STATE OF TENNESSEE
HEALTH FACILITIES COMMISSION
665 MAINSTREAM DRIVE, SECOND FLOOR
NASHVILLE, TENNESSEE 37243

HOME CARE ORGANIZATION HOME HEALTH BRANCH APPLICATION

This form shall be completed by any agency requesting to establish a home health branch location. Each branch request must be submitted and will require a separate approval. **The licensed parent agency must return the branch application request to the above address for review**.

NOTE: ANY BRANCH APPROVAL GRANTED IS FOR STATE PURPOSES ONLY. THE DETERMINATION OF WHETHER AN APPLICANT IS A BRANCH LOCATION FOR MEDICARE PURPOSES WILL BE MADE BY CMS.

Agency Name _____

Street Address _____

City/Zip _____ Telephone Number (___)_____

Geographic Area (CON Approved Counties) _____

_____

Current Branch Office Location(s) _____

_____

New Branch Street Address _____

City/Zip _____ Telephone Number (___)_____

Outline the organizational structure (or provide and organizational chart of the:

A. Parent _____

_____

B. Branch _____

_____

Describe how administration, supervision and services will be shared with the parent _____

_____

_____

Services provided at the:	Parent	Branch			Parent	Branch
Skilled Nursing	☐	☐		Home Health Aide Services	☐	☐
Physical Therapy	☐	☐		Medical Supplies & Appliances	☐	☐
Occupational Therapy	☐	☐		Hospice Services	☐	☐
Speech Therapy	☐	☐		Durable Medical Equipment	☐	☐
Medical Social Services	☐	☐		Other (specify):	☐	☐
Homemaker Services	☐	☐				

Provide the name and title of the employee(s) responsible for the following: (Please Print)

	Parent		Branch
Contracting for services provided:			
Title:			
Making staff assignments:			
Title:			

Name and title of the employee the branch office will report to_____

Actual mileage from the parent office to the branch _____ Average travel time _____

Average travel time from branch office to patient _____

Parent agency's current caseload _____ Anticipated caseload of branch _____

Comments _____

_____

Signature and title of person completing application request _____

Date of Request _____ Requested Effective Date _____

Please list the counties in which you are providing services:

_____

_____

_____

_____

_____

_____

_____

_____

_____