# In-Home Care Services Renewing Provider Application 2026-2027
# Due to SourcePoint: August 4th, 2025
# Application Renewal Fee: $250

## 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: Provider Name-Application items # and Name of Document.**
- **Applicants not following the above directions will be asked to resubmit.**

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 **thirteen (13)** sections to the application which must be submitted via DropBox. For certain sections (where indicated), only submit documents if information has changed.

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 (service coordinator/scheduler)
   e. the person designated to handle billing
   f. the contact people 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 are 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. **Disclosure of Ownership and Proof of Ownership (only submit if information has changed)**

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

4. **Proof of Service:** provide a copy of: **(only submit if information has changed)**
   a. current Code of Regulations ***or*** Bylaws ***or*** Operating Agreement

5. **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(tpxmpll31vntzk3v1ds44ack))/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.

6. **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*

7. **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 and # 3.3 will **not** be considered for approval.

8. **Request for Taxpayer Identification Number and Certification (only submit if information has changed)**

   Provide IRS Form W9.

9. ****Authorization Agreement for Electronic Payment (only submit if information has changed)**

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

10. **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.

11. **Other government/Levy-funded programs**

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

12. **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.

13. **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 _____

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

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

| | Name and Title | E-mail 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 system notifications will be sent. <u>Please note: it is a HIPAA violation to share user information with others in the agency.</u>**

| | 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<br>☐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.**

*Mobile ERS Unit pricing only applies to existing units already in place in clients' homes. No new referrals will be sent for Mobile units.

| **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<br>☐No<br>Price: | ☐Yes<br>☐No<br>Price: | |
| Emergency Response-Cellular | Month | $ | ☐Yes<br>☐No<br>Price: | ☐Yes<br>☐No<br>Price: | |
| Emergency Response-Mobile Unit* | Month | $ | ☐Yes<br>☐No<br>Price: | ☐Yes<br>☐No<br>Price: | |
| Emergency Response-GPS | Month | $ | ☐Yes<br>☐No<br>Price: | ☐Yes<br>☐No<br>Price: | |
| Emergency Response-Extra Pendant | ☐Month<br>☐One-Time Purchase | $<br>$ | ☐Yes<br>☐No<br>Price: | ☐Yes<br>☐No<br>Price: | |
| Emergency Response-Smoke Detector | Month | $ | N/A | | |
| Lock Boxes | Month | $ | N/A | | |
| Emergency Response Other i.e. product/service not listed above | ☐Month<br>☐One-Time Purchase | $ | ☐Yes<br>☐No<br>☐N/A<br>Price: | ☐Yes<br>☐No<br>☐N/A<br>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<br>☐One-Time Purchase | $ | |
| Non-Monitored Medication Dispenser | ☐Month<br>☐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 ☐<br>Medium Lot ☐<br>Large Lot ☐ | $<br>$<br>$ | |
| Snow Removal | City of Delaware ☐<br>Outside Delaware City ☐ | $<br>$ | |
| 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. DISCLOSURE OF OWNERSHIP (if applicable)

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.*

## 4. PROOF OF SERVICE (if applicable)

Submit documentation supporting compliance with Condition of Participation #1.2:

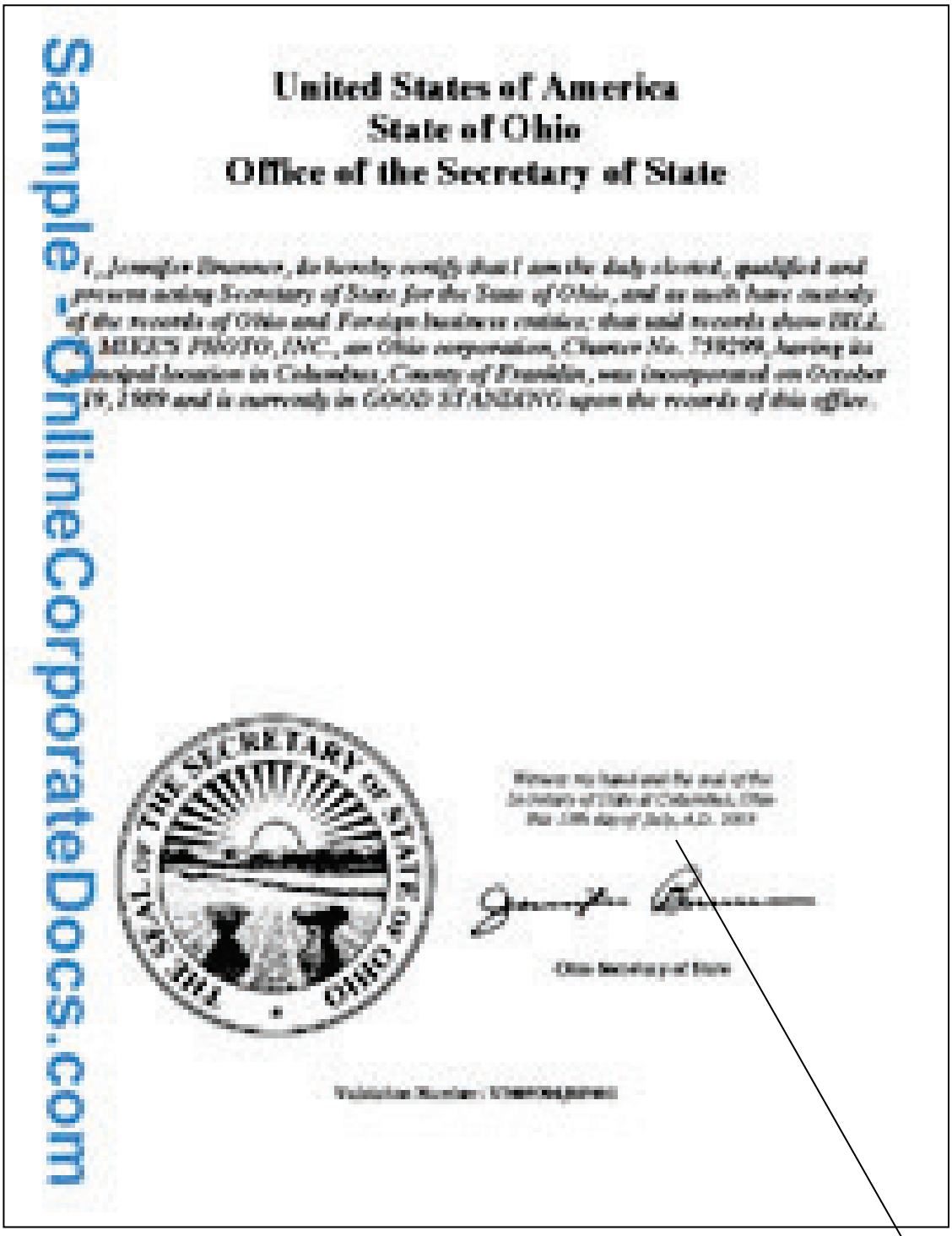
*The Provider must have code of regulations/ bylaws/operating agreement effective at least one year prior to the date of application (amendments within the prior one year are permitted) and promptly provide a copy of any amendments thereto after the date of application).*

## 5. 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



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

I, Jennifer Brunner, do hereby certify 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 BILL MEYERS PHOTO, INC., an Ohio corporation, Charter No. 710199, 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.



**Date must be within 60 days of application submission**

## 6. 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)*

## 7. 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:*
  *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/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."***

## 8. REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION (if applicable)

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).*

## 9. Authorization Agreement for Electronic Payment / Automatic Deposit (if applicable)

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 is late or missed payments.

Signature Date

Name of Authorized Individual Title

## 10. 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

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 insure 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

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

_____

_____

_____

**12**. ***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

_____ _____

Printed Name Title

**13. 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. Disclosure of Ownership** | ☐ |
| **4 (a). Proof of Service: Articles of Incorporation or Organization** | ☐ |
| **4 (b). Proof of Service: Bylaws or Operating Agreement or Code of Regulations** | ☐ |
| **4 (c). Proof of Service: Document supporting length of service in Central Ohio** | ☐ |
| **5. Certificate of Good Standing Dated in Last 60-Days** | ☐ |
| **6. Current Worker's Compensation Certificate** | ☐ |
| **7. Liability Insurance Certificate** | ☐ |
| **8. IRS W-9 Form** | ☐ |
| **9. Authorization of Electronic Payment and Voided Check** | ☐ |
| **10. Non-Discrimination Affidavit** | ☐ |
| **11. List of Other Contracted Programs** | ☐ |
| **12. Signature** | ☐ |
| **13. Non-Medical Home Health Care License** | ☐ |