VERMONT
DEPT. OF DISABILITIES, AGING & INDEPENDENT LIVING

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
- ☐ ASD Billing Codes & Rates Table (revenue codes 072 and 073)
- ☐ The Vermont Adult Protective Services Mandated Reporting Requirements
- ☐ State of Vermont Electronic Visit Verification Requirements
- ☐ Critical Incident Reporting Policy

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:

☐ Addison	☐ Grand Isle	☐ Washington	☐ Orlean
☐ Chittenden	☐ Lamoille	☐ Caledonia	☐ Windham
☐ Franklin	☐ Orange	☐ Essex	☐ Windsor
☐ Bennington	☐ 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.

*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.*