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
GEOGRAPHIC SERVICE AREA(S) EXPANSION

FACILITY NAME: _____

CITY: _____

CONTACT PERSON: _____

PHONE: _____ EMAIL: _____

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

CHECK OFF	ITEM
	1. Main agency location (physical address)
	2. What is your current approved geographic service area(s)? List by specific city/town name or if an entire county, identify the county. (ex: Cities of Cheyenne and Wheatland or County of Laramie, etc.)
	3. a) What additional geographic service area(s) would you like to expand to? List by specific city/town name or if an entire county, identify the county. (ex: Cities of Cheyenne and Wheatland or County of Laramie, etc.) b) Is the requested extended geographic service area contiguous to the currently approved area?
	4. Provide a detailed narrative outlining why are requesting to expand in each area(s). Explain the access of care need and provide data. (For example, is there no other providers in that area, to many clients for the number of providers in the area, etc. and provide as much supporting data as you can.)
	5. What services will be provided to each area and are they the same services as your current service area(s)?
	6. How will administration manage staff assignment and supervision? How will you monitor the added service area(s)?
	7. How will each area(s) be staffed? What will be the discipline type/qualifications of staff to ensure adequate coverage?
	8. If your agency uses contracted services, then a statement is needed to verify the contracting agency will be able to provide their services (list what services) and in what geographic area(s) they will serve.
	9. What is the process to ensure regulatory requirements for client onsite home supervisory visits are being met in each area(s)? How will client medical record information be kept secure and sent to agency's main office from staff in the service area(s)?

	10. How will you ensure clients in each area(s) will be served in cases of inclement weather or road restrictions?
	11. Have you received referrals from the new service area(s)? How many?
	12. Do you have any type of physical office located in the new service area(s)? If so, what is the address and what operations are being done in this location?
	13. Include a map that clearly identifies your current service area(s) and the new geographic service area(s) expanding to.
	14. If you are a Medicare/Medicaid certified provider, you will need to submit a CMS-855 to the MAC. Please identify the date the CMS-855 was submitted to MAC. Please send us copy of the MAC approval upon receipt.

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:**	