**INSTRUCTION FOR COMPLETING THE CSS HOP APPLICATION**

**PLEASE TYPE OR PRINT All INFORMATION EXCEPT SIGNATURE**

1. **IDENTIFYING INFORMATION**
2. **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.
3. **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.
4. **Doing Business As (dba),** if applicable: If your agency or business uses a name that is different from your legal name, please enter.
5. **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)
1. **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.
2. **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.
3. **PASSPORT/MyCare Ohio Certification?** Please check “yes” or “no”.
4. **Are employees bonded?** Please check “yes” or “no”.
5. **Days of Operation/ Hours of Operation**
6. **Accredited:** JCAHO, CHAPS, Other? Please check “yes” or “no”.
7. **Ownership**: Please check the option that best describes ownership of your business.
8. **Legal Structure**: Please check the option that best describes your legal structure.
9. **Name, Title, Address and Phone of Individual Authorized to Sign Provider Agreement.**
10. **STATEMENT OF UNDERSTANDING**

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

1. **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.

1. The **Item Numbers** refer to the Conditions of Participation that require the material to be submitted.
2. The **Description** refers to the material that must be included as an application attachment.
3. **Suggested Documentation** refers to the type of material that will fulfill the description in Item #15.
4. **SERVICES APPLYING TO PROVIDE**

**Type of Service**: Homemaker Service, Personal Care Service, and Respite Service.

**Service Delivery Area**: **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.
**Rate:** Enter your expected rate of reimbursement, for each service.

1. **PROVIDER INFORMATION FORM**

This form is intended to update information maintained and utilized by Clermont Senior Services staff for your agency. **Please keep in mind, especially with regard to Referrals for Service, this information may be critical to your agency’s ability to receive and accept referrals, and to be awarded services.**

**Information Regarding Rate Calculations**

All Applicants desiring to provide any of the following services in Clermont County are required to complete and submit a separate rate for each service they anticipate providing with their Application.

**Homemaker Service**

**Personal Care Service**

**Respite Care Services**

**HOP reserves the right to adjust rates or establish ceilings.**

Applicants submitting an application with a requested rate higher that 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.**

**Service Referral and Award**

* Only Providers who have specified that they will 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 services that has the greater number of units.

**All Applicants** must provide

* HOP Application for Service Provider Certification
* Application HOP Rate Sheet
* Insurance Declaration
* Workers’ Compensation Certificate
* Copy of Registration/Certificate of Good Standing from the Ohio Secretary of State Office.

**All New Applicants** must provide

* Statement of Ownership (list of all persons with 5% or more ownership)
* List of the names/addresses of governing body.
* Statement of purpose/description of specific services provided
* 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, number 14, 15, and 16 on the HOP Application for Service Provider Certification for further information and suggested documentation.*

* Articles of Incorporation
* IRS 501(3) (c) determination letter
* CPA management letter
* Personnel Policy
* Discrimination Policy/Affirmation Action Plan

**Existing Provider Applicants**

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