Wyoming Department of Health
Aging Division - Healthcare Licensing and Surveys
Hathaway Building, Suite 510, 2300 Capitol Avenue, Cheyenne, WY 82002
Fax: (307) 777-7127 - Telephone: (307) 777-7123
E-mail: WDH-OHLS@wyo.gov - Website: http://www.health.wyo.gov/ohls

HOME HEALTH AGENCY
Checklist for State Licensure

FACILITY NAME: _____

CITY: _____

CONTACT PERSON: _____

PHONE: _____ EMAIL: _____

Please mail or E-mail the following items to Healthcare Licensing and Surveys:

CHECK OFF	ITEM
	1. A completed license application form and required fee.
	2. Proof of a fidelity bond of no less than $2,500 augmented in relation to the number of employees.
	3. Copy of organizational chart that reflects the administrative control and lines of authority for the delegation of responsibility from management down to the client care level.
	4. Qualifications of administrator including resume and supporting documentation.
	5. Qualifications of supervisory nurse including resume, supporting documentation and professional license number.
	6. Copy of agreement with consulting nurse, if applicable.
	7. Copy of policy or procedure for ensuring all employees will have a DFS central registry check. Please provide verification of the DFS screen for the manager and all current employees.
	8. Copy of policy and procedure regarding scope of services provided.
	9. Copy of policy and procedure on quality management program.

	10. Copy of policy and procedure on client rights.
	11. Copy of written grievance procedure.
	12. Copy of policy and procedure indicating there shall be one person designated responsible for maintaining the confidentiality of personnel records.
	13. Copy of policy and procedure on employee health, including communicable disease information.
	14. Copy of policy and procedure on screening of potential employees.
	15. Copy of policy and procedures on advance directives.
	16. Copy of policy and procedures on homemaker services and training. (If your agency will not be providing homemaker services you must submit written documentation stating such.)

FOR HEALTHCARE LICENSING AND SURVEYS USE ONLY	
Date:	**Surveyor Assigned to Review:**
Surveyor Recommendation Review Summary/Comments: **Date** **Surveyor Signature:**	
State Survey Agency Director/Administrator (or designee) Comments: **Additional Information Needed:** ☐ **Approved:** ☐ **Denied:** ☐ **Date:** **Signature:**	