*Home Health Agency*

*Medicare Deemed Status Certification Checklist*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Applicant Name |  | | | |
|  |  | |  | |
| Agency Name (d/b/a) |  | | | |
|  |  | |  | |
| Agency Address |  | | | |
| Agency Telephone |  | End of Fiscal Year (mm/dd) | |  |
|  |  |  |  |  |
| Contact person |  | | | |
|  |  | |  | |
|  |  |  |  | |
|  | Tel # FAX# | | Email | |

**All the following must be completed before submitting this request. Please check** ⌧**.**

|  |  |  |
| --- | --- | --- |
| ATTACHED: **CMS-1561**, three copies all fresh-ink original copies. | ATTACHED: **CMS-1572 (a&b).**  Omit #s 7, 8, 11, 21, 22 | |
| ATTACHED: **HHS 690**, requires fresh-ink original.  -OR-  ATTACHED: Email receipt from on-line submission. | If the agency is owned by an organized entity such as a corporation, trust, or limited partnership, enter the 9-digit identification number registered with the Massachusetts Secretary of State: | |
| ATTACHED: OMB 0990-0243 **Civil Rights Information** with signed checklist and attachments.  -OR-  ATTACHED: Email receipt from on-line submission. |  |  |
| Identification number not applicable |
| ATTACHED: A **deemed status letter** from a Medicare-approved Accrediting Agency. It will state that your agency meets Medicare Conditions of Participation and the effective date of this finding. | The Fiscal Intermediary has issued a written approval of the provider’s CMS- 855A application. | |
|  | The agency is enrolled in OASIS. | |

|  |  |
| --- | --- |
| **With its completion of the requirements, above, the agency requests to be recommended for Medicare certification.** | |
|  |  |
| Name | Title |
|  |  |
| Signature | Date |

|  |  |
| --- | --- |
| Submit this request with attachments to: | Licensure Coordinator  Department of Public Health  Division of Health Care Facility Licensure and Certification  67 Forest Street  Marlborough, MA 01752 |