Office Use Only:

_____ New Provider Information

_____ Updated Provider Information

CHOICE/SSBG/Title III PROVIDER ENROLLMENT PROFILE

SECTION I

Legal Business Name: _____

Doing Business As Name (if applicable): _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mailing Address (if different from above): _____

Phone: (____) _____ **Fax:** (____) _____ **Website Address:** _____

EXECUTIVE DIRECTOR

Name: _____ **Phone:** (____) _____

Email Address: _____ **Fax:** (____) _____

Name/Title of person signing contract, if different from Executive Director:

_____

Name/Title of person completing packet:

_____

REFERRAL CONTACT PERSON

Name: _____ **Phone:** (____) _____

Email Address: _____ **Fax:** (____) _____

CLAIMS/AUTHORIZATIONS CONTACT PERSON

Name: _____ **Phone:** (____) _____

Email Address: _____ **Fax:** (____) _____

Employer Tax ID #: _____

DUNS #: _____ [For more information: http://fedgov.dnb.com/webform]

Type of Organization: ____Faith-Based ____For-Profit Corp ____Government Entity ____Limited Liability Corp

____Non-Profit Corp (include 501(c)(3) certification letter) ____Partnership ____Sole Proprietorship ____Support

Year of Incorporation/Start-Up Date: _____

SECTION II

1.	Has your agency been accredited by an outside organization? If yes, which organization? _____	____ Yes _____ No
2.	Are you licensed by the State of Indiana? **If yes, please provide a copy of all relevant state licenses.**	_____Yes _____No
3.	Does your company carry general liability insurance in a minimum amount of $1,000,000.00 (one million)? **A Certificate of Insurance with CICOA listed as an Additional Insured must accompany this application.**	_____Yes _____No
4.	Are your employees, who will handle funds or provide services relevant to a contractual relationship with CICOA, bonded and insured to protect against losses resulting from criminal acts and wrongful and negligent performance of duties? Please provide certificates detailing amounts of coverage.	_____Yes _____No
5.	Are you certified to provide Medicare services in Indiana?	_____Yes _____No
6.	Are you certified to provide Medicaid services in Indiana?	_____Yes _____No
7.	Are you certified to provide Medicaid Waiver services in Indiana?	_____Yes _____No
8.	Are your workers employees of your agency?	_____Yes _____No
9.	Are you an Equal Opportunity Employer?	_____Yes _____No
10.	How do employees report time services are provided?	_____Phone clock-in _____Timesheet _____Other: _____
11.	Do you have a minimum time requirement for service visits? _____ _____	_____Yes _____No
12.	Do you allow the hiring of clients' family members to provide their care? Briefly describe: _____ _____	_____Yes _____No
13.	Are your workers supervised and evaluated? By whom and how often? _____ _____	_____Yes _____No
14.	Do your workers receive on-going training? Briefly describe: _____ _____	_____Yes _____No
15.	Are updates/new information shared with direct care staff? Briefly describe: _____ _____	_____Yes _____No
16.	Do you have procedures for handling client concerns and complaints? Briefly describe: _____ _____	_____Yes _____No

17. Is your organization able to serve the elderly and those with disabilities regardless of age? If no, which population do you serve? _____	_____Yes _____No
18. Are your employees allowed to transport clients? Briefly describe your policies for transporting clients: _____ _____	_____Yes _____No
19. Are your employees allowed to handle client funds? If so, briefly describe your procedures for handling client funds: _____ _____	_____Yes _____No

20. Standard Office Hours: _____

Describe After-Hours/On-Call Accessibility: _____

List Observed Holidays: _____

Check here if your agency has the staffing capacity to provide services during evening and overnight hours if needed: ☐

Check here if your agency has the staffing capacity to provide services on holidays when office is closed: ☐

21. Describe methods used to determine when weather emergencies or other circumstances would cause your organization to close and force cancellation of client services and how clients will be informed of cancellations (please provide written agency procedures):

_____

_____

22. **CICOA Aging & In-Home Solutions** requires provider agencies to provide back up for staff unable to be at their assignments for any reason. Describe your policies regarding back up (please provide written agency procedures):

_____

_____

23. Please mark the counties in which you intend to provide services:

____Boone ____Hamilton ____Hancock ____Hendricks

____Johnson ____Marion ____Morgan ____ Shelby

24. Is your office location wheelchair accessible?	_____Yes _____No
25. Is your office location near public transit?	_____Yes _____No

26. How should people contact you? ☐ Phone ☐ Email ☐ Referrals ☐ Walk-In ☐ Website

27. Are services available or clients who speak languages other than English?	_____Yes _____No

If yes, please list other languages? _____

28. Please provide the private pay rates for your services. Keep in mind that the private pay rate should not be any lower than the rate paid for Medicaid waiver and/or CHOICE clients. _____ _____	
29. Is your organization a minority-owned agency?	_____Yes _____No
30. Is your organization a women-owned agency?	_____Yes _____No

SECTION III

Please indicate which services your agency intends to provide under CHOICE, SSBG and Title III funding. **All rates listed below are caps. Each service may be provided at a lower rate. Please indicate in the Additional Comments section the rate to be charged if lower than the cap.**

Rates effective beginning 2/1/2020

Check if service will be provided	Service Code	Service	Unit Rate	Unit of Measure	Additional Comments
☐	AD1	Category 1 Level 1 – Adult Day Service	$2.82	0.25 HR	
☐	AD1	Category 2 Level 1 – Adult Day Service	$2.64	0.25 HR	
☐	AD2	Category 1 Level 2 – Adult Day Service	$3.40	0.25 HR	
☐	AD2	Category 2 Level 2 – Adult Day Service	$3.18	0.25 HR	
☐	AD3	Category 1 Level 3 – Adult Day Service	$3.91	0.25 HR	
☐	AD3	Category 2 Level 3 – Adult Day Service	$3.66	0.25 HR	
☐	ADST	Transport – Adult Day Srvc	$18.19	TRIP	
☐	*ATCH	Specialized Med Equip – INST	$.01	UNIT	***Complete Attachment B***
☐	*ATCM	Specialized Med Equip – MAI	$.01	UNIT	***Complete Attachment B***
☐	ATTC	Attendant Care	$5.82	0.25 HR	
☐	*DURM	Durable Medical Equipment	$.01	UNIT	***Complete Attachment B***
☐	*EMOI	Environmental Mod – INST	$.01	UNIT	***Complete Attachment B***
☐	*EMOM	Environmental Mod – MAI	$.01	UNIT	***Complete Attachment B***
☐	HCA	Home and Community Assistance (Homemaker)	$4.99	0.25 HR	
☐	HOHE	Home Health Aide	$5.59	0.25 HR	
☐	*OTH	Other Services	$.01	UNIT	***Complete Attachment B***
☐	PRSI	Per Rsp System – INSTALL	$54.51	1 UNIT	*Complete Attachment B with specified Rate
☐	PRSM	Per Rsp System – MONTHLY	$54.51	1 UNIT	Complete Attachment B with Specified Rate
☐	PEST	Pest Control	$.01	1 UNIT	*Complete Attachment B*
☐	SKNU	Skilled Nursing (RN)	$14.33	0.25 HR	

☐	SKNU	Skilled Nursing (LPN)	$10.57	0.25 HR	
☐	SFC 1	Structured Family Caregiving Level 1	$60.50	Per Day	
☐	SFC 2	Structured Family Caregiving Level 2	$71.04	Per Day	
☐	SFC 3	Structured Family Caregiving Level 3	$81.58	Per Day	
☐	*SUPP	Home Health Supplies	$.01	UNIT	***Complete Attachment B***
☐	*VMOD	Vehicle Modification	$.01	UNIT	***Complete Attachment B***

ATTACHMENT B

SERVICE DESCRIPTION

ONLY COMPLETE THIS SECTION WITH INFORMATION ABOUT THE SERVICES IN SECTION III WHICH ARE HIGHLIGHTED AND MARKED WITH AN ASTERISK. ATTACH ADDITIONAL PAGES AS NECESSARY.

PROVIDER NAME:

_____

SERVICE NAME:

_____

SERVICE DESCRIPTION (include cost of service):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____