Attachment

Notification of District Interest to Contract for the Provision of Personal Care Services

Completion of this form by the social services district indicates district interest in contracting for the provision of personal care services with the identified licensed home care agency (LHCSA) or certified home health agency (CHHA).

District: ____

Name and Title of Contact Person Completing form: ______________________

Telephone Number of Contact Person: (____) ______________________

FAX Number of Contact Person: (____) ______________________

Signature of Authorizing Representative: ______________________

Date of Completion:

Name of Provider Agency: ______________________

Address of Agency: ______________________

Telephone Number of Agency: (____) ______________________

FAX Number of Agency : (____) ______________________

Name(s) of Authorized Representative(s): ______________________

MMIS Identification Number : ______________________

Date of Department of Health Approval for Personal Care Aide or Home Health Aide Training

Plan: ____

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(District should request and maintain a copy of the Training Plan Approval in their files)

The Provider agency will be providing nursing assessments: [ ] Yes [ ] No

The Provider agency will be providing nursing supervision: [ ] Yes [ ] No

The Provider agency will be providing PCS through a Shared Aide Model: [ ] Yes [ ] No

The Provider agency will be providing PCS through a Consumer Directed Model: [ ] Yes [ ] No

The Provider Agency will be providing Personal Emergency Response Services (PERS): [ ] Yes [ ] No

The Provider Agency will be providing PCS through a Limited License Home Care Services Agency: [ ] Yes [ ] No

Rationale for expansion of PCS contracts: ______________________________

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(District should indicate need for expansion of PCS providers.)

Return Completed Form To: bltcr-pc@health.ny.gov

Questions should be directed to the Personal Care Rate Unit at (518) 473-4421