NOTIFICATION OF DISTRICT INTEREST

TO CONTRACT FOR THE PROVISION OF PERSONAL CARE SERVICES

(This form is to be completed ONLY by LDSS responsible party)

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). This form must be signed by and arrive to PersonalCare-Rates@health.ny.gov e-mail address directly from LDSS for the NYS Department of Health to be able to process it.

District: _____

Name and Title of Contact Person Completing form: _____

Telephone Number of Contact Person: (____) _____

Signature of Authorizing Representative: _____ Date of Completion: _____

Name of Provider Agency: _____

Provider Agency's MMIS Identification Number : _____

Address of Agency: _____

Telephone Number of Agency: (____) _____

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

Date of Personal Care Aide or Home Health Aide Training Plan approval by NYS DOH: _____

(District should request and maintain a copy of the Training Plan approval on file)

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

_____

_____

_____

_____

Please return the signed form / direct questions to Bureau of Nursing Home and Long Term Care Rate Setting e-mail: PersonalCare-Rates@health.ny.gov.