Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 26—Home Health Agencies

19 CSR 30-26.010 Home Health Licensure Rule

PURPOSE: This rule defines the minimum requirements for the provision of home health services by state licensed home health programs.

PUBLISHER’S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) State Licensure Requirements.
(A) This rule incorporates by reference 42 CFR 484, Medicare Conditions of Participation: Home Health Agencies, for Missouri licensed home health agencies. Missouri licensed home health agencies shall strictly meet the currently applicable Medicare Conditions of Participation and surveys performed for state licensure will be conducted per Medicare standards.
(B) Licensed home health agencies shall provide dementia-specific training about Alzheimer’s disease and related dementias to their employees and those persons working as independent contractors who provide direct care to or may have daily contact with residents, patients, clients, or consumers with Alzheimer’s disease or related dementias.
   1. The training required for persons providing direct care shall address the following areas, at a minimum:
      A. An overview of Alzheimer’s disease and related dementias;
      B. Communicating with persons with dementia;
      C. Behavior management;
      D. Promoting independence in activities of daily living; and
      E. Understanding and dealing with family issues.
   2. Employees or independent contractors who do not provide direct care for, but may have daily contact with, persons with Alzheimer’s disease or related dementias shall receive dementia-specific training that includes, at a minimum:
      A. An overview of Alzheimer’s disease and related dementias; and
      B. Communicating with persons with dementia.
   3. Dementia-specific training about Alzheimer’s disease and related dementias shall be incorporated into orientation for new employees with direct patient contact and independent contractors with direct patient contact. The training shall be presented by an instructor who is qualified by education, experience, and knowledge in the current standards of practice regarding individuals with Alzheimer’s disease and other related dementias. The training shall be provided annually and updated as needed.

(2) State Licensure Management.
(A) All licensed home health agencies shall be licensed and shall conduct all their business in their legal name or in their doing business as (d/b/a) name as properly registered with the secretary of state.
(B) Initial Application Procedure for Home Health Agencies.
   1. The applicant shall provide the Department of Health and Senior Services (department) with a completed application for home health license, included herein, copy of registration with secretary of state, a completed State Disclosure of Ownership and Control Interest Statement form, included herein, and sufficient evidence that the home health agency has established appropriate policies and procedures for providing home health services according to sections 197.400 to 197.478, RSMo. The licensure fee must accompany the application and is nonrefundable.
   2. The applicant shall establish a business location as described in and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

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for correcting the cited deficiencies.

C. Upon receipt of the required plan of correction for achieving license compliance, the department shall review the plan to determine the appropriateness of the corrective action and respond to the agency. If the plan is not acceptable, the department shall notify the management or designee and indicate the reasons why the plan was not acceptable. A revised plan of correction shall be provided to the department.

D. If an agency does not acknowledge the deficiencies, the agency must, within ten (10) calendar days, request in writing a resurvey by the department. If, after the resurvey, the home health agency still does not agree with the findings of the department, it may seek a review of the findings of the department by the Administrative Hearing Commission. A copy of the letter requesting the review must be sent to the department.

E. Upon expiration of the completion date for correction of deficiencies specified in the approved plan of correction, the department shall determine if the required corrective measures have been acceptably accomplished. The department shall document that the corrective action has been satisfactorily completed. If the department finds the home health agency still fails to comply with sections 197.400 to 197.478, RSMo, the department may rewrite the deficiencies and request another plan of correction or may take action to suspend or revoke the license.

(F) Refusal to Issue/Suspension/Revocation of License. The department shall refuse to issue or shall suspend or shall revoke the license of any home health agency for failure to comply with any provision of sections 197.400 to 197.478, RSMo, or with any rule or standard of the department adopted under the provisions of sections 197.400 to 197.478, RSMo, or for obtaining the license by means of fraud, misrepresentation, or concealment of material facts.

1. Any home health agency which has been refused a license or which has had its license revoked or suspended by the department may seek a review of the department’s action by the Administrative Hearing Commission. A copy of the letter requesting the review must be sent to the department.

2. The department will not consider application for home health licensure for a period of twelve (12) months after revocation or denial of the agency’s license.

(G) Voluntary Termination.

1. To voluntarily terminate a home health agency license, the agency must submit to the department, in writing, on agency letterhead the following information:

   A. A request for termination of their state license (include license number);

   B. State the effective date of termination;

   C. State disposition of active caseload; and

   D. Location of medical record storage.

2. The agency must enclose the original voided license with the voluntary termination letter.

(H) Complaint Procedure. The department may accept complaints by phone or in writing:

1. Any person wishing to make a complaint against a home health agency licensed under the provisions of sections 197.400 to 197.478, RSMo, may file the complaint in writing with the department setting forth the details and facts supporting the complaints.

2. The department may also accept complaints regarding a licensed home health agency by phone and may document that the complaint was received.

3. The nature of the complaint will determine if an investigation is appropriate or if referral of the complaint to another agency is needed.

4. An on-site visit may be made by a department representative and deficiencies may be written.

5. The process for documentation of complaints will be determined by the department.

6. The agency must comply with paragraph (2)(E)3. in response to deficiencies written as a result of a complaint investigation.
APPLICATION FOR HOME HEALTH AGENCY LICENSE

In accordance with the requirements of the Missouri Home Health Agency Licensing Law (Chapter 197, RSMo Cumulative Supp. 1983) Regulations and Codes, application is hereby made for a license to conduct and maintain a Home Health Agency (See Missouri Home Health Agency Licensing Law "Definitions", Section 197.400.)

THIS INFORMATION, WITHOUT FURTHER VERIFICATION, WILL BE PROVIDED TO BOTH MEDICARE AND MEDICAID OFFICES AND TO UPDATE THE STATE HOME HEALTH DIRECTORY.

<table>
<thead>
<tr>
<th>NAME OF AGENCY</th>
<th>TELEPHONE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS (STREET, CITY, STATE, ZIP)</td>
<td>COUNTY</td>
</tr>
<tr>
<td>HOME HEALTH AGENCY ADMINISTRATOR</td>
<td>SUPERVISORY NURSE</td>
</tr>
</tbody>
</table>

OWNERSHIP AND MANAGEMENT (CHECK ONLY ONE)

<table>
<thead>
<tr>
<th>GOVERNMENTAL</th>
<th>NON-GOVERNMENTAL</th>
<th>PROPRIETARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>COUNTY</td>
<td>CORPORATION</td>
<td>INDIVIDUAL</td>
</tr>
<tr>
<td>CITY-COUNTY</td>
<td>CORPORATION</td>
<td>PARTNERSHIP</td>
</tr>
<tr>
<td>DISTRICT</td>
<td>OTHER (EXPLAIN)</td>
<td>CORPORATION</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FREESTANDING AGENCY</th>
<th>HOSPITAL-BASED AGENCY</th>
<th>SNF/ICF BASED AGENCY</th>
<th>REHABILITATION FACILITY-BASED AGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIEF OFFICER OF GOVERNING BODY</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

GEOGRAPHIC AREA COVERED BY AGENCY OPERATION

LIST COUNTY(IES):

PROFESSIONAL SERVICES (indicate ALL services offered by agency)

Place a "1" in the block for each service provided by AGENCY STAFF or by contract with an individual. If services are provided UNDER ARRANGEMENT with another agency, place a "2" in the block.

<table>
<thead>
<tr>
<th>NURSING CARE</th>
<th>MEDICAL SOCIAL SERVICES</th>
<th>PHYSICAL THERAPY</th>
<th>HOME HEALTH AIDE SERVICE</th>
<th>OCCUPATIONAL THERAPY</th>
<th>OTHER (SPECIFY)</th>
<th>SPEECH THERAPY</th>
</tr>
</thead>
</table>

DIRECT PROFESSIONAL SERVICE (indicate your agency's direct service) [Choose only one]

<table>
<thead>
<tr>
<th>NURSING CARE</th>
<th>MEDICAL SOCIAL SERVICES</th>
<th>PHYSICAL THERAPY</th>
<th>HOME HEALTH AIDE SERVICE</th>
<th>OCCUPATIONAL THERAPY</th>
<th>OTHER (SPECIFY)</th>
<th>SPEECH THERAPY</th>
</tr>
</thead>
</table>

MEDICARE/MEDICAID PARTICIPATION

Is this agency Medicare certified? [ ] Yes [ ] No
If yes, list Medicare provider number

Is this agency Medicaid certified? [ ] Yes [ ] No
If yes, list Medicaid provider number

Number of Employees on the Agency Staff (Full-Time Equivalents). If service is provided by non-employees enter "BY MANAGEMENT."

A. REGISTERED PROFESSIONAL NURSES
B. LPN/LVN LICENSED VOCATIONAL NURSES
C. QUALIFIED PHYSICAL THERAPISTS
D. QUALIFIED OCCUPATIONAL THERAPISTS
E. QUALIFIED SPEECH PATHOLOGIST OR AUDIOLOGIST
F. HOME HEALTH AIDES
G. ALL OTHERS
**BRANCH LOCATIONS** (Identify each approved branch location. All branches must operate under the parent name. Continue on bottom of page if additional room is needed.)

<table>
<thead>
<tr>
<th>Address:</th>
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<th>Address:</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>Telephone No.</td>
<td>Telephone No.</td>
<td>Telephone No.</td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervising Nurse:</td>
<td>Supervising Nurse:</td>
<td>Supervising Nurse:</td>
</tr>
</tbody>
</table>

**SUBUNIT LOCATIONS** (Identify each subunit location, license number and Medicare provider number.)

|                                                                         |                                                                         |                                                                         |
|                                                                         |                                                                         |                                                                         |
| Telephone No.                                                           | Telephone No.                                                           | Telephone No.                                                           |
|                                                                         |                                                                         |                                                                         |
| Administrator:                                                         | Administrator:                                                         | Administrator:                                                         |
| Lic. No.:                                                               | Provider No.:                                                          | Lic. No.:                                                               |
|                                                                         |                                                                         | Provider No.:                                                          |

**CERTIFICATION**

being duly sworn by me on their oath, deposes and says that they have read the foregoing application and that the statements contained therein are correct and true and of their knowledge, and further gives assurance of the ability and intention of the

Home Health Agency to comply with the regulations promulgated under the Missouri Home Health Agency Licensing Law (Chapter 197, RsMo. Cumulative 1983).

It is further certified that the

NAME OF AGENCY

will comply with all recommendations for correction and/or improvements as contained in the most recent Licensing Survey Report prepared by the Department of Health and Senior Services and submitted to said Home Health Agency.

**SIGNATURES**

PRESIDENT OF BOARD OF TRUSTEES, OWNER OR ONE PARTNER OF PARTNERSHIP

HOME HEALTH AGENCY ADMINISTRATOR
STATE DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

<table>
<thead>
<tr>
<th>Name of Entity</th>
<th>D/B/A</th>
<th>Provider No.</th>
<th>Telephone No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City, State, County</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVII, XIX, or XX? ☐ Yes ☐ No

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVII, XIX, or XX? ☐ Yes ☐ No

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. List any additional names and addresses under "Remarks". If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>EIN</th>
</tr>
</thead>
</table>

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Unincorporated Associations ☐ Corporation ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

(d) Are any owners of the disclosing entity also owners of other facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Provider Number</th>
</tr>
</thead>
</table>

IV. (a) Has there been a change in ownership or control within the last year? ☐ Yes ☐ No

If yes, give date ____________________________

(b) Do you anticipate any change of ownership or control within the year? ☐ Yes ☐ No

If yes, give date ____________________________

(c) Do you anticipate filing for bankruptcy within the year? ☐ Yes ☐ No

If yes, give date ____________________________

V. Is this facility operated by a management company, or leased in whole or part by another organizations? ☐ Yes ☐ No

If yes, give date of change in operations ____________________________

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? ☐ Yes ☐ No

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)

<table>
<thead>
<tr>
<th>Name</th>
<th>EIN</th>
</tr>
</thead>
</table>

Address

WHOEVER KNOWINGLY AND WILFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY, OR SECRETARY, AS APPROPRIATE.

<table>
<thead>
<tr>
<th>Name of Authorized Representative (Typed)</th>
<th>Title</th>
</tr>
</thead>
</table>

Signature

Date

Remarks

MO 560-2145 (09-01)  HHA-30
AUTHORITY: section 197.445, RSMo 2000
and section 660.050, RSMo Supp. 2008.*
Original rule filed Aug. 17, 1998, effective
2008, effective June 30, 2009. **

*Original authority: 197.445, RSMo 1983, amended

**Pursuant to Executive Orders 20-04, 20-10, and 20-12, 19 CSR
30-26.010, subsection (1)(A) and section 197.400(3), RSMo was
suspended from April 9, 2020 through December 30, 2020 and sub-
section (1)(B) was suspended from April 22, 2020 through Decem-