Application and Information Packet

Home Options Program

Proposed Contract Period   **01/01/2016 – 12/31/2017**

GENERAL INFORMATION

The software is hosted by Clermont Senior Services. Users connect via the internet through a secure connection to access the system.

Providers are required to have internet access to enable connection to the software. Any type of internet access via an **ISP** (**I**nternet **S**ervice **P**rovider) or direct connect should work.

It is the provider's responsibility to ensure they can connect to the internet and can access the Clermont Senior Services homepage (www.clermontseniors.com).

If the provider uses a firewall to access the internet, they may need to open port 3389 for Remote Desktop Protocol.

The computer software allows the user the ability to print notices and reports at their location, and expects a printer to be accessible to the PC used to connect to the computer system (either connected directly to the PC or available as part of a local area network). Most high quality name brand (HP, Lexmark, Canon, IBM, etc.) inkjet or laser jet printers will work with the system. Multifunction printer/fax/copier machines are not guaranteed to work and may not be supported. Due to lack of fonts and emulation modes, we cannot support dot matrix printers.

> The Provider must have an adequate computer hardware/software system in order to access, and print from, Clermont Senior Services system. Approval must be sought and given in writing by Clermont Senior Services for a waiver of this requirement.

WHAT YOU NEED
- Adequate computer/hardware/software system to access CSS software system.
- Internet browser.
- High Speed Internet Access (Minimum DSL and/or cable modem)
- CSSI's website address: http://qhop.clermontseniors.com.
- User Name and Password. (Provided at training.)

TECHNICAL SUPPORT
CSS provides support to providers as it relates to the software system. Staff is available to handle the administrative needs of the computer system, such as assigning users and passwords.

CSS IT staff will provide technical support for provider's communications with the HOP computer system only. We cannot provide support for the provider's computer equipment or connectivity to the internet except as it relates to connection to the software. Questions regarding these specifications or to obtain additional information regarding connectivity or problems please contact:

Coverage and Service
CSS will provide support Monday – Friday between the hours of 8:00 a.m. – 4:30 p.m. and will be staffed during these hours. In the event your call goes to voicemail, please leave a message and the call will be returned as soon as possible, but no longer than 4 business hours.

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IT Department
(513) 536-4016
(513) 536-4116 fax

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Terms/Definitions

The following terms and abbreviations will be used throughout the Application and Information Packet:

CSS: Clermont Senior Services
HOP: Home Options Program
PY: Program Year
RFS: Request for Service

CSS reserves the right to reject any Application

Application available for download @ www.clermontseniors.com

Enclosed in this Application Packet:

Conditions of Participation
Service Specifications
Employee Code of Ethics
OAC Criminal Check Rule
New Applicant Information
Instructions for Completing Application
Application Provider Certification
Application Rate Page
Sample Copy of HOP Service Agreement
CSSI Staff Direct Phone Lines
Home Care Service Eligibility Guidelines
"Service With Heart" Cultural Philosophy Guide

Due Date
Applications must be submitted in a sealed envelope plainly marked CSS-HOP Application on the outside. They must be either hand delivered or sent via any method which produces a return receipt.

Applications must be received:
        By Friday, November 6, 2015
        No later than 2:00 p.m.

Send/Delivered Applications to:
        Rachel Snyder, Home Care/Case Management Director
        2085 James E. Sauls, Sr. Drive
        Batavia, Ohio 45103

Information Regarding Rate Calculations
All Applicants desiring to provide the following services in Clermont County are required to complete and submit a separate Rate Calculation Worksheet with their Application for each individual service they anticipate providing.

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Homemaker Service
Personal Care Service
Respite Care Services

HOP reserves the right to adjust rates or establish ceilings.

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Applicants submitting an Application with a requested rate higher than the established ceiling rate will be extended an Agreement/contract* at the ceiling rate. Applicants submitting a requested rate equal to or lower than the established ceiling rate will be extended a contract at the rate requested in their Application.   (*Applicants must be approved and certified before a Service Agreement can be issued.)

Please note that the term of this Agreement will be for two years. REMEMBER the rate you request on the Application has a direct impact on the ceiling rate established by HOP!

Service Referral and Award
- Only Providers who have specified that they serve the customer's zip code will be presented for consideration.
- Any Provider that has been placed on "hold" will not appear on the referral list or offered the referral.
- If Homemaker, Personal Care Services, and Respite are to be offered, the referral will be based on the cost of the service that has the greater number of units.

HOP reserves the right, with the consent of the customer, to transition a customer to another Provider based on, but not limited to, consideration of price or quality of service.

I.   All Applicants

1. HOP Application for Service Provider Certification
2. Application HOP HC Rate Page 8.11
3. Insurance Declaration
4. Workers' Compensation Certificate
5. Copy of Registration/Certificate of Good Standing from the Ohio Secretary of State's Office

II.   All New Applicants

If you are a new Applicant, the following should be returned along with your completed Application Packet:

1. Statement of Ownership (list of all persons with 5% or more ownership)
2. List of the names/addresses of governing body
3. Statement of purpose/description of specific services provided.
4. Table of Organization (T.O.) identifying lines of administration, advisory, contractual, and supervisory authority to the direct care level.
For the above, please refer to the application attachment requirement, numbers 14, 15 and 16 on the HOP Application for Service Provider Certification for further information and suggested documentation.
5. Articles of Incorporation
6. IRS 501 (3) (c) determination letter
7. CPA Management letter
8. Personnel Policy
9. Discrimination Policy/Affirmative Action Plan

III.   Existing Provider Applicants

1. New Information *in the case of any changes* relative to information required of new applicants

INSTRUCTIONS FOR COMPLETING THE CSS HOP APPLICATION.

PLEASE TYPE OR PRINT ALL INFORMATION EXCEPT SIGNATURE.

I.   IDENTIFYING INFORMATION:

1. **Legal Name of Applicant:** Enter your full legal name. Except for Sole Proprietor applicants, the legal name must match the legal name attached to your Federal Tax ID Number.
2. **Federal Tax Identification Number:** Please enter your Employer Identification Number (EIN) if you are required to have an EIN by the Internal Revenue Service Instructions for Employer Identification Number.
3. **Doing Business As (dba)**, if applicable: If your agency or business uses a name that is different from your legal name, please enter.
4. **Sites Doing Business in This Service Area:** Please enter the following for the locations where you do business:
    *   Administrator/Director
    *   Street
    *   City, state, and zip code
    *   Area code and phone number
    *   FAX number, if available, where materials can be FAXed to you
    *   E-Mail address
    *   Intake/Scheduler (if applicable)
5. **Medicare Certified Home Health Agency?** Please check "yes" if your agency is Medicare certified, or "no" if you are not. If you checked "yes", please enter your Provider Number.
6. **Medicaid Certified Home Health Agency?** Please check "yes" if your agency is Medicaid certified, or "no" if you are not. If you checked "yes", please enter your Provider Number.
7. **PASSPORT/MyCare Ohio Certification?** Please check "yes" or "no."

8. **Veterans Affairs Home Care Provider?** Please check "yes" if your agency is certified by the VA, or "no" if you are not. If you checked "yes", please enter your Provider Number.
9. Accredited: JCAHO, CHAPS, Other? Please check "yes" or "no."
10. Days of Operation/Hours of Operation
11. Are employees bonded? Please check "yes" or "no."
12. **Ownership:** Please check the option best describing ownership of your business.
13. **Legal Structure:** Please check the option that best describes your legal structure.
14. **Name, Title, Address and Phone of Individual Authorized to Sign Provider Agreement.**

II.   STATEMENT OF UNDERSTANDING

The signature, title and date indicate that the applicant attests to the statements to which the signature is attached.

III.   APPLICATION ATTACHMENTS

Submit only if new provider or if change in ownership since last application. Please mark each attachment with the Item Number and submit with application.

15. The **Item Numbers** refer to the Conditions of Participation that require the material to be submitted.
16. The **Description** refers to the material that must be included as an application attachment.
17. **Suggested Documentation** refers to the type of material that will fulfill the description in Item #15.

IV.   SERVICES APPLYING TO PROVIDE:

18. **Type of Service:** Please place a check in the designated space for each service you are applying for.
19. **Service Delivery Area:** Complete this section if you are providing services in limited areas of the County. **PLEASE INCLUDE ZIP CODES OF AREAS YOU WILL SERVICE**. It will be assumed you will provide service throughout the entire County if no areas are designated.
19. **Rate:** Please enter your expected rate of reimbursement**.**