre-approved loan from Financial Institution for the total amount of the project.**
- **For individual investors or partners, a recent (not more than 90 days old) proof of bank deposit for the amount needed for the project.**
- **For existing agencies, provide documentation of financial resources to fund the project signed by a Certified Public Accountant who is not directly employed by the applicant.**

D. Complete Attachment #1 "Budget Projections"

- **Projection needs to be very detailed and provide basis for your projection.**

E. Complete Attachment #2 "Cost per Visit Projections"

CRITERION # 4 **"Whether the project will foster cost containment through improved efficiency and productivity."**

A. In what manner will the proposed project reduce the cost or demand for health care services in the service area and save State and Federal money? Please provide documentation and discussion.

CERTIFICATION

This form completed by: _____

Name Title

_____

Corporation, Company or Agency

_____

Address

_____

City State Zip

_____

Phone

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

_____ _____

Date Signature

_____

Title

ATTACHMENT # 1

BUDGET PROJECTIONS
FISCAL YEAR _____

Revenue (Sources) $_____
Medicaid $_____
Private Insurance $_____
Private Pay $_____
Others $_____

Total Revenue $_____

SALARY AND FRINGE:
ADMINISTRATIVE PERSONNEL:
(Specify)

_____ $_____
_____ $ _____
_____ $ _____
_____ $ _____
_____ $ _____

TOTAL ADMINISTRATIVE AND FRINGE $ _____

SERVICE DELIVERY PERSONNEL:
Nurses:
RNs $ _____
LPNs $ _____
Total Nurse Salary and Fringe $ _____

Aids:
Salaried $ _____
Contract $ _____
Total Aid Salary and Fringe $ _____

THERAPISTS:
Physical:
Salaried $ _____
Contract $ _____
Total PT Salary and Fringe $ _____
Speech:
Salaried $ _____
Contract $ _____
Total ST Salary and Fringe $ _____

Occupational:
Salaried $ _____
Contract $ _____
Total OT Salary and Fringe $ _____
Medical Social Worker
Salaried $ _____
Contract $ _____
Total MSW Salary and Fringe $ _____
TOTAL SALARY AND FRINGE **$ _____**

TRANSPORTATION:
Administrative $ _____
Nurses $ _____
HHH $ _____
Other (Specify) $ _____
_____ $ _____
_____ $ _____
_____ $ _____

TOTAL TRANSPORTATION $ _____

MEDICAL SUPPLIES:
Skilled Nursing $ _____
HHA $ _____
Other (Specify) $ _____
_____ $ _____
_____ $ _____
_____ $ _____
TOTAL MEDICAL SUPPLIES $ _____

MAINTENANCE AND OPERATION
Rent, Utilities, etc. $ _____
Office Supplies and Equip $ _____
Other (Specify) $ _____
_____ $ _____
_____ $ _____
_____ $ _____
TOTAL MAINTENANCE AND OPERATION $ _____

TOTAL PROJECTED COST **$ _____**

TOTAL PROJECTED INCOME OR LOSS **$_____**

						ATTACHMENT # 2	
		First 12 Month Period					
		Cost Per Visit Projections					
DISCIPLINE	DIRECT SALARY AND FRINGE COSTS	TRANSPORTATION COSTS	MEDICAL SUPPLY COSTS	ALLOCATED ADMINISTRATIVE COST	TOTAL COST	TOTAL VISITS	COST PER VISIT
SKILLED NURSING							
HHA							
PHYSICAL THERAPY							
OTHER THERAPY							
MSW							
OTHER (SPECIFY)							
TOTAL							