2023-2024 Subcontractor ITN Phase 1 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)	☐Respite Care (In-home)
☐Chore	☐Home delivered meals (Hot)	☐Specialized Medical Equipment, Svc & Supplies
☐Companionship	☐Homemaker	Other: _____
☐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: _____ Language(s) spoken by office personnel: _____

Are your workers classified as independent contractors (1099) and/or employee (W2), specify? _____

Number of direct service staff/workers currently with your agency: _____

Do you have direct service staff/workers available that speak additional languages? _____

Specify language(s) spoken by the direct service staff/workers: _____

Does your agency provide services on the weekends? _____

Specify agency hours of operation: _____

Specify workers service days and hours: _____

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

If Yes, is eCIRTS access Active? ☐ Yes ☐ No

Are you currently using eCIRTS for DOEA funded programs (OAA, CCE, HCE, ADI, etc.)? ☐ Yes ☐ No

Do you have a subcontractor code under 13145? If Yes, provide number. ☐ Yes ☐ No | Provider Code: _____

BILLING INFORMATION if different from Primary Address			
Name (billing name):			
Billing Address:			
City:	State:	ZIP:	Phone:

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

NATIONAL PROVIDER IDENTIFIER	
Name:	
NPI number:	NPI Effective Date:

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 ☐ Other: _____

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

INSURANCE Workers' 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.)

3. Is your agency planning to provide service countywide (Miami-Dade County)? ☐ Yes ☐ No
   (If no, specify service location areas or zip codes where services will be provided.)

Providers are to review and abide by the Department of Elder Affairs 2023 Programs and Services Handbook located at: https://elderaffairs.org/publications-reports/programs-services-handbook/

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 under the DOEA Aging Network will be completed for all employees and volunteers who meet the definition of direct service provider to include executives, administrators, financial officers, coordinators, managers, supervisors, and any person responsible for day-to-day DOEA funded operations. Any individual meeting the definition of direct service provider who has a disqualifying offense who is not exempt by DOEA from disqualification, 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.

I understand that if my agency is selected, additional information will be requested and must be submitted prior to becoming a Subcontracted Provider for United HomeCare.

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

Submit all applicable documents from the list below. Failure to provide information requested will prohibit United HomeCare from reviewing your application. Providers selected will be required to submit additional documentation prior to contract execution.

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 include the coverage amounts. (Please request from your insurance agent to add United HomeCare as a Certificate Holder.)
   NOTE: if you independently contract your workers and require your workers to submit liability insurance, please submit clarification and the process your agency follows.
3. A copy of the most recent (preferably 2021) tax document.
4. A copy of your W-9.
5. A copy of your Accreditation Certificate, if applicable.
6. A copy of your Occupational License / Local Business Tax Receipt (LBT) (County and City, if applicable).
7. A copy of your Emergency Plan and CEMP approval letter, if applicable.
8. Certification and Assurances form.
9. Provider rates form with your rates for the services you want to provide.

Form completed by:

Printed name of authorized representative

Signature of authorized representative

Authorized representative's title

Date signed

United HOMECARE®
There's just no place like home.

50 years of caring

8400 NW 33rd Street, Suite 400
Miami, FL 33122

For written inquiries, submit to this email by October 16th:
itncce@unitedhomecare.com