United
HOMECARE

February 2017

Dear Provider:

Thank you for your interest in participating in the Invitation to Negotiate ("ITN") process for selection of Community Care for the Elderly ("CCE") Subcontractors for United HomeCare ("UHC").

Attached is the CCE Subcontractor Application you must complete and return to UHC no later than March 31, 2017. Please complete all pertinent sections and attach all required supporting documentation. Incomplete applications will not be considered.

Our Credentialing Committee will be reviewing all applications received and will be making recommendations on selection of CCE Subcontractors to UHC's Provider Relation's Department. Selected Subcontractors will be notified via certified mail by 5:00pm on May 1, 2017. At the time of notification a new CCE Subcontractor Agreement will be sent for execution which will become effective July 1, 2017.

Should you have any questions regarding the Application please contact 305-716-0731.

Once again, thank you for your interest in becoming a UHC Subcontracted Provider.

Sincerely,

Provider Relations

Timeline

DESCRIPTION	DATE	TIME
1. Request for ITN Proposal release	February 21, 2017	5:00 PM
2. Pre-ITN Subcontractor meeting	February 27, 2017	10:00 AM – 11:30 AM
3. ITN Documents available to be picked up at United HomeCare	February 27, 2017	
4. Intent to submit a proposal	March 1, 2017	5:00 PM
5. Deadline for written inquiries to: ARrodriguez1@unitedhomecare.com	March 7, 2017	5:00 PM
6. UHC response to written inquiries	March 15, 2017	5:00 PM
7. Last day for ITN proposal submission at: United HomeCare 8400 NW. 33rd Street Suite # 400 Miami, FL 33122	March 31, 2017	5:00 PM
8. Contract Release via Certified Mail	May 1, 2017	5:00 PM
9. Contract Effective Date	July 1, 2017	12:01 AM

United
HOMECARE

NOTICE OF INTENT TO SUBMIT AN INVITATION TO NEGOTIATE (ITN) PROPOSAL

FOR 2017/2018

SUBCONTRACTOR DESIGNATION FOR UNITED HOMECARE'S

COMMUNITY CARE FOR THE ELDERLY (CCE) AND HOME CARE FOR THE ELDERLY (HCE) PROGRAMS

I certify that the agency listed below intends to apply for subcontractor designation under the ITN.

_____ _____
Signature of Authorized Representative Printed Name of Authorized Representative

_____ _____
Authorized Representative's Title Date signed

Agency Name:_____

Address:_____

City, State & Zip code:_____

Name Contact Person:_____

Title of Contact Person:_____

Email Address:_____

Telephone Number:_____

Fax Number:_____

For Internal Use Only:

Date Received:_____

Time Received:_____

Received By:_____

United HOMECARE

Subcontractor ITN Application

SUBCONTRACTOR IDENTIFICATION	
Legal business name:	
Doing business as (if applicable):	
Contact person:	Email:
Tax ID number:	License number (required):

Is your organization a Home Health Agency? ☐ Yes ☐ No

Is your organization part of a Nurse Registry? ☐ Yes ☐ No

SUBCONTRACTOR TYPE

___Adult Day Care	___Home-delivered meals (Frozen)	___Pest Control Rodent
___Chore	___Home-delivered meals (Hot)	___Respite Care (In-home)
___Companionship	___Homemaker	___Specialized Medical Equipment, Svc, & Supplies
___Enhanced Chore	___Housing Improvement	
___Emergency Alert Response (Installation & Maintenance)	___Personal care	
___Escort	___Pest Control (Initial & Maintenance)	

PRIMARY OFFICE /SERVICE ADDRESS

Subcontractor location:			
Address :			
City:	State:	ZIP:	County:
Phone:	Fax:	Primary contact:	
Administrator/Owner (full name):			
Does Subcontractor bill from this address? ☐ Yes ☐ No			
Office hours:_____	Languages spoken:_____		

Are your workers classified as independent contractors (1099) or employee (W2)? _____

Do you currently have access to the Client Information and Registration Tracking System (CIRTS)? ☐ Yes (see questions below) ☐ No

If Yes: Is CIRTS access Active? ☐ Yes ☐ No

Are you currently using CIRTS for other DOEA funded programs (OAA, ADI, etc.)? ☐ Yes ☐ No

Do you have a subcontractor location code under 11900? If Yes, Provide number. ☐ Yes ☐ No | Location Code: _____

BILLING INFORMATION if different from Primary Address

Name (billing name)			
Address Line:			
City:	State:	ZIP:	Phone:

If there are additional office/service locations, please attach a separate sheet indicating the address, phone/fax numbers.

NATIONAL PROVIDER IDENTIFIER
Name:
NPI number:

LICENSURE **(Attach a copy of current licensure**			
State:	Date of license:	License number:	Expiration date:
State:	Date of license:	License number:	Expiration date:

ACCREDITATION/CERTIFICATION **(Attach a copy of current accreditation certificate or survey.)**

☐ ACHC ☐ CHAP ☐ JCAHO ☐ NOT ACCREDITED

Date of initial accreditation: _____/_____/___

Date of last survey: _____/_____/_____

Has provider had an on-site survey by a state agency? ☐ Yes ☐ No Date of last state survey:_____/_____/_____

Is provider participating in the Medicare program? ☐ Yes ☐ No Date of last accreditation survey: __/_____/_____

INSURANCE **(Attach a copy of your Certificate of Liability insurance general and professional coverage.)**	
Liability coverage	
Current carrier name:	
Policy number:	Coverage type: ☐ Occurrence-based ☐ Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $

Worker's compensation coverage	
Current carrier name:	
Policy number:	Coverage type: Per Each Employee
Effective date:	Expiration date:
Per accident: $	Aggregate: $

Please answer the following questions with a "Yes" or "No". Provide an explanation for each question answered with a "Yes" and attach hereto.

1. Has any disciplinary action ever been taken against any business or professional license held by the Agency/Organization or any of its principal officers? ☐ Yes ☐ No (If yes, please attach a separate paper with an explanation.)

2. Has the Agency/Organization or any of its principal officers ever surrendered a professional license in the state of Florida or any other state? ☐ Yes ☐ No
   (If yes, please attach a separate paper with an explanation.)

ATTESTATION AND INFORMATION RELEASE AUTHORIZATION
All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify United HomeCare of any changes thereto. I hereby release United HomeCare and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I consent and agree that level two criminal history background screening will be completed for all employees or volunteers who meet the definition of direct service provider. Any subcontractor, employee or volunteer meeting the definition of direct service provider who has a disqualifying offense is prohibited from providing services to the elderly as set forth in 430.0402 F.S. Upon request, verification of compliance will be shared with United HomeCare. I understand United HomeCare requires all direct service providers to attend and complete the Abuse, Neglect & Exploitation training. I understand that as an applicant for participation as a Subcontractor for United HomeCare, I have the right to review information obtained from primary verification sources during the ITN process. Owner/registered agent printed name: _____ Date: _____ Owner/registered agent signature: _____ Social security number (SSN)/date of birth (DOB) (Required if not licensed by AHCA): SSN: ____/____/_____ DOB: ___/___/_____

Enclosures

Please submit all applicable documents from the list below with your completed and signed application. Failure to provide this information will prohibit United HomeCare from reviewing your application.

1. A copy of your state license for each location and/or specialty
2. A copy of your Certificate of Liability Insurance Policy face sheet with United HomeCare listed as a certificate holder. Insurance factsheet should include effective date, expiration date, and also include the coverage amounts. (Please request from your insurance agent, to add United HomeCare as a Certificate Holder)
3. A copy of the most recent (preferably 2016) tax document: Form 1120 for Corporations, Form 1065 for Partnerships/LLCs, or Form 1040 for Individuals.
4. A copy of your Occupational License
5. A copy of your Local Business Tax Receipt (LBT) (County and City-if applicable)
6. A copy of your Emergency Plan
7. A completed Background Screening Affidavit of Compliance-Employer
8. A copy of your HIPAA/Privacy policy
9. A copy of your Confidentiality policy
10. A copy of your Fraud, Waste, and Abuse Policy
11. Completion of the following four (4) forms: Verification of Employment Status Certification, Certification Regarding Scrutinized Companies List, Certification Regarding Lobbying/Certification for Contracts, Grants, Loans, and Agreements, and Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Lower Tier Covered Transactions

Form completed by:

_____ _____

Printed name of authorized representative **Signature of authorized representative**

_____ _____

Authorized representative's title **Date signed**