# HOP APPLICATION FOR SERVICE PROVIDER CERTIFICATION

**Contract Year 2016-2017**

**IDENTIFYING INFORMATION**

| | | | |
|---|---|---|---|
| 1. Legal Name of Applicant: | | | 2. Federal Tax ID #: |
| 3. Doing Business As (d.b.a.) if applicable: | | | |
| 4. Sites Doing business in this service area: | | | |
| | Site #1: | Site #2: | Site #3: |
| Admin./Director: | | | |
| Street Address: | | | |
| City, State and Zip: | | | |
| Phone Number: | | | |
| Fax Number: | | | |
| Email address: | | | |
| Intake/Scheduler: | | | |

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|---|---|---|---|---|---|---|---|
| 5. Medicare Home Health Agency? | ☐ Yes Provider #: | | | | | ☐ No | ☐ N/A |
| 6. Medicaid Home Health Agency? | ☐ Yes Provider #: | | | | | ☐ No | ☐ N/A |
| 7. Current Passport/MyCare Ohio Provider? | ☐ Yes Provider #: | | | | | ☐ No | ☐ N/A |
| 8. Current Veterans Affairs Provider? | ☐ Yes Provider #: | | | | | ☐ No | ☐ N/A |
| 9. Are employees bonded? ☐ Yes ☐ No | | | | | | | |
| 10. Days of Operation? | ☐ Mon. | ☐ Tues. | ☐ Wed. | ☐ Thurs. | ☐ Fri. | ☐ Sat. | ☐ Sun. |
| Hours of Operation? | | | | | | | |
| 11. Accredited? | JCAHO ☐ Yes ☐ No ☐ N/A<br>CHAPS ☐ Yes ☐ No ☐ N/A<br>OTHER ☐ Yes ☐ No ☐ N/A Name: | | | | | | |
| 12. Ownership: | ☐ Private | ☐ Private/Non-Profit | ☐ Public/Government<br>☐ Charitable/Religious | ☐ Publicly Traded | ☐ Other | | |
| 13. Legal Structure | ☐ Sole Proprietorship | ☐ Partnership | ☐ Corporation<br>☐ Non-Profit Corporation | ☐ Voluntary Corporation | ☐ S Corporation | | |
| 14. Name, Title, Address, and Phone # of individual authorized to sign Provider Agreement:<br>Name: Title:<br>Address: Phone #: | | | | | | | |

**STATEMENT OF UNDERSTANDING**

The applicant affirms that the information contained in this application is true to the best of their knowledge and belief. The applicant assures that it currently provides, the services for which it is applying. The applicant also affirms that the Conditions of Participation and all applicable Service Specifications have been read and are understood. The undersigned further understands that implementation of and adherence to the Conditions of Participation and Service Specifications in the delivery of authorized services will be binding in accordance with the provider agreement in order to receive reimbursement for services delivered and to maintain provider certification.

| | |
|---|---|
| **Signature:** | **Title:** |
| **Printed Name:** | **Date:** |

**APPLICATION ATTACHMENTS**

**Every** application must include copies of **each** of the following items as attachments to the application submitted to Clermont Senior Services. These items shall be marked with the application attachment number. The item numbers refer to the Conditions of Participation. **Attachments required only if new provider or if change in ownership since last application.**

| 15. **ITEM #** | 16. **DESCRIPTION** | 17. **SUGGESTED DOCUMENTATION** |
|---|---|---|
| COP 1.1 | Statement of ownership. | A list of all persons with 5% or more ownership. |
| COP 1.1 | List of the names and addresses of the governing body. | **Not applicable to individual owner/operator** Board of Directors roster. |
| COP 1.2 | Statement of purpose/description of specific services provided. | Corporations: As stated in Articles of Incorporation Others: Description of programs or services offered. |
| COP 1.3 | Table of organization (T.O.) identifying lines of administrative, advisory, contractual and supervisory authority to the direct care level. | **Not applicable to individual owner/operator.** Printed or written table of organization. Corporations & multi-location business T.O. must show placement of corporate and regional offices. T.O. must clearly show placement of the services to be provided for HOP. |