

## HOME CARE PROVIDER APPLICATION

Prior to completing this application, please attest that you have read, understand, and are prepared to comply with the following:

- Home Care Provider Standards
- Home Care Provider Certification Requirements
- The Universal Provider Standards
- [Choices for Care Program Manual](#)
- [Medicaid Rate Table \(revenue codes 072 and 073\)](#)
- [The Vermont Adult Protective Services Mandated Reporting Requirements](#)
- [State of Vermont Electronic Visit Verification Requirements](#)

### Agency Information

Agency Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

*Street address*

\_\_\_\_\_

*City*

*State*

*Zip Code*

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

1. Are you currently enrolled as a **Medicaid Provider**?

Yes  No

If no, do you understand that submission of this application does not guarantee approved enrollment as a Vermont Medicaid Provider and that you will be responsible for submitting a Vermont Medicaid Provider enrollment application?

Yes  No

1. Are you prepared to meet **Electronic Visit Verification** Requirements?

Yes  No

2. Do you currently have an Electronic Visit Verification System?

Yes  No

If yes, what is the name of the system you currently use?

## Service Area Coverage

Please check all prospective service areas:

- |                                     |                                     |                                     |                                  |
|-------------------------------------|-------------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Addison    | <input type="checkbox"/> Grand Isle | <input type="checkbox"/> Washington | <input type="checkbox"/> Orlean  |
| <input type="checkbox"/> Chittenden | <input type="checkbox"/> Lamoille   | <input type="checkbox"/> Caledonia  | <input type="checkbox"/> Windham |
| <input type="checkbox"/> Franklin   | <input type="checkbox"/> Orange     | <input type="checkbox"/> Essex      | <input type="checkbox"/> Windsor |
| <input type="checkbox"/> Bennington | <input type="checkbox"/> Rutland    |                                     |                                  |

## Description of Capacity

Please provide a description of the unmet needs within each identified service area. Additionally, specify the current staffing capacity to address these needs, or outline a plan for recruiting additional staff to meet the demand. If additional space is needed, please attach description to the application.

## References

Please attach two letters of support from individuals currently receiving services and/or Vermont stakeholders that currently use or will refer to your services if approved. For example, the regional Area Agency on Aging, Hospital, or Home Health Agency. List below the contact information for each letter of support.

Full name: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Full name: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_

## Supporting Documentation

To be considered for review, this application must include the following policies and procedures in compliance with Home Care Provider Standards. All document names must clearly indicate their corresponding citation number. Please note that we cannot assume which documents are intended to address specific requirements.

Please check that each of the following is attached:

- Admission Transitions and Discharge (1.3)
- Complaint and Grievances (1.4)
- Conflict of Interest (1.5)
- Confidentiality (1.6)
- Abuse Neglect and Exploitation (1.8)
- Emergency Management (1.9)
- Health and Safety (1.10)
- Communication (1.11)
- Critical Incident Reporting (1.12)
- Quality Management (1.14)

The following attachments are required for consideration:

- Two (2) Letters of Support from individuals currently receiving services and/or Vermont stakeholders that currently use or will refer to your services if approved

## Applicant Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Completed applications can be sent to [AHS.DAILASDProviderEnrollment@vermont.gov](mailto:AHS.DAILASDProviderEnrollment@vermont.gov).

\*Alternatively, applications may be mailed to:

**DAIL- Adult Services Division**  
Attention: New Provider Enrollment  
280 State Drive, HC2 South  
Waterbury, VT 05671-2070

*\*Please note that mailed applications require longer processing times.*