Home Care Grant

Application Checklist

- ☐ Completed Homecare/Home Health/Hospice Agency Applicant Information Form
- ☐ Completed Client Information and Home Care Plan
- ☐ Copies of all current applicable DOH licenses and Accreditations, as applicable
- ☐ Completed HIPAA Release Authorization
- ☐ Completed Confidential Information
- ☐ Completed Financial Affidavit
- ☐ Completed W-9 for each EIN included on application
- ☐ Copy of current Workers Compensation Certificate of Insurance
- ☐ Copy of current General Liability Certificate of Insurance
  - ☐ Minimum limit requirement:

    $1,000,000 per occurrence
    $3,000,000 aggregate

  - ☐ The following must be listed as an additional insured:

    Pennsylvania Home Care Association and
    Pennsylvania Foundation for Homecare and Hospice
    600 N. 12th Street, Suite 200
    Lemoyne, PA 17043

Send completed application packet to:
Attn: Home Care Grant Program
600 N. 12th Street, Suite 200
Lemoyne, PA 17043
Fax 717-975-9456

Questions accepted via email at mlicht@pahomecare.org or phone at 717-975-9448, ext. 27.

Home Care Grant

Homecare/Home Health/Hospice
Agency Applicant Information Form

Organization Name: _____

EIN/TIN: _____ Date of Inception: _____

IRS Address Line 1: _____

IRS Address Line 2: _____

IRS City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Website: _____

Primary Contact: _____ Title: _____

Prim. Contact Email: _____ Phone: _____

Are you a multi-site provider? □ No □ Yes, *add list w/ address, phone, fax of locations.*

Commonly owned organizations to be included in application:

_____ EIN: _____

_____ EIN: _____

_____ EIN: _____

Check All That Apply: □ Pennsylvania Home Care Agency Licensed *(attach copy of license)*

□ Pennsylvania Home Health Agency Licensed *(attach copy of license)*

□ Pennsylvania Hospice Agency Licensed *(attach copy of license)*

□ Accredited through _____ *(attach copy of license)*

□ Active Member of Pennsylvania Homecare Association

Office Hours:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

24/7 On Call: □ Yes □ No

Languages staff speak: _____

Agency County Coverage:

□ Adams	□ Clinton	□ Lackawanna	□ Pike
□ Allegheny	□ Columbia	□ Lancaster	□ Potter
□ Armstrong	□ Crawford	□ Lawrence	□ Schuylkill
□ Beaver	□ Cumberland	□ Lebanon	□ Snyder
□ Bedford	□ Dauphin	□ Lehigh	□ Somerset
□ Berks	□ Delaware	□ Luzerne	□ Sullivan
□ Blair	□ Elk	□ Lycoming	□ Susquehanna
□ Bradford	□ Erie	□ McKean	□ Tioga
□ Bucks	□ Fayette	□ Mercer	□ Union
□ Butler	□ Forest	□ Mifflin	□ Venango
□ Cambria	□ Franklin	□ Monroe	□ Warren
□ Cameron	□ Fulton	□ Montgomery	□ Washington
□ Carbon	□ Greene	□ Montour	□ Wayne
□ Centre	□ Huntingdon	□ Northampton	□ Westmoreland
□ Chester	□ Indiana	□ Northumberland	□ Wyoming
□ Clarion	□ Jefferson	□ Perry	□ York
□ Clearfield	□ Juniata	□ Philadelphia	

Business References

#1 Company: _____

Phone: _____ Email: _____

Contact Name: _____ Relationship: _____

Address: _____

#2 Company: _____

Phone: _____ Email: _____

Contact Name: _____ Relationship: _____

Address: _____

#3 Company: _____

Phone: _____ Email: _____

Contact Name: _____ Relationship: _____

Address: _____

Home Care Grant

Confidential Information

Have you, an agent, or a managing employee ever:

- □ Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program, limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

- □ Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in anyway, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority(e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

- □ Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

- □ In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

If you answered "yes" to any of the above, please attach documentation/explanation.

By signing below, you certify that the information provided by your organization is accurate and complete. You attest that your organization in good standing with the PA Department of Health and any other applicable regulatory bodies of oversight.

_____	_____
Signature of Authorized Designee	Title
_____	_____
Print Name	Date

PENNSYLVANIA FOUNDATION FOR HOME CARE AND HOSPICE

Home Care Grant

Client Application and Selection Process

Eligibility Criteria for Foundation Funds

- Individuals who temporarily or permanently reside in the Commonwealth of Pennsylvania
- Individuals who demonstrate a home health care need for home health care services
- Individuals with monthly income less than $5,000 (single) or $10,000 (dual income, including spouse/partner, excluding any child income)*
- Individuals who are not currently receiving or are not eligible for comparable home health care services through the following programs:
    - Any Pennsylvania Medicaid Waiver Program (including managed care programs)
    - Veterans who are receiving home health care benefits through the Aide and Attendance Program
    - Any other similar program as determined by the Foundation

All fund disbursements are at the sole discretion of the Pennsylvania Foundation for Homecare and Hospice ("The Foundation"). Nothing in this application or program creates any guarantee of funding or any obligation on the part of the Foundation to provide funding to any individual.

Agencies are limited to one (1) referral per month and should reserve referrals for clients with the highest need level.

Funding Policies and Procedures

Once approved, individuals will be granted access to funds of up to $2,500 per client to be used as 100 hours of non-medical home care services at $25/hour OR 25 skilled home health visits at $100/visit. Funds are payable directly to pre-approved licensed agencies.

Agencies must invoice The Foundation for payment of funds upon the termination of grant funded services. Invoices should include dates of service, hours completed, client name, agency name, agency address (payable to), and a signature of client confirmation of services. Approved invoices will be paid within 30 days of receipt via a check issued to the provider by The Foundation.

Funds must be utilized within one (1) year of approval from the Foundation. Upon the expiration of the year, the Foundation will grant the agency a 60-day period to submit invoices for payment. After this time, if an invoice has not been received, the Foundation will redirect the allocated $2,500 to another client for use.

Exceptions:

1. If a client is put on hold due to a hospitalization, facility stay, family visitation, or other similar scenario, the agency must notify the Foundation via email to receive an extension beyond one year for the complete use of funds.

2. If a client passes prior to the completion of the allotted $2,500 of services, the agency shall notify The Foundation via email and submit a final invoice for those services that were utilized. The Foundation will prorate the funds as follows:
   $25/hour for non-medical services rendered OR $100/visit for skilled services rendered.

3. If a client becomes eligible for home health care services through a PA Medicaid Waiver Program, Veterans Affairs' Aide and Attendance Program, or through another similar program, services through this Foundation will cease. It is the responsibility of the client, the representative and the agency to notify The Foundation when other home health care funding sources become available. Providers will be paid only the portion of the grant that was rendered prior to approval through the alternative funding source, calculated as $25/hour for non-medical care or $100/visit for skilled care.

Funding Request and Submission Process

- The client or client representative and the supporting agency must complete the attached Client Application in full.

- Send the application to:
  The Pennsylvania Foundation for Homecare and Hospice
  600 N. 12th Street, Suite 200
  Lemoyne, PA 17043
  Fax: 717-975-9456

- A notification of approval/declination of funding will be sent to the agency and client/ representative via email. Upon notice of approval, services may begin. All 100 hours OR 25 visits of home health care must be utilized within one year of this date, except as provided above.

- Upon completion of care, the agency will send an invoice to The Foundation including the following:

a. Client name
b. Dates of service
c. Hours completed per date of service
d. Agency name
e. Agency address (payable to)
f. A signature from the client verifying that the services were provided as invoiced (signed timesheets, EVV, or a one-page statement will do)

- For approved invoices, payment will be rendered to the agency within 30 days of receipt via a check issued to the provider by The Foundation.

*Income limits and other terms and conditions are subject to change, at the sole discretion of The Foundation.

HIPAA Release Authorization

I,_____, hereby authorize my physicians, nurses, home care agency, and all other health care providers and their staff (collectively, "health care providers") involved in my health care treatment, to release information regarding my location, medical condition, diagnosis and prognosis, as well as any other information about me, to include individually identifiable health information, and to freely converse and communicate, both orally and in writing, with the persons named below.

This document does not grant health care decision-making authority and does not in any way affect, inhibit, or otherwise limit the authorization granted in any existing health care power of attorney that I may have executed.

This document, executed by me pursuant to the Health Insurance Portability and Accountability Act of 1996, is effective immediately and is not to be affected by any subsequent incapacity.

I hereby release the disclosers of the above information from any liability for its release to the persons below. This authorization shall be in force and effect only for a period of one year from the date signed, below. The persons to whom my health care providers may disclose the above information, including individually identifiable health information, are:

The PA Foundation for Home Care and Hospice
and any of its employees or representatives
600 N. 12th Street, Suite 200, Lemoyne, PA 17043
Phone: 717-975-9448

AND

Name: _____ Phone:_____

Address: _____

AND

Name: _____ Phone:_____

Address: _____

_____ _____

Client/Representative Signature **Date**

_____ _____

Witness Signature **Witness Printed Name**

Financial Affidavit

Date: _____

County: _____

State: _____

Client/Affiant (Full Legal Name): _____

I, the undersigned,_____, who is a resident of

_____County, State of_____, makes this his/her statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts and things set forth are true and correct to the best of his/her knowledge: I certify that_____, the applicant for home health care services, has a total personal monthly income that does not exceed $5,000 (single) or $10,000 (dual income, including spouse/partner, excluding any child income*),in accordance with the guidelines and service criteria defined by the Pennsylvania Foundation for Home Care and Hospice's Home Care Grant program. Furthermore, I certify that the applicant for home health care services is not currently receiving similar services through a Pennsylvania Medicaid Waiver Program nor is the applicant a veteran receiving similar services through the VeteransAffairs'Aide and Assistance Program or similar program.

_____ _____

Client/POA Signature **Date**

_____ _____

Witness Signature **Witness Printed Name**

Home Care Grant

Client Information and Home Care Plan

Client Demographics

Name_____ Phone_____ DOB_____

Address_____

Emergency Contact_____ Relationship_____

Email_____ Phone_____

PCP Name_____ Phone_____

Planned Frequency of Home Health Care Services

(subject to change by customer request)

Care to be delivered in increments of_____ hours per_____ *(i.e. 2 hrs/week)*

Type of Care Requested

Personal Care

- ☐ Toileting
- ☐ Incontinence Care
- ☐ Bathing
- ☐ Grooming
- ☐ Lifting/Transfer Assistance
- ☐ Ambulation Assistance
- ☐ Medication Reminders

Other _____

Homemaker

- ☐ Meal Preparation
- ☐ Housekeeping
- ☐ Laundry
- ☐ Transportation

Skilled Care

- ☐ Skilled Assessment/Observation
- ☐ Medication Adherence/Management
- ☐ Disease Management
- ☐ Patient Education

Reason for Home Health Care Need

Check all that apply:

- ☐ Decline in Health Status
- ☐ Hospitalization within 30 days
- ☐ Discharge from LTCF within 30 days
- ☐ Other: _____
- ☐ Supplementing private pay services
- ☐ Waiting for funding approval through:_____

Other Current In-Home Services

Check all that apply:

- ☐ Meals on Wheels
- ☐ Other funded skilled Home Health Care
- ☐ Other funded non-medical Home Care
- ☐ Personal Emergency Response System
- ☐ Telehealth
- ☐ Other:

Client, representative and agency must notify The Foundation immediately if another funding source for home care services becomes available while active with The Foundation's Home Care Grant.