ATTACHMENT B

Updated August 3, 2020

2021 PARTICIPATION PROPOSAL
LICENSED HOME CARE SERVICES AGENCIES

All Applicants must submit the following information to the e-mail address set forth in the Invitation. Answers should be completed within this Participation Proposal Form, unless otherwise directed.

1. **Application Information:**

Applicant Name:	
License Number:	
Accreditation Agency and Date, if applicable:	
Number of home care workers in pilot counties:	

2. **Authorized for the Pilot Counties:**

☐ Yes ☐ No

3. **Complies with federal and state minimum wage laws:**

☐ Yes ☐ No

4. **Licensed by the DOH to provide the following services:**

- Personal care
  ☐ Yes ☐ No
- Housekeeping
  ☐ Yes ☐ No

- Homemaker
  - ☐ Yes ☐ No
- Home health aide
  - ☐ Yes ☐ No

LHCSA will offer the following optional services:

- Remote patient monitoring
  - ☐ Yes ☐ No
- Store and forward technology
  - ☐ Yes ☐ No

5. Rate Schedule:

Complete Exhibit 1 to provide standard and preferential hourly rates for private pay consumers for personal care, housekeeping, homemaker, home health aide, remote patient monitoring, and store and forward technology. These rates will be listed on the Department of Health website.

6. Medicaid:

a. Must be enrolled in NY Medicaid, and render services to Medicaid fee-for-service members:

☐ Yes ☐ No

b. Must have a contract with one or more Medicaid Managed Long-Term Care plan(s) in one or more of the pilot counties. Please list the MLTC plans and which of the pilot counties this is available:

_____

_____

7. Annual LHCSA Consumer Satisfaction Survey:

Include a copy of the most recent completed Consumer Satisfaction Survey or results of most recent relicensure survey and accepted plan of correction, if applicable, with the proposal.

☐ Yes ☐ No

8. Training:

a. Complies with required state in-service training:

☐ Yes ☐ No

b. Complete Exhibit 2 to provide a description of continuing education offered to home care workers. Include documentation of completion of training by home care workers in the most recent year well as the LHCSA's policy if there are deficiencies with home care workers not completing or passing the required training.

9. Agree to accept all consumers who access services through the pilot, except where it is determined the consumer cannot be served safely at home:

☐ Yes ☐ No

10. Agree to cooperate with contractors selected by DOH to administer the pilot, including to share information requested:

☐ Yes ☐ No

11. Abide by federal and state laws and regulations pertaining to privacy and confidentiality of consumer information:

☐ Yes ☐ No

12. Ready to begin November 1, 2020:

☐ Yes ☐ No

ATTESTATION TO PARTICIPATION PROPOSAL

The following must be signed and executed by an individual with the capacity and legal authority to bind the Applicant to the authenticity of the information provided.

I, _____, here by attest that I have been duly authorized to execute this Participation Proposal on behalf of Applicant, and to the best of my knowledge, the information and data provided by Applicant in response to the Invitation and Requirements for Participation in the NY State of Health, the Official Health Plan Marketplace (the "Invitation") is accurate, true, and complete. I understand that the NY State of Health will rely on my statements above in reviewing the Participation Proposal and the related information and data submitted in response to the Invitation. In completing the approval process set forth in the Invitation, Applicant shall, always, strictly adhere to all applicable federal and state laws, regulations, and instruction as they currently exist and may hereafter be amended or enacted.

_____
Print Name

_____
Print Title

_____
Signature

_____
Date