



**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