



In-Home Care Services New Provider Application 2026-2027

Due to SourcePoint: August 4th, 2025

Application Fee: \$400

About SourcePoint's IN-HOME CARE SERVICES

SourcePoint provides in-home care for older people so they can live safely in their own homes and avoid institutional care until it may be absolutely necessary. In order to provide the wide variety of needed in-home services, SourcePoint contracts with private businesses and organizations to care for our clients. Our service providers are vetted through a rigorous application process to be sure they will provide the highest quality services to SourcePoint clients. This application is the first step in that review process.

Each of SourcePoint's clients has a unique set of needs, and a package of services is tailored to fit those needs by one of our licensed, professional Care Consultants. The Care Consultant works one-on-one with the client to determine what services the individual needs and wants to receive. Once that assessment has been made, the Care Consultant then makes the opportunity available to our service providers to bid on supplying the needed service. All requests for bids are client-driven and coordinated by our professional social work staff, and services may be discontinued at any time when a client's needs and wants change or when our staff determines that the service is no longer needed.

Instructions for Submission of Application:

All applications and supporting materials must be submitted via DropBox, using the URL:

<https://www.dropbox.com/request/FZjBPcNzbryUNosiU5xg>

Please submit application and each supporting document in separate files*

***All files must be titled using the following naming convention: Agency Name-Application item # and Name of Document.**

Applicants not following the above directions will be asked to resubmit.

All potential applicants are expected to have an applicant meeting with Jodi Wood, Provider Relations Specialist, prior to submitting an application.

Applicants are expected to have examined all Conditions of Participation and relevant Service Specifications and requirements available on SourcePoint's website prior to submitting an application.

There are fourteen (14) sections to the application which must be submitted via **DropBox**. The required documents are:

- 1. Organization Contact Form:** This form has been provided in application materials. Please provide:
 - a. the name, address, telephone, fax number, Web address etc. of the applicant organization,
 - b. the person(s) authorized to submit this application and enter into the contract
 - c. the administrative or management person who will be responsible for communicating with the Provider Relations Specialist to manage ongoing topics regarding this application
 - d. the contact person that has been designated to work directly with the Care Consultants in receiving referrals and managing clients
 - e. the person designated to handle billing

- f. the persons supervising the service coordinator/scheduler and biller
- g. confirmation that you agree to comply with the Conditions of Participation and all Service Specifications that apply to your application. All individuals involved in the administration of and provision of **IN-HOME CARE SERVICES** contracted service is expected to be both aware of and in compliance with these Specifications as well.

2. Service Quotation Sheet:

This document has been provided in application materials. For the services that you wish to offer, indicate the unit cost and the geographic area that you will serve.

If you do not plan or are not able to serve all of Delaware County, indicate which zip codes your agency will serve, otherwise indicate "county-wide". A list of zip codes is attached for your convenience.

The period covered by this application shall begin from the date of approval of your Application through December 31, 2027.

3. Statement of Organizational Purpose

Write a description of your organization, its history, purpose and mission.

4. Disclosure of Ownership and Proof of Ownership

Write a disclosure statement of ownership. Proof should be evident in other portions of application. If not, provide proof of ownership as well.

5. Proof of Service: provide a copy of:

- a. current Articles of Incorporation or Organization
- b. current Code of Regulations or Bylaws or Operating Agreement
- c. Provide documentation establishing that services have been provided in the Central Ohio community for at least one year.
 - i. Some examples include any of the above documents if an operating address is included, tax form dated at least one year ago, proof of contract with another Central Ohio service agency, other official document dated at least one year ago with address located in Central Ohio area.

6. Certificate of Good Standing

Current, dated within 60 days of application submission, Certificate of Good Standing issued by the Secretary of the State of Ohio with the application found on Secretary of the State of Ohio's website at .

[https://cogs.ohiosos.gov/\(S\(xlwj2tkrv0oflimo4vkhkmsw\)\)/index.aspx](https://cogs.ohiosos.gov/(S(xlwj2tkrv0oflimo4vkhkmsw))/index.aspx)

*Exception: Self Employed (individual person) Chore Service Provider

If your organization operates under any trade names or fictitious names please submit a copy of the most recent registration of trade name or fictitious name with the Ohio Secretary of State or the U.S. Patent and Trademark Office with the application.

7. Workers' Compensation Certificate

Provide a copy of your current Bureau of Workers' Compensation Certificate of Premium Payment.

*Exception: Self Employed (individual person) Chore Service Provider

8. Documentation of Liability Coverage

Provide evidence of required insurance coverage with the application.

See Conditions of Participation #3.2 & 3.3 as to the required insurance coverage. Applicants that do not meet all required insurance under #3.2 & 3.3 will not be considered for approval.

9. Request for Taxpayer Identification Number and Certification

Provide IRS Form W9.

10. **Authorization Agreement for Electronic Payment

Provided with application materials. SourcePoint utilizes electronic funds transfers for Provider payments. Applicants are required to complete, sign and submit this document.

11. Non-Discrimination and Equal Employment Opportunity Affidavit

SourcePoint is strongly committed to non-discrimination and equal employment opportunity. All applicants are required to complete and sign this document.

12. Other government/Levy-funded programs

List all other government/Levy-funded programs with which your agency contracts.

13. Signature page

Signature indicates agency is agreeable to the Conditions of Participation contained in the Purchase of Service Application and will comply with these Conditions.

14. Ohio Department of Health Non-Medical Home Health Service license

The Ohio Administrative Code requires all home health agency providers who provide non-medical health services to be licensed. Please provide proof of current license.

1. ORGANIZATION CONTACT FORM

Applicant Organization Name: _____

Address: _____

Web site address: _____

Office Phone w. area code: _____ Fax w. area code _____

Federal Tax I.D. _____ Type of Agency: ☐ Public ☐ Private/For-Profit ☐ Private/Non-profit

Contacts: **these should not all be the same individual**

	Name and Title	Email Address	Direct Phone Number
Signing authority for agency			
Ongoing Contract Oversight			
Service Coordinator / Scheduler			
Supervising Service Coordinator/Scheduler			
Fiscal/Billing Contact			
Supervising Billing Contact			

SourcePoint utilizes a case management system for billing, client referrals, and ongoing communication with care consultants (case managers). Each agency is permitted to have 2 users designated to receive system notifications from care consultants and other SourcePoint staff. Please indicate individual's name and email where login information will be sent. Please note: it is a HIPAA violation to share user information with others in the agency.

	Name and Title	E-mail Address	Direct Phone Number
User #1			
User #2			

2. SERVICE QUOTATION FOR DELAWARE COUNTY

In-Home Care Services

Service	Unit of Service	Unit Cost	Zip Codes to Served and Additional Information (Can enter "Entire County")
Homemaking	One Hour	\$	
Escort	One Hour	\$	
Personal Care	One Hour	\$	
Respite Care	One Hour	\$	
Nursing	One Hour	\$	

Adult Day Care Services

Service	Unit of Service	Unit Cost	Zip Codes to Served and Additional Information (Can enter "Entire County")
Adult Day Care	1-day	\$	
Adult Day Care Bath Available?	☐ Yes ☐ No	\$	

Institutional Respite Services

Service	Unit of Service	Unit Cost	Zip Codes to Served and Additional Information (Can enter "Entire County")
High-Need Clients	1-Day (24 hours)	\$	
Low-Need Clients	1-Day (24 hours)	\$	

Medical Transportation Services

Service	Unit of Service	Unit Cost	Zip Codes to Served and Additional Information (Can enter "Entire County")
Medical Transportation	Minimum Trip Cost	\$	
Medical Transportation	Rate Per Loaded Mile	\$	
Medical Transportation	Charge for Boarding Assistance	\$	
Medical Transportation	Charge for Wait Time	\$	Definition of Wait Time:
Medical Transportation	Charge for No Show	\$	
Medical Transportation (Other)		\$	

Emergency Response System Services

****Flier/Handout must be submitted with price sheet for each Emergency Response System offered; flyer must be clearly titled according to which service it corresponds i.e. Landline/Voice, Cellular, GPS, etc.**

Service	Unit of Service	Unit Cost	Fall Detector?	Fall Detector Built-In to Unit?	Zip Codes to Served and Additional Information (Can enter "Entire County")
Emergency Response-Voice System	Month	\$	☐ Yes ☐ No Price:	☐ Yes ☐ No Price:	
Emergency Response-Cellular	Month	\$	☐ Yes ☐ No Price:	☐ Yes ☐ No Price:	
Emergency Response-GPS	Month	\$	☐ Yes ☐ No Price:	☐ Yes ☐ No Price:	
Emergency Response-Extra Pendant	☐ Month ☐ One-Time Purchase	\$ \$	☐ Yes ☐ No Price:	☐ Yes ☐ No Price:	
Emergency Response-Smoke Detector	Month	\$	N/A		
Lock Boxes	Month	\$	N/A		
Emergency Response Other i.e. product/service not listed above	☐ Month ☐ One-Time Purchase	\$	☐ Yes ☐ No ☐ N/A Price:	☐ Yes ☐ No ☐ N/A Price:	

Medication Dispenser Services

Service	Unit of Service	Unit Cost	Zip Codes to Served and Additional Information (Can enter "Entire County")
Monitored Medication Dispenser	☐ Month ☐ One-Time Purchase	\$	
Non-Monitored Medication Dispenser	☐ Month ☐ One-Time Purchase	\$	
One-time Purchase of Medication Dispenser	One-time Purchase	\$	
Monitoring Cost of Purchased Medication Dispenser	Month	\$	

Other Services

Service	Unit of Service	Unit Cost	Zip Codes to Served and Additional Information (Can enter "Entire County")
Home Accessibility Modification*	1 modification	Bid Approved	
Home Repair	1 home repair	Bid Approved	
Durable Medical Equipment**	1 item	Via Price Listing	
Furnace Inspection	1-time	Bid Approved	
CHORE Services	Completed Job	Bid Approved	
Extermination/Pest Control Services	Completed Job	Bid Approved	
Lawn Mowing	Small lot Medium Lot Large Lot	\$ \$ \$	
Snow Removal	City of Delaware Outside Delaware City	\$ \$	
Other Service			

*Home Modification examples include, but are not limited to:

- Grab bars in showers/bathtubs
- Handrails to enter/exit the home
- Handrails to transition from one area of the home to another
- Tub cuts
- Walk-in/roll-in showers
- Stair lifts – Inside residence
- Wheelchair ramps and lifts

**Durable Medical Equipment examples include, but are not limited to:

- Raised toilet seat
- Bedside commodes
- Shower bench
- Handheld shower head
- Wheelchair
- Walker

ZIP CODES SERVED IN DELAWARE COUNTY

City	Zip Code
Ashley	43003
Centerburg	43011
Columbus	43235
Columbus	43240
Delaware	43015
Dublin	43017
Galena	43021
Johnstown	43031
Kilbourne	42032
Lewis Center	43035
New Albany	43054
Ostrander	43061
Powell	43065
Prospect	43342
Radnor	43066
Richwood	43344
Shawnee Hills	43065
Sunbury	43074
Waldo	43356
Westerville	43082

3. STATEMENT OF ORGANIZATIONAL PURPOSE

Provide a written description of your organization, its history, purpose and mission.

4. DISCLOSURE OF OWNERSHIP

Submit documentation supporting compliance with Condition of Participation #1.1:

The Provider must provide disclosure of ownership, and promptly provide notice of any change in ownership, and provide a written statement defining Provider's purpose

5. PROOF OF SERVICE

Submit documentation supporting compliance with Condition of Participation #1.2:

The Provider must have articles of incorporation/organization and code of regulations/ bylaws/operating agreement effective at least one year prior to the date of application (amendments within the prior one year are permitted) and promptly provide a copy of any amendments thereto after the date of application).

6. CERTIFICATE OF GOOD STANDING FROM SECRETARY OF STATE

See example and submit documentation supporting compliance with Condition of Participation #1.3:

The Provider must provide a Certificate of Good Standing from the Secretary of State and provide immediate written notification of any change of Provider's status from that of "good standing."

Example of Certification of Good Standing from Secretary of State

Sample - OnlineCorporatedocs.com

**United States of America
State of Ohio
Office of the Secretary of State**

I, Jennifer Brunner, do hereby verify that I am the duly elected, qualified and present acting Secretary of State for the State of Ohio, and as such have custody of the records of Ohio and Foreign business entities; that said records show HILL MEKES PHOTO, INC., an Ohio corporation, Charter No. 738299, having its principal location in Columbus, County of Franklin, was incorporated on October 19, 1989 and is currently in GOOD STANDING upon the records of this office.



Witness my hand and the seal of the
Secretary of State of Ohio at Columbus, Ohio
the 10th day of July, A.D. 2019



Ohio Secretary of State

Publication Number: 1706000000000000

Date must be within 60 days of
application submission

7. WORKERS' COMPENSATION CERTIFICATE

Submit documentation supporting compliance with Condition of Participation #1.5.1:

The Provider must provide a written statement certifying compliance with Federal and state wage & hour laws & state Workers' Compensation laws. (Not applicable to self-employed without any employees)

8. DOCUMENTATION OF LIABILITY COVERAGE

Submit documentation supporting compliance with Condition of Participation #3.2-3.3:

The Provider shall submit evidence of business insurance coverage for the required one year prior to the date of application.

Throughout the term of the Letter of Understanding, the Provider shall obtain and maintain a comprehensive insurance program affording, at a minimum, the coverage indicated below (to be submitted with application):

- **Comprehensive Public General Liability:** \$1,000,000 single limit occurrence including coverage for:
 1. Personal Injury and Property Damage
- **Automobile Liability:** \$1,000,000 single limit occurrence including owned, hired and non-owned motor vehicles providing coverage for damages because of bodily injury or property damage arising out of the ownership, operation, maintenance or use of a motor vehicle.
- **Employee Dishonesty/Crime/Theft:** Coverage of not less than \$25, 000, which may be satisfied by inclusion within the Comprehensive Public General Liability policy, by a separate Employee Dishonesty Policy or rider or a bond issued by a bonding or surety company.

The Provider shall add SourcePoint as an additional named insured on the required liability insurance Policies as well as the following language and extensions:

"SourcePoint is an additional insured with respect to work and/or services performed by the named insured as required by written contract or agreement. All insurance shall be primary and non-contributory with any insurance carried by the Additional Insureds. This includes a Waiver of Subrogation in favor of the additional insured. 30-day notice of cancellation applies."

9. REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

Submit documentation supporting compliance with Condition of Participation #1.5.4:

The Provider must provide a properly completed Request for Taxpayer Identification Number and Certification (IRS Form W9).

10. Authorization Agreement for Electronic Payment / Automatic Deposit

Complete this document for compliance with Condition of Participation 7.1.

I hereby authorize SourcePoint to initiate credit entries and when necessary, to initiate correction adjustments to my bank account listed below:

Reason for Request

- ☐ New Authorization / New Application
☐ Revision to Current Authorization

Type of Account

- ☐ Checking
☐ Savings

Payee (Vendor or Employee Name):	
Bank Name:	
Branch:	
City	
State:	
Zip Code:	
Bank Telephone Number:	
ABA/Routing Number	
Account Number	
Contact name & Email for Billing Issues	

Note: Please provide a voided check with this form.

*It is the agency's responsibility to notify SourcePoint **via telephone** if there are any changes to this bank account information. Failure to do so may result in late or missed payments

Signature

Date

Name of Authorized Individual

Title

11. NON-DISCRIMINATION AND EQUAL OPPORTUNITY EMPLOYMENT CERTIFICATION

Complete this document for compliance with Condition of Participation 1.5.2

I, _____
Name Title
Of _____
Applicant Organization

I certify that the Applicant Organization does not and shall not discriminate against any employee or applicant for employment because of age, race, handicap, religion, color, sex, sexual orientation or national origin. If awarded the contract with SourcePoint, the Applicant Organization shall take affirmative action to ensure that applicants are employed and that employees are treated, during employment, without regard to their race, disability, religion, color, sex, sexual orientation or national origin, except as permitted by law in order to accommodate such employee. If successful under the application, the Applicant shall post non-discrimination notices in conspicuous places available to employees and applicants for employment setting forth the provisions of this certification.

Applicant Organization: _____

Address _____
Street Suite

City State Zip Code

Signature Date

Name of Authorized Individual Title

12. Please list any other government or Levy-funded programs with which your agency contracts:

13. *My signature below certifies that I have read, understood and on behalf of the Applicant organization agree to the Conditions of Participation contained in the Purchase of Service Application; that I am authorized to obligate the Applicant organization to comply with these Conditions; and, further, that I have read, understand, agree to and am authorized to commit the Applicant organization to the provision of service(s) set forth in the Service Specifications for those services for which we are submitting a quotation*

Signature

Date

Printed Name

Title

14. OHIO DEPARTMENT OF HEALTH NON-MEDICAL HOME HEALTH CARE LICENSE

Please submit proof of current license.

Application Checklist- Verify all items are submitted as required

Application Item	Submitted
1. Organizational Contact form with appropriate Contacts provided	☐
2. Service Quotation Sheet with all services wishing to offer for 2026-2027	☐
3. Statement of Organizational Purpose	☐
4. Disclosure of Ownership	☐
5 (a). Proof of Service: Articles of Incorporation or Organization	☐
5 (b). Proof of Service: Bylaws or Operating Agreement or Code of Regulations	☐
5 (c). Proof of Service: Document supporting length of service in Central Ohio	☐
6. Certificate of Good Standing Dated in Last 60-Days	☐
7. Current Worker's Compensation Certificate	☐
8. Liability Insurance Certificate; Additional Insured Document	☐
9. IRS W-9 Form	☐
10. Authorization of Electronic Payment and Voided Check	☐
11. Non-Discrimination Affidavit	☐
12. Listing of other contracted programs	☐
13. Signature Page	☐
14. Non-Medical Home Health Care License	☐