



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

**HOME CARE ORGANIZATION HOME MEDICAL EQUIPMENT 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	<input type="checkbox"/>	<input type="checkbox"/>	Home Health Aide Services	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Medical Supplies & Appliances	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Hospice Services	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Durable Medical Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Medical Social Services	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>
Homemaker Services	<input type="checkbox"/>	<input type="checkbox"/>			

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:

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