

Home Health Agency (HHA) – Parent Closure

Complete all the following information.

Health Facility Identification Number (HFID): _____

CMS Certification Number (CCN): _____

HHA Doing Business Name (DBA) name: _____

HHA address: _____

Effective date of closure: _____

Will the agency remain licensed? ☐ Yes ☐ No

Next Steps for HHA

- Email form to health.hrd-fedlcr@state.mn.us.
- Submit the CMS 855A to the Medicare Administrator Contractor (MAC). See [CMS 855A Medicare Enrollment Application \(PDF\) \(https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf\)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf).
- If deemed status, notify the accrediting organization.

Affirmation

☐ I certify that the information provided on this form is accurate and complete.

Signature of Administrator/Authorized Agent: _____

Name (print or type): _____

Title: _____

Date: _____

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4200
Health.HRD-FedLCR@state.mn.us

09/10/2025

If you have questions, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.