**Connections Area Agency on Aging**

 **Non-Waiver Provider Application Form**

**FY 2023**

Agency Name:

Agency Address:

Phone: Fax:

**Referral Contact**: Phone:

E-Mail for **Referral Contact**:

**Billing Contact**: Phone:

E-Mail for **Billing Contact**:

**Application/Contract/Credentialing Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_**

Email for **Application/Contract/Credentialing Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Instructions**: *Application cannot be processed if the directions are not followed.*

Place an X in the Vendor Service column for every service(s) you provide. Enter the rate that you will bill for each service you want to provide. If your rate exceeds the Maximum Reimbursement Rate, the Application will not be approved. Attach a copy of your liability and worker’s compensation insurance to application. Mark the boxes on the back of the page that insurance is attached and sign the application. When the application is approved, it will be signed by Connection staff and a copy will be returned to you with a billing file via e-mail. Connections reserves the right to select the most cost-effective provider for a consumer.

|  |  |  |  |
| --- | --- | --- | --- |
| **Please Mark the service(s) you will provide** | **Services Available** | **Rate** **Please enter the rate you will be charging**. (If your rate is higher than max reimbursement, enter a note on the form as to whether you will or will not accept the maximum reimbursement rate. | **Maximum Reimbursement Rate** |
|  | Chore Services |  | $20.00/ hour |
|  | Emergency Response – Initial Installation |  | $50.52/initial installation fee |
|  | Emergency Response – Ongoing Monthly |  | $39.29/ ongoing monthly fee |
|  | Home Delivered Meals |  | $8.10/per meal |
|  | Homemaker |  | $25.00/hour |
|  | Home Repairs/Environmental Adaptations |  | Per individual bid |
|  | Material Aide/Assistive Devices |  | Per individual bid |
|  | Medication Management |  | $101.00/ per session |
|  | Mental Health Outreach |  | $24.27/quarter hour |
|  | Nutrition Counseling |  | $33.66/ hour |
|  | Personal Care |  | $35.00/hour |
|  | Protective Payee Service |  | $20.80/hour |
|  | Respite (in home) |  | $20.00/hour  |
|  | Transportation - Assisted |  | $57.86 Long trip/one way$21.61 Short Trip/one way |
|  | Transportation |  | $28.92 Long trip/one way$10.80 Short Trip/one way |

**Service Area**

**Please mark the Geographic Service Area that as a provider, you will provide services to:**

**[ ]** All counties

[ ] Adams [ ] Adair [ ] Cass [ ] Cherokee [ ] Clarke [ ] Decatur [ ] Fremont [ ] Harrison [ ] Ida [ ] Mills [ ] Monona

[ ] Montgomery [ ] Page [ ] Plymouth [ ] Pottawattamie [ ] Ringgold [ ] Shelby [ ] Taylor [ ] Union [ ] Woodbury

**Profit Status**

**Please check:** [ ]  Non-Profit

[ ]  For Profit

**[ ]  I have attached a copy of my insurance Certificate of Liability.**

**[ ]  I have attached a copy of my verification of Workman’s Compensation Insurance.**

**[ ]  I have attached a copy of my W-9.**

**Certification**

I certify that I have read and agree to the Connections Area Agency on Aging Non-Waiver Program Operational Guidelines. I also certify that the above information is current and accurate.

**Provider**: Signature of Authorizing Official; Title Date

**Connections AAA**: Signature of Authorizing Official; Title Date

**Covid Assurances**

The wellbeing of our clients is of foremost importance to us. To this end we are asking all providers to tell us what precautions they are taking to prevent the spread of the coronavirus to clients as well as staff. The CDC and the State of Iowa have provided guidelines for everyone to follow. We are asking you to please provide us with a list of the safeguards your agency has instituted to address the risks associated with this Covid – 19 pandemic by answering the following questions.

Are you:

(Yes or No)

\_\_\_\_\_ Requiring staff to wear face masks?

 \_\_\_\_\_ Providing the face masks?

\_\_\_\_\_ Requiring staff to wear latex gloves?

\_\_\_\_\_ Providing the gloves?

\_\_\_\_\_ Providing hand sanitizer and disinfectant wipes?

\_\_\_\_\_ Limiting travel/vacations of staff?

\_\_\_\_\_ Requiring staff to self-quarantine for 14 days after returning?

\_\_\_\_\_ Daily monitoring staff for symptoms? How, over the phone, in person, taking daily temperatures?

\_\_\_\_\_ Requiring staff to self-quarantine for 14 days after the onset of any symptoms?

\_\_\_\_\_ Requiring staff to follow social distancing recommendations?

\_\_\_\_\_ Following all these recommendations within your office and with your own staff?

Name of person completing the form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of person completing the form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_