



**Assisted Living Waiver Program
Home Health Agency in Public Subsidized Housing
Initial Provider Application**

****No handwritten applications will be accepted. Use type only.***

Date: _____

Parent Agency Legal Name: _____

Parent Agency Street Address: _____

Parent Agency City, State, and Zip Code: _____

Parent Agency Phone Number: _____ Parent Agency Fax: _____

Parent Agency Contact Email Address: _____

Branch Office Name: _____

Branch Office Service Location Address: _____

Branch Office City, State, and Zip Code: _____

License Number of Parent Agency: _____ Number of Slots Available: _____

National Provider Identification (NPI) Number (required): _____

Submit the following documentation with this form:

1. A letter to the Department of Health Care Services, Assisted Living Waiver Program, with the name and address of the proposed site, along with a short summary of the proposed population served. This letter must also include a request for a specified number of available waiver slots and a proposed date of operation.
2. A copy of the operating agreement that includes the address of the publicly funded housing site where the provider delivers services. This document must also include information regarding use of space, access to the building, and access to residents. An agreement regarding meals may be included.

3. A copy of the letter submitted to the California Department of Public Health, Licensing and Certification Program, requesting inclusion of the proposed site to the existing Home Health Agency license.
4. Copies of all newly hired professional and para-professional staff licenses and/or certifications, along with the fingerprint clearances for each.
5. Copies of all staff in-service training programs for the new site.
6. A summary of the contingency plans to deliver in the event of a disaster or emergency.
7. A copy of the schedule of all awake staff on-site 24 hours per day, seven days per week.
8. A summary of the system which maintains confidential medical records for each resident. Records, at a minimum, must include a service plan and progress notes, and must be signed by the individual participant. The agency shall agree to make those records available for audit.
9. A summary of the response system that enables waiver participants to summon assistance from personal care providers.
10. A summary of the process for soliciting and/or obtaining feedback from clients regarding their satisfaction with services.
11. A summary of the quality assurance program that allows the tracking of client complaints and incident reports, including abuse, neglect, and medication errors.

Submit completed application with requested supporting documentation to:

**Department of Health Care Services
Integrated Systems of Care Division
Assisted Living Waiver Program
1501 Capitol Avenue, MS 4502
Sacramento, CA 95814**

When the review of this submission has been completed, you will be contacted regarding the status of your application.

Facility Contact Signature

Date Signed

Printed Name

Telephone Number