Aging & In-Home Services of Northeast Indiana, Inc. (AIHS)

New Provider Application Process

Provider Name: _____

Please provide a copy of the following items in the order listed:

- ☐ **Provider Contact Information Sheet**
- ☐ **Attachment A** – services, counties of service and applicable rates indicated
- ☐ **Certificate(s) of Liability Insurance -** ($1,000,000 or greater)
  AIHS must be named as additional insured on the form
- ☐ **Drug Free Workplace Certification,** signed and dated
- ☐ **Proof of Medicaid Waiver Certification**
- ☐ **Copy of current ISDH license,** Home Health Agency or Personal Services Agency, OR Copy of other Licenses as applicable
- ☐ **IRS W-9 Form, signed** (form date 10-2018)
- ☐ **Copy of Certificate of Incorporation** from Indiana Secretary of State
- ☐ **Copy of Mission Statement**
- ☐ **Organizational Chart or Organizational Structure**
- ☐ **Consumer Complaint and Quality Assurance process**
- ☐ **Required Screening for new hires, including policy for obtaining Criminal History records**
- ☐ **Policy for Coverage of Staff Absences**
- ☐ **Staff Training Schedule**
- ☐ Equipment & Supply Providers: **Delivery and Return Policies**

Application packet - including all items in the above list – or any questions, can be submitted to:

MAIL to: Aging & In-Home Services of Northeast Indiana, Inc.
Beth Krudop, Vice President of Administration
8101 W. Jefferson Blvd.
Fort Wayne, IN 46804-4163

FAX to: 260-422-4916, ATTN: Beth Krudop

E-Mail to: info@agingihs.org ATTN: Beth Krudop

Aging and In-Home Services of Northeast Indiana, Inc.

PROVIDER CONTACT INFORMATION
For Memorandum of Understanding
CHOICE, SSBG, FCAR, OAA

Corporation/Provider Name: _____

Doing Business As: _____

*Address: _____

_____

Phone: _____ Fax : _____

Email: (1) _____

Email: (2) _____

Email: (3) _____

Minimum one e-mail address required; multiple e-mail addresses recommended for correspondance re: meetings, etc.

* (This address is for both billing and correspondance)

Administrator/Manager: _____

Phone: _____ Email : _____

Contact person for Consumer Pick List: _____

Position: _____

Phone: _____ Email : _____

Contact person for Case Managers: _____

Position: _____

Phone: _____ Email : _____

Contact person for Billing and Payments: _____

Position: _____

Phone: _____ Email: _____

Please check all certified/licensed funding sources that apply:

Medicare: ___ VA: ___ Hospice: ___

Medicaid Traditional (non-MAW): ____

Copies to ☐ Fiscal

Aging In-Home Services of Northeast Indiana, Inc.

July 1, 2019 through June 30, 2021

Attachment A

COUNTIES SERVED

*Rates set by the Indiana Family and Social Service Administration (FSSA) will be applied to these services									
For ALL Services: Please indicate each service, including the counties, and any rates not set by FSSA									
PROVIDER:									
SERVICES	*Adams*	*Allen*	*DeKalb*	*Huntington*	*LaGrange*	*Noble*	*Steuben*	*Wells*	*Whitley*
***HMK**									
Homemaker									
***ATTC & RATT**									
Attendant Care & Respite Attendant Care									
***HOHE & RHHA**									
Home Health Aide & Respite Home Health Aide									
***SKNU**									
LPN & Respite LPN									
RN & Respite RN									
***PHTH, OCTH, SPTH**									
Physical Therapy									
Occupational Therapy									
Speech Therapy									
***PRSI/PRSM**									
Emergency Response System - Installation									
Emergency Response System - Monthly Fee									
***AD1/AD2/AD3/ADST**									
Adult Day Service Level I									
Adult Day Service Level II									
Adult Day Service Level III									
Adult Day Service Transportation - One Way									
TRAN									
Transportation - unassisted - one way									
Transportation - assisted/WC - one way									
RES									
Nursing Facility Respite									
OTHER (OTH)									
Supplies - Please attach your catalog									
Home Modifications - rates are established via bidding process upon request									
Other Specific Services: (Please List)									

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

STATE OF INDIANA
DRUG-FREE WORKPLACE CERTIFICATION

Pursuant to Executive Order No. 90-5, April 12, 1990, issued by Governor Evan Bayh, the Indiana Department of Administration requires the inclusion of this certification in all contracts with and grants from the State of Indiana in excess of $25,000. No award of a contract or grant shall be made, and no contract, purchase order or agreement, the total amount of which exceeds $25,000, shall be valid unless and until this certification has been fully executed by the Contractor or Grantee and attached to the contract or agreement as part of the contract documents. False certification or violation of the certification may result in sanctions including, but not limited to, suspension of contract payments, termination of the contract or agreement and/or debarment of contracting opportunities with the State for up to three (3) years.

The Contractor/Grantee certifies and agrees that it will provide a drug-free workplace by:

(a) Publishing and providing to all of its employees a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; and

(b) Establishing a drug-free awareness program to inform employees about (1) the dangers of drug abuse in the workplace; (2) the Contractor's policy of maintaining a drug-free workplace; (3) any available drug counseling, rehabilitation, and employee assistance programs; and (4) the penalties that may be imposed upon an employee for drug abuse violations occurring in the workplace;

(c) Notifying all employees in the statement required by subparagraph (a) above that as a condition of continued employment the employee will (1) abide by the terms of the statement; and (2) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

(d) Notifying in writing the contracting State Agency and the Indiana Department of Administration within ten (10) days after receiving notice from an employee under subdivision (c) (2) above, or otherwise receiving actual notice of such conviction;

(e) Within thirty (30) days after receiving notice under subdivision (c) (2) above of a conviction, imposing the following sanctions or remedial measures on any employee who is convicted of drug abuse violations occurring in the workplace: (1) take appropriate personnel action against the employee, up to and including termination; or (2) require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State or local health, law enforcement, or other appropriate agency; and

(f) Making a good faith effort to maintain a drug-free workplace through the implementation of subparagraphs (a) through (e) above.

THE UNDERSIGNED AFFIRMS, UNDER PENALTIES OF PERJURY, THAT HE OR SHE IS AUTHORIZED TO EXECUTE THIS CERTIFICATION ON BEHALF OF THE DESIGNATED ORGANIZATION.

	AIHS
Printed Name of Organization	Contract/Grant ID Number
Signature of Authorized Representative	Date
Printed name and Title	