**Branch/Alternative Delivery Site Addition Application**

**Facility Name (DBA):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Effective Date of Branch/Alternative Delivery Addition:** \_\_\_\_\_\_\_\_\_\_\_\_ **State ID#**:\_\_\_\_\_\_\_\_\_

*In order for CMS to review applications for Home Health Agency Branch or Hospice Alternative Delivery Site certification, the following information must be submitted:*

1. **Location** *(document the physical address, phone and fax numbers):*

**Parent Office**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Branch Office/Alternative Delivery Site**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please **attach** a listing of the **geographical area and metropolitan statistical area** (MSA) served by parent and branch/alternative delivery site. Include the parishes, cities, and zip codes. Please indicate the date the geographical area was approved by CMS. ***(Attachment A)***
2. **Organization**

Patient census of parent = \_\_\_\_\_\_\_\_

Anticipated census of branch/alternative delivery site = \_\_\_\_\_\_\_\_\_

1. Please ***attach*** the **organizational chart** delineating lines of authority, reporting, and professional and administrative control for the HHA and the branch or the Hospice Agency and the alternative delivery site. Identify the person who will resolve patient care issues at the branch/alternative delivery site. ***(Attachment B)***
2. Describe how the **governing body assumes responsibility** for overall operations of the parent and branch or alternative delivery site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Attach** a copy of the policy for addressing clinical and other **emergency situations**. ***(Attachment C)***
2. **Attach** a copy of the agency’s plans for addressing **staff absenteeism**. ***(Attachment D)***
3. **Supervision**

Describe how and by whom the HHA or Hospice parent will provide daily supervision of the proposed branch or alternative delivery site’s operations. *(Does the parent and branch or alternative delivery site share staff on a daily basis? Who will provide daily supervision of the operations for the branch or alternative delivery site? How will the agency provide supervision? How will staff coordinate care and services?)*

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1. **Services**

List services provided directly and under arrangement by the parent and the branch or alternative delivery site. Indicate any services shared by the parent and the branch or alternative delivery site.

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| --- | --- | --- | --- |
| **Services Offered** | **Direct** | **Under Arrangement** | **Shared** |
| Nursing Services |  |  |  |
| Physical Therapy |  |  |  |
| Occupational Therapy |  |  |  |
| Speech & Language Pathology |  |  |  |
| Medical Social Worker |  |  |  |
| Home Health Aide |  |  |  |
| Chaplain (Hospice) |  |  |  |

**Note:** You must submit a CMS 855A to the fiscal intermediary for any branch requests. Your request for a branch addition cannot be forwarded to CMS until the FI has accepted/approved the 855A.