

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
INITIAL
HOME CARE AGENCY/REGISTRY LICENSURE SURVEY**

Name of Entity: _____

DBA: _____

Address: _____

Application Type: Home Care Agency _____ Home Care Registry _____ Both _____

Contact Person if any Questions

Phone

LICENSURE SURVEY QUESTIONS

1. List the number of direct care workers employed and/or rostered by the agency.
2. Describe or attach your agency or registry's prerequisites for hiring and/or rostering of direct care workers. If attached, please label as exhibit A.
3. Criminal background checks are required for all employed or rostered direct care workers, office staff and the direct owner(s). Describe your agency or registry's policy for requiring background checks and prohibiting individuals with a prohibited conviction or Department of Aging ineligibility determination from being hired or rostered. If attached, label as exhibit B. Also attach a copy of the background checks or copy of the completed request form for the direct owner(s).
4. Does the agency or registry provide services to consumers less than 18 years of age?
5. If services are provided to consumers less than 18 years of age, have all staff, including office staff and direct owner(s) had child abuse clearances completed or initiated?

6. If services are provided to consumers less than 18 years of age, please describe or attach a copy of the process in place that ensures all staff employed and/or rostered, including office staff and direct owner(s) receive child abuse clearances. If attached, label as exhibit C. Also attach a copy of the ChildLine verification or copy of the completed request forms for the direct owner(s).

7. Do you hire or roster individuals on a provisional basis pending the outcome of a criminal background check and ChildLine verification, if necessary?

If so, describe or attach the provisional hiring process, which must include termination procedures if a criminal history or ChildLine verification indicates a prohibited offense or occurrence and the system in place for monitoring provisionally hired or rostered individuals. If attached, label as Exhibit D.

8. Describe or attach an outline of your agency or registry's training program and/or competency exam process, including the process for competency review. If attached, label as Exhibit E.

a. If direct care workers are not directly trained or tested for competency by the agency or registry, describe or attach a copy of the process used to verify the individual has successfully completed a training program approved by the Department. If attached, label as Exhibit F.

9. All individuals employed and/or rostered who have direct consumer contact are required to be screened for active tuberculosis prior to consumer contact and annually thereafter. Describe or attach your policy that addresses this process. If attached, label as Exhibit G.

10. Describe or attach your policy that addresses the consumer's right to be involved in the service planning process and to receive services with reasonable accommodations of individual needs and preferences. If attached, label as Exhibit H.

11. Describe or attach your policy that addresses termination of consumer services. If attached, label as Exhibit I.

12. All individuals affiliated with the home care agency and/or registry are prohibited from assuming power of attorney or guardianship over a consumer utilizing your services. Describe or attach your policy that addresses this. If attached, label as Exhibit J.

13. Agencies and registries are prohibited from allowing a consumer to endorse a check over to the home care agency or registry. Describe or attach your policy that addresses this. If attached, label as Exhibit K.

14. Attach a sample(s) copy of the information packet which will be provided to the consumer prior to the commencement of services. (Label as Exhibit L.) **THE PACKET MUST INCLUDE THE FOLLOWING:**

- a. A form or other document that will show a list of services to be provided to the consumer, the hours when they will be provided and the identity of the direct care worker that will provide the services.
- b. Cost of the services to be provided on an hourly or weekly basis.
- c. Department of Health contact information for inquiries about licensure requirements and agency/registry compliance.
- d. Department of Health hotline and local AAA Ombudsman telephone numbers.
- e. Hiring/Competency requirements of direct care workers.
- f. Disclosure addressing employee or independent contractor status of the direct care worker providing services to the consumer, and the resultant tax and insurance obligations and other responsibilities of the consumer.

**NOTE: PLEASE COMPLETE LICENSURE SURVEY
AFFIRMATION BELOW**

Application is made to operate a home care agency and/or home care registry in accordance with the Health Care Facilities Act (35 P.S. §§448.801a – 448.904b).

I affirm that all of the information provided herein is COMPLETE and TRUE. Incomplete or inaccurate information will result in licensure denial.

I further agree to conduct said facility in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Department of Health.

Print Name of Authorized Representative

Signature of Authorized Representative*

Date

**Authorized Representative - the individual within the Applicant organization with the legal authority to give assurances, make commitments, enter into contracts, and execute documents on behalf of the Applicant, including this Application. The signature of the Authorized Representative certifies that commitments made on this Application will be honored and ensures that the Applicant agrees to conform to applicable law and regulations.*