*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** ⌧**.**

|  |  |
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| [ ]  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. |

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| **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 CoordinatorDepartment of Public HealthDivision of Health Care Facility Licensure and Certification67 Forest StreetMarlborough, MA 01752 |