

# Home Health Agency Branch Questionnaire

## Purpose

The purpose of this questionnaire is to gather information so that a determination can be made as to whether a new home health agency (HHA) location should be classified as a branch office, or parent agency. Parent agencies require an on-site survey before either can participate in the Medicare program. A branch may or may not be surveyed immediately.

## Definitions

A determination will be made based on the following Medicare home health agency definitions located at 42 CFR 484.2.

- *Parent home health agency* means the agency that develops and maintains administrative controls of 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 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 for 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 the denial. Approvals will generally be made retroactive to the date on which the branch office met the criteria for conditions of participation.

An agency has two options when a location is denied branch status. It can close the location or request a survey of the location as a parent.

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 locations 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 this 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, request a survey as a parent agency.

## Timing of the Branch Request

The State Agency must be notified prior to when home health agency services are being provided from a new location. Costs associated with services rendered from the new location should not be claimed in the cost report for the parent location until the new location has been approved and appropriately classified by HCFA. An adequate assessment cannot be made for a location that is planned but is not operating. The questionnaire should be completed with respect to how the location is actually operating.

## Supervision

References to supervision are found at 42 CFR 484.2, 484.14(d), 484.30(a)&(b), 484.32(a)&(b), 484.34 and 484.36(d). See the copy of the Part 484 of the Code of Federal Regulations which accompanies this questionnaire. 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 HHA's personnel in the furnishing of services to a patient on the patient's premises.

**Note:** Currently, many home health agencies operate based upon a model by which each branch location has a day-to-day manager, and, as such, is essentially self-supervising. For example, the manager may be a nurse who supervises the nurses and home health aides assigned to the branch with very little intervention from the parent location. Further, the therapy services may be provided under contract rather than by agency employees. For home health agencies that fit this model (self-supervising on a daily basis) an optional supervision question has been added requesting information about how the parent location oversees the branch locations.

## How to Complete this Questionnaire

On separate sheets of paper, show the number of each question and your answer. Do not skip any of the numbered questions. Your response sheets must show every number from the questionnaire, in order and your answer to the question represented by the number. If any requested information is not present in your response, the response will be returned to you, and no processing will go forward until all requested information is received at the State Agency in the form prescribed by this questionnaire.

**Complete a separate questionnaire for each proposed branch location.**

## Contact for Assistance

If you have questions, please email: [Health.HRD-FEDLCR@state.mn.us](mailto:Health.HRD-FEDLCR@state.mn.us)

# Questionnaire

## Basic Information

1. **Ownership.** Indicate whether or not the parent and the new location are owned by the same entity
  - Yes, name the owning entity or entities: \_\_\_\_\_ or
  - No. If they are not commonly owned, the new location cannot be determined to be a branch, there is no need to complete this questionnaire. (In large corporate structures, the parent and the new location must have the same owner at the lowest level in the corporate hierarchy.) If the new location represents an acquisition from another HHA, please enclose with your response copies of the legal documents that support the acquisition of the location. Indicate the name, address, and Medicare provider number of the parent from which the location was acquired.
2. **Parent (Corporate) Site:**
  - Medicare provider number: \_\_\_\_\_
  - HFID number: \_\_\_\_\_
  - Name: \_\_\_\_\_
  - Address: \_\_\_\_\_
  - City, State, & Zip: \_\_\_\_\_
  - Telephone number (including area code): \_\_\_\_\_
3. List all the names, addresses, telephone numbers (including area code) of **all other HHA locations (except for the new location)** for which this questionnaire is being completed). Include the Medicare provider number and HFID numbers for any branches.
  - a. Specify the mileage between the parent and current branch office(s).
  - b. Driving time between the parent and current branch office(s).
  - c. Note any unusual conditions such as urban congestion, travel by non-interstate, etc., that could affect travel time.
  - d. Please attach an organizational chart with staff names, titles and key management position descriptions to better illustrate lines of authority and administrative flow for both the parent and for each branch location including the proposed branch location.
4. **Service Area (Counties Served)** – Indicate the geographic area served:
  - a. **Parent** (these must have been approved by MDH and CMS previously and must be contiguous):  
\_\_\_\_\_
  - b. **New location** (proposed Counties wanting to service if different from parent: these must be contiguous to the parent): \_\_\_\_\_

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5. **Proposed New Location:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, & Zip: \_\_\_\_\_

Telephone number (including area code) of the new location: \_\_\_\_\_

6. Date the **new location** will treat its first patient: \_\_\_\_\_

7. **Business Hours** –Indicate the hours and the days of the week during which services are provided, for example, 8:00 A.M. to 5:00 P.M., Monday through Friday (include on call hours).

a. Parent: \_\_\_\_\_

\_\_\_\_\_

b. New location: \_\_\_\_\_

\_\_\_\_\_

8. Proximity

a. What is the mileage and approximate travel time between the **parent** office **and** the **new** location?

b. Note any unusual conditions such as urban congestion, travel by non-interstate, etc., that could affect travel time.

c. Please mark the counties you intend to offer services on the attached county map.

9. **Mark the services provided by the parent**, indicating whether each service is provided directly, through a contract or both.

Service Provided by Parent	Service Provided Directly	Service Provided by Contract
Skilled Nursing		
Home Health Aide		
Physical Therapy		
Occupational Therapy		
Other, specify:		

10. Indicate the number of **active** patients served from the **parent** location on the date this questionnaire is signed. \_\_\_\_\_

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11. Mark the services provided by the **new location**, indicating whether each service is provided directly, through a contract or both.

Service Provided by New Location	Service Provided Directly	Service Provided by Contract
Skilled Nursing		
Home Health Aide		
Physical Therapy		
Occupational Therapy		
Other, specify:		

**Administrative Function**

- 12. Agency administrator’s name/title:
- 13. Please show how the parent location exerts supervisory and administrative control over the proposed location.
- 14. List activities the Administrator is involved with the proposed location (include frequency/types of contacts) Include a copy of the Administrator’s job description.
- 15. Please provide several examples of how and when the Administrator and/or key staff from the parent office would be involved in the proposed branch location patient admission/care decisions.
- 16. Please explain and demonstrate the governing body’s role in managing the branch.
- 17. Are there common policies and procedures governing all operational aspects of the organization? If not, in what areas are they different?
- 18. Staff at **parent**. Attach a list of the number and type of employees, including contracted staff, at the parent office. Include their working hours. 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 workers, quality assurance staff, etc.
- 19. Staff at **new location**. List the number and type of employees, including contracted staff, at the new location. Include their working hours. 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 workers, quality assurance staff, etc.

## Supervision

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

### 20. Identify your supervising nurse or physician (42 CFR 484.14).

- a. How does this individual supervise and direct the skilled nursing and other therapeutic services of the agency for all locations of the home health agency?
- b. How is this person or qualified alternate made available during all agency operating hours?
- c. Include supporting documentation of any supervisory visits to the new location, such as: calendars, checklists, advisory notes, etc.
- d. What is the frequency of visits by the parent agency nurse supervisor?
- e. Is direct nursing supervision at the proposed location the same as that of the parent office? Please explain.
- f. Is a designated RN supervisor available to the proposed location during all hours of operation?

### 21. Please indicate the name and title of any parent or branch personnel who perform supervisory activities (as defined by regulations) at the **new location**.

- a. Indicate whether these supervisory personnel are assigned to the parent or the new location or both.
- b. Spell out the exact nature of the supervisory function and the frequency of the supervisory activity.
- c. Include supporting documentation of these visits to the new location such as: calendars, checklists, advisory notes, etc.

### 22. Answer this question only if the new location is self-supervising on a daily basis.

- a. Within your organizational structure how does your agency ensure the quality of care and appropriate delivery of services at the new location?
- b. Describe the ways by which the parent exercises 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 see if their needs are being met, etc.
- c. Describe these activities by type and frequency and the parent staff that performs them. If some of the new location staff is contracted, specifically describe how the services performed by contracted staff are overseen by the parent.

## Services

23. Identify which staff, if any, routinely provides home health agency services (skilled nursing, home health aide, physical therapy, occupational therapy, speech pathology, and medical social services) to patients at both the parent and the new location (attach and label pages if needed).
- Identify the services, under what circumstances, and how often this sharing of services occurs.
  - How will patient care services be coordinated between the parent office and the multi-site?
24. 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

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

25. Do administrative services originate from a central location, a corporate office, or a regional office other than the parent location?
- No.
- Yes, indicate the address of this location and explain the functions that it performs: \_\_\_\_\_
- \_\_\_\_\_
26. How are agency policies and procedures disseminated to the new location? \_\_\_\_\_
- \_\_\_\_\_
27. How does the parent office intend to provide procedural guidance, supervision, orientation/in-service training of proposed branch location staff? \_\_\_\_\_
- \_\_\_\_\_
28. Write the title of the person who performs each of the following functions for the new location and the parent location in the table below. (Ex: Administrator, or Hiring Manager...)

Function Performed	Parent Location	New Location
Hiring and firing		
Orientation and training		
Employee evaluations		
In-services		

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Function Performed	Parent Location	New Location
Contracts for services under arrangement		
Intake of new patients		
Billing		
Payroll		
Personnel records		
Custody of discharge patient records		

29. List those factors that favor viewing the proposed new branch location as a single entity under the parent site's provider number. \_\_\_\_\_  
 \_\_\_\_\_





*Protecting, Maintaining and Improving the Health of All Minnesotans*

## Submission Information

**The following must be signed and dated by the administrator of the parent home health agency and attached to the questionnaire when submitted.**

I certify that the responses to this HHA branch questionnaire are true, correct, and complete.

Signature: \_\_\_\_\_

Print your name: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Please submit completed questionnaire and signature page by email to: [Health.HRD-FEDLCR@state.mn.us](mailto:Health.HRD-FEDLCR@state.mn.us)

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Health Regulation Division  
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*To obtain this information in a different format, call: 651-201-4200.*

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