GOVERNMENT OF BERMUDA

Ageing and Disability Services and Health Insurance Department

Home Care Agency Application

Registration with Ageing and Disability Services (ADS) is required for home care agencies and their staff providing home care services to clients paid for, partially or in full, by the following government departments:

- Health Insurance Department (FutureCare and HIP Personal Home Care Benefit)
- Department of Financial Assistance
- Department of Social Insurance (War Veterans Benefit)

Guidance:
All applications must have:

1. A completed and signed application form
2. The required documentation for each provider, available upon request.
3. Agencies to be paid by the Future Care or HIP Personal Home Care Benefit must complete the HID Electronic Payment form.

Incomplete applications will not be reviewed.

Completed applications are mailed/delivered to:

ads@gov.bm
or
Ageing and Disability Services,
Ministry of Health and Seniors, Ground floor
25 Church St. Hamilton, HM12

For more information contact: Ageing and Disability Services at 292 7802, or ads@gov.bm

The information used in this application form will be kept confidential and will be used for the purposes of monitoring the health sector and contacting you; it may also be shared with the Bermuda Health Council and other Governmental agencies for the same purposes.

Home Care Agency Application

Section A: Applicant Information

i. Provider Type:

☐ Home Care Agency

ii. Contact Details

Agency Name:		
BHeC Registration Number:		
Agency Owner:	**Name:**	**Contact number:** **Email:**
Preferred Agency Contact Person:	**Name:**	**Job Title:**
Agency Address:		
	Unit, Suite, Floor # *Street Address*	
	Address Line 2 (if applicable)	
	Parish *Postal Code*	
Agency Telephone:		**Agency Cell:**
Agency Fax:		**Agency Email:**

The applicant Home Care Agency must submit:

1. **A list of all current employees including** the following information: Full name, date of birth, job title, provider type (as listed in section B), primary contact information, start date of employment. All listed employees must have the minimum requirements for their provider type listed in Section B and the specified documentation on file at the Agency.
2. A completed copy of Sections E &F for each employee.

Section B: Care Provider Requirements

Personal Caregiver	1. Current CPR and First Aid Certification – Photocopy of current training certificate or course 2. Magistrate's Court or Bda Police Service Record Check – a letter issued within the last 12 months 3. Medical Certificate – a letter from your doctor indicating mental and physical fitness to provide care 4. Two written references- 1 character and 1 professional 5. A resume – on a separate piece of paper outline previous work experience
Skilled Caregiver (Nursing Associate /Geriatric Aide)	1. Active Bda Nursing Council Registration as a Nursing Associate (Nursing Assistant/ Geriatric Aide)- Photocopy of current registration card 2. Current CPR Certification - Photocopy of current training certificate or course 3. Magistrates Court of Bda Police Services Record Check – a letter issued within the last 12 months 4. Medical Certificate – a letter from your doctor indicating mental and physical fitness to provide care
Registered Nurse:	1. Active Bda Nursing Council Registration as a Registered Nurse- Photocopy of current registration card 2. Current CPR Certification - Photocopy of current training certificate or course 3. Magistrates Court of Bda Police Services Record Check- a letter issued within the last 12 months 4. Medical Certificate – a letter from your doctor indicating mental and physical fitness to provide care

Section C: Home Care Agency Owner Screening Questions - if you answered yes, to any of the below, submit with your application on a separate paper further explanation for answering yes.			
1.	Have you been convicted of, pled guilty or no contest to a crime in Bermuda or any other country?	YES ☐	NO ☐
2.	Have you had any disciplinary or probationary action taken against you by any licensing authority in Bermuda or another country? This includes: probation, suspension, revocation, or denial of a license.	YES ☐	NO ☐
3.	Have you had any form of investigation or disciplinary action by any health or social services related agency in Bermuda or another country?	YES ☐	NO ☐
4.	Do you have a mental or physical condition, and/or an alcohol or drug dependency which could interfere with your current ability to provide care?	YES ☐	NO ☐

Section D: Declaration Statement of Applicant *(Home Care Agency Owner)*

By my signature :

1. I agree the information submitted in this application and in any required or following documentation is true and accurate to the best of my knowledge. I understand that false statements may result in the denial or removal of registration.
2. I agree for Ageing and Disability Services and/or HID to contact relevant persons (including but not limited to regulatory and government entities) to verify the information provided for this application.
3. I agree to notify Ageing and Disability Services of any changes to the information provided in this registration form including changes to the submitted employee list.
4. I am indicating that each provider employed at the agency meets the provider qualifications and the required documentation providing evidence of such for each employee is on file and available upon request.
5. I understand that the Health Insurance Department will issue electronic versions of their Explanation of Payment for any claims submitted to them. Notifications will be emailed to the agency email address indicated in Section A. ii.

Printed Name of Applicant

Signature of Applicant

Date

Section E: Employee Screening Questions - if any employee answered yes, to any of the below, submit with your application on a separate paper the person's name, further explanation for answering yes and agency's rationale for employment.			
5.	Have you been convicted of, pled guilty or no contest to a crime in Bermuda or any other country?	YES ☐	NO ☐
6.	Have you had any disciplinary or probationary action taken against you by any licensing authority in Bermuda or another country? This includes: probation, suspension, revocation, or denial of a license.	YES ☐	NO ☐
7.	Have you had any form of investigation or disciplinary action by any health or social services related agency in Bermuda or another country?	YES ☐	NO ☐
8.	Do you have a mental or physical condition, and/or an alcohol or drug dependency which could interfere with your current ability to provide care?	YES ☐	NO ☐

Section F: Declaration Statement for Employees

By my signature :

1. I agree the information submitted in this application and in any required documentation is true and accurate to the best of my knowledge. I understand that false statements may result in the denial or removal of registration.
2. I agree for Ageing and Disability Services and/or HID to contact relevant persons (including but not limited to regulatory and government entities) to verify the information provided for this application.
3. I agree to notify Ageing and Disability Services of any changes to the information provided in this registration form including changes

Printed Name of Employee

Signature of Employee Date

GOVERNMENT OF BERMUDA

Ministry of Health and Seniors

Health Insurance Department

ELECTRONIC PAYMENT AGREEMENT

RETURN THIS FORM TO:
Health Insurance Department
Attention: Claims Settlement Section
PO Box HM 2160
Hamilton HM JX Bermuda

OR Fax to: (441) 295-9213
OR E-mail to: hip@gov.bm

Please complete all fields, printing or typing information clearly. Fields designated with asterisks ** are required.

Personnel	
**Organization Name:	
**Contact/Accounting Officer:	

Contact Details	
**E-mail:	
**Telephone (direct):	
Fax:	
Mailing Address (for Correspondence):	

Bank Details	
**Bank Name:	
**Account Name:	
**Account Number:	

Street Address – Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Mailing Address – PO Box HM 2160, Hamilton HM JX Bermuda
Phone: (441) 295-9210 Fax: (441) 295-9213 Email: hip@gov.bm Website: www.gov.bm/department/health-insurance

Swift Address: (** to be completed for banks located outside of Bermuda)	
**Bank Address:	
Bank Clearing Details (if applicable):	
Payment Reference (if applicable):	

I hereby authorize the Health Insurance Department to satisfy payment obligations due to me/the Business Organization, by making deposits to the account indicated above. I understand that receipt of the electronic fund transfer(s) will fulfill the Health Insurance Department's payment obligation for the full amount on the date the fund transfer is completed. All correspondence with the Health Insurance Department concerning this agreement or any changes to account information should be sent to the address at the top of this form.

**SIGNATURE: _____

**DATE: _____

**PRINTED NAME: _____

(** Mandatory Fields)

PLEASE NOTE THAT ANY CHARGES INCURRED BY THE GENERATION OF ELECTRONIC PAYMENTS WILL NOT BE CHARGED TO THE CLIENT. ALL FEES STRICTLY RELATED TO THE PROCESSING OF ELECTRONIC PAYMENTS ARE THE SOLE RESPONSIBILITY OF THE HEALTH INSURANCE DEPARTMENT.