HOME CARE ORGANIZATION SUBOFFICE REQUEST

This form must be completed by all Home Care Organizations who wish to operate a suboffice. One form must be submitted for each suboffice location. A suboffice is defined in Section 90-000(s)(5) of the written directive and the administrative responsibilities are outlined in Section 90-030. If more space is required, attach additional sheet and please type or print clearly. For instructions on how to complete this form, refer to page two.

REQUEST TYPE

☐ Initial ☐ Renewal ☐ Change of Ownership ☐ Update

A. HOME CARE ORGANIZATION INFORMATION

HOME CARE ORGANIZATION NAME			HOME CARE ORGANIZATION NUMBER
HOME CARE ORGANIZATION ADDRESS	CITY	STATE	ZIP CODE
LICENSEE NAME(S)			AREA CODE/TELEPHONE ( )

B. SUBOFFICE INFORMATION

STREET ADDRESS	CITY	STATE	ZIP CODE

OPERATING DAYS AND OPERATING HOURS (no more than 24 hours within a seven calendar-day period)

C. SUBOFFICE DESIGNEE

DESIGNEE NAME(S)	DESIGNEE(S) TITLE

D. QUESTIONS (if more space is needed, please attach a separate sheet.)

1. What is the primary purpose for the suboffice?

2. How will the Home Care Organization ensure the following:

a. No full-time staff

b. No permanently stored records with confidential client and/or Home Care Aide information

I DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS FORM ARE CORRECT TO THE BEST OF MY KNOWLEDGE

HOME CARE ORGANIZATION LICENSEE SIGNATURE	COUNTY WHERE SIGNED	DATE

HOME CARE ORGANIZATION SUBOFFICE REQUEST INSTRUCTIONS:

Please type or print clearly and ensure that the form is filled out completely.

- Request Type: Check appropriate box.
- **Section A: Home Care Organization Information**
    - o Home Care Organization Name: Enter the name used to designate the primary Home Care Organization.
    - o Home Care Organization Number: Enter the Home Care Organization Number for the primary Home Care Organization.
    - o Home Care Organization Address: Enter the physical location address of the Home Care Organization.
    - o Licensee(s): Enter the name(s) of the person(s) or organization legally responsible for the primary Home Care Organization. Enter full names (Individuals enter first, middle name, and last name). Please enter the area code with telephone number of the Home Care Organization.
- **Section B: Suboffice Information**
    - o Suboffice Address: Enter the physical location address of the suboffice.
    - o Operating Days and Operating Hours: Enter the day and hours that the suboffice will be utilized. The suboffice cannot be used more than 24 hours within a seven calendar day time period.
- **Section C: Suboffice Designee**
    - o Designee Name and Title: Please enter the name and title of person who will represent the suboffice.
- **Section D: Questions**
    1. Please explain the primary purpose of the suboffice including how the Home Care Organization will utilize the suboffice.

    2a. Please describe how the Home Care Organization will ensure that staff is not present at the suboffice full-time (no more than 24 hours within a seven calendar day time period).

    2b. Please describe how the Home Care Organization will ensure that confidential records containing client, staff, volunteer, or Home Care Aide personal identifying information will not be permanently stored at the suboffice.