



A Community Foundation
Making a Difference — Together

South Central Pennsylvania Home Care Grant Application Checklist

- Completed Homecare/Home Health/Hospice Agency Applicant Information Form
- Completed Client Information and Home Care Plan
- Copies of all current applicable DOH licenses and Accreditations, as applicable
- Completed HIPAA Release Authorization
- Completed Confidential Information
- Completed Financial Affidavit
- Completed W-9 for each EIN included on application
- Copy of current Workers Compensation Certificate of Insurance
- Copy of current General Liability Certificate of Insurance
 - Minimum limit requirement:
 - \$1,000,000 per occurrence
 - \$3,000,000 aggregate
 - The following must be listed as an additional insured:
 - Pennsylvania Home Care Association and
 - Pennsylvania Foundation for Homecare and Hospice
 - 600 N. 12th Street, Suite 200 Lemoyne, PA 17043

Send completed application packet to:

*Attn: Pennsylvania Foundation for Homecare and Hospice
South Central Pennsylvania Home Care Grant Program
600 N. 12th Street, Suite 200
Lemoyne, PA 17043
Fax 717-975-9456*

*Questions accepted via email at mlicht@pahomecare.org
or phone at 717-975-9448, ext. 27.*



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South Central Pennsylvania Home Care Grant Homecare/Home Health/Hospice Agency Applicant Information Form

Organization Name: _____

EIN/TIN: _____ Date of Inception: _____

IRS Address Line 1: _____

IRS Address Line 2: _____

IRS City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Website: _____

Primary Contact: _____ Title: _____

Prim. Contact Email: _____ Phone: _____

Are you a multi-site provider? No Yes, add list w/ address, phone, fax of locations.

Commonly owned organizations to be included in application:

_____ EIN: _____

_____ EIN: _____

_____ EIN: _____

- Check All That Apply: Pennsylvania Home Care Agency Licensed (*attach copy of license*)
 Pennsylvania Home Health Agency Licensed (*attach copy of license*)
 Pennsylvania Hospice Agency Licensed (*attach copy of license*)
 Accredited through _____ (*attach copy of license*)
 Active Member of Pennsylvania Homecare Association

Office Hours:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

24/7 On Call: Yes No Languages staff speak: _____

Agency Service Coverage [please select the county(ies) and zip code(s) your agency services]:

- | | | |
|---|--|--|
| <input type="checkbox"/> Perry County
<i>Zip Codes</i> | <input type="checkbox"/> Northern Adams County
<i>Zip Codes</i> | <input type="checkbox"/> Cumberland County
<i>Zip Codes</i> |
| <input type="checkbox"/> 17006 | <input type="checkbox"/> 17303 | <input type="checkbox"/> 17007 |
| <input type="checkbox"/> 17020 | <input type="checkbox"/> 17304 | <input type="checkbox"/> 17013 |
| <input type="checkbox"/> 17024 | <input type="checkbox"/> 17306 | <input type="checkbox"/> 17015 |
| <input type="checkbox"/> 17037 | <input type="checkbox"/> 17307 | <input type="checkbox"/> 17065 |
| <input type="checkbox"/> 17040 | <input type="checkbox"/> 17316 | <input type="checkbox"/> 17081 |
| <input type="checkbox"/> 17045 | <input type="checkbox"/> 17324 | <input type="checkbox"/> 17240 |
| <input type="checkbox"/> 17047 | <input type="checkbox"/> 17337 | <input type="checkbox"/> 17241 |
| <input type="checkbox"/> 17053 | <input type="checkbox"/> 17372 | <input type="checkbox"/> 17257 |
| <input type="checkbox"/> 17062 | | <input type="checkbox"/> 17266 |
| <input type="checkbox"/> 17068 | | <input type="checkbox"/> 17324 |
| <input type="checkbox"/> 17069 | | |
| <input type="checkbox"/> 17071 | | |
| <input type="checkbox"/> 17074 | | |
| <input type="checkbox"/> 17090 | | |

Business References (Please list businesses/vendors that your agency has a working relationship with, for example, banker, accountant, health agency.)

#1 Company: _____

Phone: _____ Email: _____

Contact Name: _____ Relationship: _____

Address: _____

#2 Company: _____

Phone: _____ Email: _____

Contact Name: _____ Relationship: _____

Address: _____

#3 Company: _____

Phone: _____ Email: _____

Contact Name: _____ Relationship: _____

Address: _____



South Central Pennsylvania Home Care Grant Confidential Information

Have you, an agent, or a managing employee ever:

- Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program, limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

- Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in anyway, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority(e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

- Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider’s profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

- In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

If you answered “yes” to any of the above, please attach documentation/explanation.

By signing below, you certify that the information provided by your organization is accurate and complete. You attest that your organization in good standing with the PA Department of Health and any other applicable regulatory bodies of oversight.

Signature of Authorized Designee

Title

Print Name

Date



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South Central Pennsylvania Home Care Grant Client Application and Selection Process

Eligibility Criteria for Foundation Funds

- Individuals who temporarily or permanently reside in the Commonwealth of Pennsylvania within parts of Cumberland, Perry, Adams, and Franklin counties. Eligible zip codes are: 17006;17020;17024;17037;17040;17045;17047;17053;17062;17068;17069;17071;17074;17090;17303;17304;17306;17307;17316;17324;17337;17372;17007;17013;17015;17065;17081;17240;17241;17257;17266
- Individuals who demonstrate a home health care need for home health care services, which includes home care, home health, and hospice services
- Individuals with monthly income less than \$5,000 (single) or \$10,000 (dual income, including spouse/partner, excluding any child income)*
- Individuals who are not currently receiving, are waiting to be approved/renewed, or are not eligible for comparable home health care services through the following programs:
 - Any Pennsylvania Medicaid Waiver Program (including managed care programs)
 - Veterans who are receiving home health care benefits through the Aide and Attendance Program
 - Any other similar program as determined by the Foundation

All fund disbursements are at the sole discretion of the Pennsylvania Foundation for Homecare and Hospice ("Foundation"). Nothing in this application or program creates any guarantee of funding or any obligation on the part of the Foundation to provide funding to any individual.

Agencies do NOT have to be a member of the PA Homecare Association and are not limited to the number of applications that can be submitted. A client is eligible for funding once every calendar year.*

Income limits and other terms and conditions are subject to change, at the sole discretion of the Foundation.

Funding Policies and Procedures

Once approved, individuals will be granted access to funds of up to \$2,500 per client to be used as 100 hours of non-medical home care services at \$25/hour OR 20 skilled home health visits at \$125/visit. Funds are payable directly to pre-approved licensed agencies.

Agencies must invoice the Foundation for payment of funds upon the termination of grant funded services. Invoices should include dates of service, hours completed, client name, agency name, agency address (payable to), and a signature of client confirmation of services. Approved invoices will be paid within 30 days of receipt via a check issued to the provider by The Foundation.

Funds must be utilized within one (1) year of approval from the Foundation. Upon the expiration of the year, the Foundation will grant the agency a 60-day period to submit invoices for payment. After this time, if an invoice has not been received, the Foundation will redirect the allocated \$2,500 to another client/consumer for use.

Exceptions:

1. If a client is put on hold due to a hospitalization, facility stay, family visitation, or other similar scenario, the agency must notify the Foundation via email to receive an extension beyond one year for the complete use of funds.
2. If a client passes prior to the completion of the allotted \$2,500 of services, the agency shall notify The Foundation via email and submit a final invoice for those services that were utilized. The Foundation will prorate the funds as follows: \$25/hour for non-medical services rendered OR \$125/visit for skilled services rendered.
3. If a client becomes eligible for home health care services through a PA Medicaid Waiver Program, Veterans Affairs' Aide and Attendance Program, or through another similar program, services through this Foundation will cease. It is the responsibility of the client, the representative, and the agency to notify the Foundation when other home health care funding sources become available. Providers will be paid only the portion of the grant that was rendered prior to approval through the alternative funding source, calculated as \$25/hour for non-medical care or \$125/visit for skilled care.

Funding Request and Submission Process

- The client or client representative and the supporting agency must complete the attached **Client Application** in full.
- Send the application to:
The Pennsylvania Foundation for Homecare and Hospice
600 N. 12th Street, Suite 200
Lemoyne, PA 17043
Fax: 717-975-9456
- A notification of approval/declination of funding will be sent to the agency via email. Upon notice of approval, services may begin. All 100 hours OR 20 visits of home health care must be utilized within one (1) year of this date, except as provided above.

- Upon completion of care, the agency will send an invoice to the Foundation including the following:
 - a. Client name
 - b. Dates of service
 - c. Hours completed per date of service
 - d. Agency name
 - e. Agency address (payable to)
 - f. A signature from the client verifying that the services were provided as invoiced (signed timesheets, EVV, or a one-page statement will do)
- For approved invoices, payment will be rendered to the agency within 30 days of receipt via a check issued to the provider by the Foundation.

** Income limits and other terms and conditions are subject to change, at the sole discretion of the Foundation.*