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 foundation@pahomecare.org or phone at 717-975-9448, ext. 22.

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: _____ Fax: _____

Contact Name: _____ Relationship: _____

Address: _____

#2 Company: _____

Phone: _____ Fax: _____

Contact Name: _____ Relationship: _____

Address: _____

#3 Company: _____

Phone: _____ Fax: _____

Contact Name: _____ Relationship: _____

Address: _____

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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