GOVERNMENT OF BERMUDA

HIP & FUTURECARE PERSONAL HOME CARE BENEFIT GUIDE

Health Insurance Department, Ministry of Health & Seniors

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Health Insurance Department
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All forms required for policyholders and providers are included in this Guide.

You can also obtain the forms from the website: www.gov.bm/personal-home-care-benefit, or directly from the Health Insurance Department.

For more information contact:
Health Insurance Department,
Sofia House, 2nd Floor,
48 Church Street, Hamilton

Mailing Address:
Health Insurance Department
P.O. Box HM 2160, Hamilton HM JX
HM 12

Phone: 441-295-9210
Fax: 441-295-9213
Email: hip@gov.bm
Website: www.gov.bm

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Benefit Overview

The Personal Home Care Benefit (PHC) was introduced in 2015 as a HIP and FutureCare benefit under the Health Insurance Act 1970.[1] The Benefit assists FutureCare and HIP policyholders with the costs of personal care services in their home.

- The benefit requires a **'Request for Benefit'** by the policyholder, their family or healthcare provider on their behalf.
- **Prior approval** by the Health Insurance Department (HID) Nurse Case Manager team is necessary to start any payments under this benefit.
- **Caregiving Providers** must be registered to be paid by this benefit.
- The specific type and amount of services the policy holder may be covered for under this benefit is determined by an individual assessment of the policy holder's care needs.
- This benefit does not cover rest home or nursing home care.

Type and Services of Personal Home Care Benefit **Maximum Limits***

Care Provider	Type of Care	Reimbursed Rate	Quantity	Maximum Monthly Reimbursement
Personal Caregiver	Assistance with personal care and /or dementia care	$15/hr	40 hr/wk	$2,610
Skilled Caregiver (Nursing Associate/Geriatric Aide)	Assistance with personal care, health monitoring, dementia care for those with fragile health status	$25/hr	14 hr/wk	$1,525
Registered Nurse	Assessments of health conditions, treatments, wound care, care planning, education of other care givers	$75/hr	12 visits/yr	NA
Day Care Program	Social and recreational activities	$25/half day or $50/day	$200/wk	$867

***This benefit has a maximum benefit limit of $60,000 per policy year for any combination of services.**

[1] S.9B Health Insurance (FutureCare plan) (Additional Benefits) Order 2009 and S.13A Health Insurance (Health Insurance Plan) (Additional Benefits) Order 2009

Policyholders - How to receive the Benefit

Eligibility Criteria:

To receive this benefit the policyholder must:

- Have an ongoing HIP or FutureCare policy for at least one year;
- Be unable to care for their personal care needs in two or more areas, or, have dementia plus one other personal care need. Examples of personal care needs are: bathing, dressing, moving, eating, and toileting;
- Agree to ongoing case management; and
- Be able to hire and manage their caregiving provider(s) or have a responsible person to do this for them.

How does the benefit work?

1. Submit a completed Personal Home Care Services Request for Benefit form (page 17 in this guide) with a Physician's letter. A template for the Physician's letter can be seen on page 19 in this guide.

2. A HID Nurse Case Manager will arrange for a home or hospital assessment.

3. If approved for the benefit, a benefit approval letter/email will be given to the policyholder with information about the type and amount of care covered by the benefit.

4. The benefit starts from the date the policyholder is approved.

5. The policyholder, or their responsible person, must find and hire a **registered caregiving provider** (See the Sample Client and Caregiving Provider Contract in this Guide recommended to be completed when hiring a caregiving provider).

6. The policyholder, or their responsible person, must review and sign every Claim Form submitted by the caregiving provider to HID for payment.

7. The benefit only pays for approved services at set rates. HID pays the caregiving provider directly. **Any services or charges that are more than what the policyholder is approved for are the policyholder's responsibility**.

Caregiving Providers

Caregiving providers must be registered with Ageing and Disability Services (ADS) and HID to receive payment from the Benefit.

- For a list of registered caregiving providers go to: https://www.gov.bm/homecare-provider-registration or contact ADS directly: ads@gov.bm.
- To learn how to register go to the **Personal Home Care Services Providers** section of this Guide.

Personal Home Care Services Providers

HID pays providers of personal home care services (caregiving providers) directly for services delivered to the policyholder approved for the Benefit.

Caregiving providers must be registered in order to receive payment.

Family and friends may register as a caregiving provider if they meet the registration requirements.

There are 4 different types of caregiving providers:

1. Personal Caregivers
2. Skilled Caregivers (Nursing Associate/Nursing Assistant/Geriatric Aide)
3. Registered Nurses
4. Day Care Programs

Steps for Registration

1. Complete the appropriate registration form:

Registration Form	Provider Type
Self-Employed Caregiver Application Form	• For all self-employed caregiving providers (See page 27 in Appendix III)
Home Care Agency Application Form	• For the Agency. The Agency's caregiving providers are registered by the Agency as part of their application. If their staff are to be paid directly by the benefit, the staff must register individually via the self-employed caregiving provider application (See page 37 in Appendix III)
Day Care Programs	• Providers must be registered as a residential care home or nursing

2. Complete the HID Electronic Payment Agreement Form**.** (included in this Guide)

3. Submit all forms and supporting documents to: ads@gov.bm or
   Ageing and Disability Services
   Ministry of Health and Seniors
   Continental Building,
   25 Church St.
   Hamilton HM12

4. Once the applications are approved, HID will send a welcome kit.

Caregiving Provider Payment Process

To be paid for caregiving services by the Health Insurance Department (HID), the following steps **must** be completed:

1. **Submit a claim to HID:** this can be at any point after the services have been provided – daily, weekly, every two weeks, monthly, etc. The frequency of submitting claims is an agreement made between the policyholder, or their responsible person, and the caregiving provider.

2. **Complete**: the Personal Home Care Services Claim Form for each policyholder.
    - If a Provider has more than one policyholder client, a Personal Home Care Services Claim Form (included in this Guide) must be completed for each client.

NOTE: Claims submitted that are not submitted correctly and/or are incomplete will be denied.

3. **Submit:** the completed Personal Home Care Claim Form to the Health Insurance Department via:
    - **Email:** hidclaims@gov.bm in the subject line put: Claim for Personal Home Care Services – Provider or Caregiver Name; or
    - **Hand Deliver to:** Health Insurance Dept., Sofia House, 2nd Floor, 48 Church St, Hamilton; or
    - **Mail to**: Health Insurance Dept., PO Box HM 2160, Hamilton HM JX

NOTE: Claims for policyholder's eligible for War Vets or Financial Assistance Home Care benefits, must be submitted to HID. HID will send the uncovered portion to other departments for review.

4. Approved claims are paid to the caregiving provider by an electronic transfer.
    - The transfer is made to the bank account provided on the HID Electronic Payment Agreement Form submitted to the Health Insurance Department as part of the provider registration.

5. HID will send the caregiving provider (or Agency) an Explanation of Payment and/or Benefit.
    - These are sent via email or paper in the event that the caregiving provider does not have an email address.
        i. For providers, email address is required as the Explanation of Payments are available in HID's online portal.

NOTE: Average turnaround time for HID to reimburse claims is approximate 14 days. Please note that as per Legislation, HID has 30 days upon receipt of a claim to reimburse the provider.

Caregiving Claim Form Guidance and examples

All fields in the Personal Home Care Services Claim Form (included in this Guide) must be filled-in for the claim to be deemed complete:

1. Ensure the policyholder and caregiving provider information is complete.
    - **Place of Service**: check the applicable box to indicate where the services were provided.

2. At the end of each day or session, the caregiving provider fills-in the following information:
    - **Date**
    - **The CPT code:**
        - The codes are at the top of the form. The code to be used is based on the approved type of care provided, not the qualifications of the provider. The policyholder's approval letter/email states their approved type of care.
        - In some cases, more than one type of care may be approved and provided by one care provider. For example, a Nursing Associate may provide both the personal caregiving (G0156) and the skilled caregiving (S9122) for the same policyholder. The caregiving provider records on a separate line on the same time sheet the hours worked each day by CPT code.
    - **Start time**
    - **Stop time**
    - **Total hours worked per day**
        - The hours recorded **must** be in full hours; partial hours cannot be accepted
    - **Indicate the hourly rate charged for services**
        - For a daycare program put the rate charged by day or half day.
        - For caregiving providers who deliver more than one type of care and charge different rates- indicate each rate in relation to type of care.
    - **Charges per day:** charges are calculated by multiplying the Total Hours by the Hourly Charge.

3. The provider signs the form at the end of the pay period.

4. The policyholder (or their responsible person) must also review the content of the form and sign, when in agreement.

NOTE: Incorrect or incomplete claims will be rejected.

See the examples of completed forms and explanations.

For more information about the payment process, see the Frequently Asked Questions in this guide or contact HID directly.

Example 1: Personal Home Care Claim Form – Self Employed Caregiving Provider

Policyholder, John C. Doe, is approved for 14 hours of personal caregiving and 4 hours of skilled caregiving services per week. Jane P. Doe is a registered Skilled Caregiving Provider and charges $18 per hour for personal caregiving and $25.00 per hour for skilled caregiving.

- On Jan 4th Jane Doe provided personal caregiving services from 9 am-12:00 pm or 3 hours in total. She also did 2 hours of skilled caregiving services from 1:00 PM to 3:00 PM.
- On the first line of the claim form, she enters her personal caregiving hours using CPT Code G0156. On the second row, she enters the same date and the start and end times for the hours she worked as a skilled caregiver and uses CPT code S9122.
- On the first line, her total hours were 3.
- On the second line, her total hours were 2.
- The hourly charge for personal caregiving - $18.00 - is entered on line 1 for January 4th. Her hourly charge for skilled caregiving is $25.00 and is entered on line 2 for January 4th.
- Jan 4th charges: line one is hours multiplied by $18.00 for a total of $54.00
- Jan 4th charges: line 2, are 2 hours multiplied by $25.00 for a total of $50.00

In this example, Jane P. Doe submitted a total of 10 hours at $18.00 per hour for a total claimed amount of $180.00. HID would pay Jane P. Doe a total of $150.00. This is because the maximum reimbursement rate for this type of care (personal caregiving) is $15.00 per hour ($15.00*10 hrs = $150.00).

Jane charged 7 hours at $25.00 for a total claimed amount of $175. HID would reimburse $175.00 as reimbursable rate from HID for skilled caregiving is $25.00.

John Smith is responsible to pay Jane P. Doe the remaining $30.00 for this period ($180.00-$150.00 = $30.00).

Example 1: PHC Claim Form – Self-employed Caregiving Provider

GOVERNMENT OF BERMUDA
Health Insurance Department

Personal Home Care Services - Claim Form

Basic Guidelines for this Form:

- This Claim Form must be submitted to Health Insurance Department (HID);
- Only Caregivers registered with ADS may be reimbursed for this benefit by HID; and only as the level of service provider(s) they are registered for.
- Reimbursement is limited to level of care the HID policyholder is approved for, and not according to caregiver qualifications.
- Benefit does not cover caregiving when policyholder is admitted or in hospital;
- Caregivers are employed by policyholder, not HID.

Policyholder's Name (First Name, Middle Initial, Last Name):	HID Policy ID:	Date of Birth (mm/dd/yyyy):
John C. Doe	000000	07/25/1943
Provider to be Paid (Agency or Individual Caregiver Name):	Care Provider Name (If different from Provider to be Paid):	
Jane C Doe		

Caregivers can only charge for the services that they are registered for:
Personal Caregiver (CG, NA, RN): G0156 **Adult Day Care (AD): S5101 (half day or 4 hours)**
Skilled Caregiver (NA, RN): S9122 **S5102 (full day)**
Registered Nurse (RN): S9124

Place of Service:
☐ (12) Home
☐ (32) Nursing Home (for day care)
☐ (33) Rest Home (for day care)

Date (mm/dd/yyyy)	CPT Code	Start Time	End Time	Total Hours (Full hours only)	Hourly Charge	Charges (Total Hours x Hourly Charge)
01/04/2018	G0156	9:00 AM	12:00 PM	3	$18.00	$54.00
01/04/2018	S9122	1:00 PM	3:00 PM	2	$25.00	$50.00
01/05/2018	G0156	9:00 AM	12:00 PM	3	$18.00	$54.00
01/06/2018	S9122	2:00 PM	5:00 PM	3	$25.00	$75.00
01/07/2018	G0156	8:00 AM	5:00 PM	4	$18.00	$72.00
01/07/2018	S9122	1:00 PM	3:00 PM	2	$25.00	$50.00

Policyholder or Responsible Person Signature: **"I confirm receipt and authorize payment of medical benefits to the undersigned provider/caregiver for the service(s) described above."**
Signed: **Policyholder's Signature** Date (mm/dd /yyyy): 01/08/2018
Care Provider's Signature: **Caregiver's Signature** Date (mm/dd /yyyy): 01/08/2018

Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12

Example 2: Personal Home Care Claim Form – Agency/Employed Caregiver:

Jane C. Smith is approved for 40 hours of personal caregiving services per week. Sally P. Doe is a caregiver who is employed by a registered Agency who charges $18 per hour for her services.

- On Jan 4th the provider worked from 9am-5pm, 8 hours in total.
- CPT Code G0156 is used for this type of care, see top of form for codes.
- To work out the number of units: For CPT code GO156, 1 unit is equal to 1 hour so the total number of units recorded for Jan 4th is **8**.
- The Hourly Charge of $18.00 is entered for January 4th.
- The Charges for Jan 4th are 8 hours/units multiplied by $18.00. The amount recorded is $144.00

Example 2: PHC Claim Form – Home Care Agency Caregiving Provider

GOVERNMENT OF BERMUDA
Health Insurance Department

Personal Home Care Services - Claim Form

Basic Guidelines for this Form:

- This Claim Form must be submitted to Health Insurance Department (HID);
- Only Caregivers registered with ADS may be reimbursed for this benefit by HID; and only as the level of service provider(s) they are registered for.
- Reimbursement is limited to level of care the HID policyholder is approved for, and not according to caregiver qualifications.
- Benefit does not cover caregiving when policyholder is admitted or in hospital;
- Caregivers are employed by policyholder, not HID.

Policyholder's Name (First Name, Middle Initial, Last Name): **Jane C. Smith**	HID Policy ID: 000000	Date of Birth (mm/dd/yyyy): 07/25/1940
Provider to be Paid (Agency or Individual Caregiver Name): **Agency Name**	Care Provider Name (If different from Provider to be Paid): **Sally P. Doe**	
Caregivers can only charge for the services that they are registered for: **Personal Caregiver (CG, NA, RN): G0156** **Adult Day Care (AD): S5101 (half day or 4 hours)** **Skilled Caregiver (NA, RN): S9122** **S5102 (full day)** **Registered Nurse (RN): S9124**		**Place of Service:** ☐ (12) Home ☐ (32) Nursing Home (for day care) ☐ (33) Rest Home (for day care)

Date (mm/dd /yyyy)	CPT Code	Start Time	End Time	Total Hours (Full hours only)	Hourly Charge	Charges (Total Hours x Hourly Charge)
01/04/2018	G0156	9:00 AM	5:00 PM	8	$18.00	$144.00
01/05/2018	G0156	9:00 AM	5:00 PM	8	$18.00	$144.00
01/06/2018	G0156	9:00 AM	5:00 PM	8	$18.00	$144.00
01/07/2018	G0156	9:00 AM	5:00 PM	8	$18.00	$144.00
01/08/2018	G0156	9:00 AM	5:00 PM	8	$18.00	$144.00

Policyholder or Responsible Person Signature: **"I confirm receipt and authorize payment of medical benefits to the undersigned provider/caregiver for the service(s) described above."**

Signed: **Policyholder's Signature** Date (mm/dd /yyyy): 01/08/2018

Care Provider's Signature: **Caregiver's Signature** Date (mm/dd /yyyy): 01/08/2018

Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12

Frequently Asked Questions

Benefits:

Can anyone have their caregiving paid for by FutureCare or HIP?

No. The person with HIP or FutureCare must apply and be approved for the Personal Home Care Benefit. See Policyholders section of the Guide for more information.

If my loved one is unable to make their own decisions, can they receive this benefit?

Yes, but only if they have a responsible person to oversee their caregiving needs.

When is a responsible person required?

A responsible person is required when the policyholder is unable to oversee and manage their own care. This is most often required for persons with dementia.

Who can be a responsible person and what do they do?

A responsible person is someone committed to the care of the policyholder. They are most often: next of kin, a family member, the person with power of attorney, or a very close friend. The case manager must be assured the person is able to act in the best interest of the policyholder and fulfill their role.

The role of the responsible person is to:

- Hire and oversee caregiver providers; and
- Approve and sign the Claim Forms submitted by the provider for payment; and
- Participate in the policyholder's ongoing care

What is personal care?

Personal Care is support with activities of daily living (ADLS) which include:

- Assistance with moving from one place to another while performing activities
- Bathing and showering
- Dressing
- Self-feeding
- Personal hygiene and grooming
- Toilet hygiene
- Personal safety

Support for instrumental activities of daily living (IADLs) is approved only if a personal also requires assistance with ADLs. IADLS include:

- Preparing meals
- Taking medications as prescribed
- Shopping for groceries or clothing
- Use of telephone or other form of communication
- Transportation

Are there limits to the benefit?

Yes. The total amount and type of services to be received by each policyholder is based on their care plan. Each type of service has a maximum fee per hour and maximum limits per week. In addition, there is a maximum of $60,000 per policy year for any combination of services. See page 5 for the overview of the services, rates and maximum weekly amounts.

How does an assessment get completed?

An assessment is the collection and analysis of information related to the policyholder's health, function, and needs for support to enable them to live safely at home. The assessment is done in the policyholder's home or in hospital, and, if

necessary, with their responsible person. One of the HID nurse case managers, or designated nurse or case manager, will complete the assessment.

What is a care plan?

A care plan outlines the type and amount of care and support services needed by a policyholder. This is decided by their assessment. The benefit approval letter/email states the amount and type of benefits the policyholder can get based on their care plan and the benefit limits.

Can a care plan include more services than what is covered by the benefit?

Yes. The care plan completed by the HID nurse case manager includes the total amount of care necessary for the policyholder. However, the benefit has limits on the type and amount of services it pays for which may be less than what is required in the care plan.

What happens if the policyholder needs or wants more care than they are approved for?

HID will only pay for the care listed in the benefit approval letter/email at the set rates. The policyholder is responsible for any additional costs.

If a policyholder currently gets their home care paid for by Financial Assistance or War Veterans, will this stop?

No, but the payment changes. Once a HIP or Future Care policyholder has been approved for the Personal Home Care Services benefit the Health Insurance Dept. (HID) becomes the first payor for home care. Claim encounter forms must be submitted directly to HID.

Please contact the Department of Financial Assistance or War Veterans directly with any questions regarding their policies and coverage for home care services.

Provider Requirements:

What are the registration requirements for providers?

Go to the Provider of Personal Home Care Services section of the PHC Guide

Can family members or friends of the policyholder be a caregiving provider?

Yes. They must register with Ageing and Disability Services and the Health Insurance Department and meet the qualification requirements.

Do caregiving providers who work for a home care agency need to register?

Yes, all caregiving providers must register but most agencies register their employees on their behalf, unless their staff are to be paid directly by HID. If the Home Care Agency staff is to be paid directly by the benefit, rather than through the Agency, then the caregiving providers must register individually as self-employed caregiving providers.

Do caregiving providers already registered with Ageing and Disability Services (ADS) need to re-register?

Caregiving providers must contact ADS to determine if re-registration is necessary.

Do caregiving providers already registered with the Health Insurance Department need to re-register?

Only if they are adding a new type of caregiving service or changing from an agency to self-employed or vice versa.

If a personal caregiver is also a trained medical/nursing professional, do they require CPR and First Aid Certification?

Personal caregivers that are registered medical or nursing professionals require an up to date CPR certification but not First Aid.

Is a written contract between the policyholder and provider required? What should be in it?

HID recommends all policyholders to have a written contract with their caregiving provider(s). This is to make sure everyone is clear on the expectations for care, schedules, wages etc. For guidance, see the Sample Client and Caregiving Provider Contract in the Guide.

Payment to Caregiving Providers:

How do caregiving providers fill in the Claims Forms and where do they get them from?

See the Personal Home Care Benefit: Claim Form Guide and examples for help on how to complete the Claim Forms. For more information or support contact the Provider Claims Manager at HID.

NOTE: As of July 16, 2018, a new Claim form and process is in place- see the Guide for more information.

Will all services delivered by an approved caregiving provider be paid for by the benefit?

No. Only the type and amount of services in the policyholder's benefit approval letter/email, that the caregiving provider is qualified to provide, will be paid for by the benefit.

How much are providers paid by the benefit?

The benefit will only pay up to the maximum reimbursement rate for each type of service listed below and only for the type and quantity of services the policyholder is approved for in their benefit approval letter/email.

Type of Care	Reimbursement Rate (maximum)	Monthly Max Reimbursement	Maximum Amount	CPT Code	Provider must be registered with ADS and HID as at least a:
Personal Caregiving: Assistance with personal care and /or dementia care.	$15/hr	$2,610	40 hr/wk	G0156	Personal caregiver- these can include family, friends, or other trusted persons
Skilled Caregiving: Caregiver certified for personal health care and/or dementia care	$25/hr	$1,525	14 hr/wk	S9122	Nursing Associate (Nursing Assistant/Geriatric Aide)
Registered Nurse visit	$75/hr	NA	12 visits/yr	S9124	Nurse (RN)
Day Care Program	$25/half day $50/day	$867	$200/wk	S5101 (half day) S5102 (full day)	Day Care Program

Please Note: the maximum benefit to the policyholder of $60,000 per policy year for any combination of care services.

What if a Nursing Associate is hired for someone approved for personal caregiving, what rate are they paid?

Payment is based on the type of care required, stated in the care plan and benefit approval letter/email, not the skill level of the provider. The Nursing Associate will be paid at $15 per hour, if the policyholder is approved for personal caregiving, not skilled caregiving.

What is the CPT Code?

The CPT code is recorded on the Claim form to identify what type of care was provided. The code determines how much the caregiving provider is reimbursed. Payment is based on the type of care approved, not the skill level of the caregiving provider.

Can caregiving providers charge more than the reimbursed rate?

Yes. The total amount charged by the caregiving provider is determined between the caregiving provider and the policyholder. Policyholders are responsible for the amount not covered by the benefit.

How often are caregiving providers paid?

The agreement between the caregiving provider and policyholder should outline the pay period (e.g. once a week, twice a month, once a month). The provider submits the required claim form(s) to the Health Insurance Department based on this pay period.

How long does it take for HID to process a claim and the provider to be paid?

It can take up to 14 days for the claim to be processed and the funds to be transferred to the caregiving provider's bank account.

Can policyholders pay for the services up front and be reimbursed by the Health Insurance Department, instead of the provider?

No. Under the Health Insurance Act, any amount covered by insurance cannot be charged to the client up front.

Does the policyholder need to pay for the care not covered by the benefit before or after the claim is submitted?

Yes. It is between the policyholder and provider to determine how much and when payment occurs for the costs of services not covered by the benefit.

How long can a provider wait to submit their claim?

A provider has up to 12 months from the date the service was provided to submit the claim. Claims submitted after this time period will not be paid.

When can services start being paid for by the benefit?

Once the policyholder is approved, starting from the date of the policyholder's care plan.

What services can I provide if I registered/qualify as …

Registered Nurse: Can provide personal caregiving, skilled caregiving and nursing services
Nursing associate: Can provide personal caregiving and skilled caregiving services
Personal Caregiver: Can only provide personal caregiving services.

Once the policyholder is approved, starting from the date of the policyholder's care plan. Caregivers should only provide the services they have been contracted to provide by the policyholder.

If the policyholder was getting services before they were approved for the benefit, can they be reimbursed for these?

No. Payment for services can start from the date the policyholder is approved for the benefit, as stated in their care plan.

Contact Information:

Ageing and Disability Services:

Street Address: Continental Building, Ground Floor, 25 Church Street, Hamilton
Mailing Address: Ministry of Health Seniors and Environment, 25 Church St Hamilton, HM 12
Phone: 441-292-7802 **Email:** **ads@gov.bm**

Department of Financial Assistance:

Physical Address: Global House, 43 Church Street, Hamilton
Telephone: 297-7600 or 295 5151 ext.1600
Fax: 295 4314

Department of Social Insurance- War Veterans

In person: Ground Floor, Government Administration Building, 30 Parliament Street, Hamilton
By Mail: P.O. Box HM 1537, Hamilton HM FX
Phone: 294-9242 ext. 1129 for War Pension enquiries **Fax:** 292-5267
294-9242 ext. 1129 for Pension enquiries
Email: socialinsurance@gov.bm

Health Insurance Department:

Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton
Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton, HM JX
Phone: 441-295-9210 **Fax:** 441-295-9213
Website: www.gov.bm/departments/health-insurance/ **Email:** hip@gov.bm

Forms

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Personal Home Care Services Request for Benefits Form

Health Insurance Department
Personal Home Care Services
Request for Benefits Form

(All sections must be completed)

FOR OFFICIAL USE

Policy Number: _____

Received Date (d/m/y) : _____

Meets Policy Requirements? : **Yes** **No**

Circle Policy Plan : **HIP** **FC** **FA** **WV**

Processed by CSR and Date (d/m/y):

_____

Please indicate if this is a ☐ New Request or ☐ Request for Re-Assessment

I. POLICYHOLDER INFORMATION:

☐ **I, the policyholder, have had an active policy with HIP or FutureCare for at least one year.** Tick the box if true. If unsure, contact a HID Customer Service Representative before completing the application. This is a requirement to be eligible for the benefit.

Name: **(Mr./Mrs./Miss/Ms.)** **(First Name)**

(Middle Name) **(Last Name)**

Home Address:

Parish: Postal Code:

Date of Birth (dd/mm/yy): / / Group Number (if applicable):

Policy Number: Social Insurance Number:

Primary Telephone Number: - Alt Telephone #: -

Email Address (if available): _____
(Hotmail accounts not accepted) (Please Print)

Tick the appropriate box:

☐ **I, the policyholder, am able to manage my own care.** (go to section II)

☐ **The policyholder is unable to manage their own care.** Provide the following information for the responsible person who will manage the policyholder's care:

Name: **(Mr./Mrs./Miss/Ms.)** **(First Name)**

(Last Name)

Relationship to Policyholder: _____ Best Times to be reached? _____

Preferred Telephone: - - -
(Home) (Work) (Other)

Email Address (if available): _____
(Hotmail accounts not accepted) (Please Print)

II. MEDICAL INFORMATION:

With this request form please submit:

- A doctor's letter (issued in the last 90 days) which must include: medical diagnosis, care needs, cognition level and list of current medications;

In addition, if the policyholder is in the hospital, please submit:

- A Multi-Disciplinary Transfer form and / or OT / PT / Speech Evaluation reports (issued in the last 30 days).
- What ward is the policyholder currently on? _____
- Name of Physician / Hospitalist if Policyholder is in Hospital:_____
- Date of admission _____Predicted Date of Discharge_____

Name of General Practitioner (GP) of Policyholder: _____

GP Practice Name:

GP's Address:

Parish: Postal Code:

Contact #: -

GP's Email Address (if available): _____
(Hotmail accounts not accepted) (Please Print)

III. CASE MANAGEMENT

If approved for this benefit, participation in case management is required.

Has the policyholder had any previous history with any agencies? If so, please specify in the table below:

Agency	Name and Title	Contact #	Email
Dept of Financial Assistance			
Office for Ageing and Disability Services			
Community Nursing			
Other _____ (Please describe)			

I, or the responsible person, agree to ongoing case management if approved for the benefit. I declare that the information I have given above is accurate to the best of my knowledge. I understand that this form does not automatically grant me coverage under this Personal Home Care Services Benefit.

Signed: _____ Date (dd/mm/yy): / /

Submit the completed form with required documentation to:
Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 **Fax:** 441-295-9213 **Email:** hip@gov.bm

Personal Home Care Physician's Letter

Health Insurance Department
Personal Home Care Services
Physician's Letter

FOR OFFICIAL USE ONLY:
Received Date (d/m/y)
*Received by:

(All Sections to be Completed)

POLICYHOLDER INFORMATION:

Name: (Mr./Mrs./Miss/Ms.) (First Name)

(Middle Name) (Last Name)

Mailing Address:

Policy ID: Contact #: --

Date of Birth (dd/mm/yy): / /

Please give name and contact of responsible person, if known, for those with dementia:

Name: _____ Contact #: --

PHYSICIAN INFORMATION:

Name of General Practitioner (GP) of Policyholder: _____

GP Practice Name: _____

GP's Address: _____

Parish: _____ Contact #: _____

GP's Email Address (if applicable): _____
(Hotmail account not accepted) **(Please print)**

MEDICAL INFORMATION:

Diagnosis	Date of Onset (d/m/y)	Comments

When completed, this form should be returned with supporting documentation to:
Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.gov.bm **Email:** hip@gov.bm

Medicine Name	Dose	Route	Frequency	Purpose
ALLERGIES if any				

Does person have cognitive ability to organize and plan own health care?
Please note date (dd/mm/yyyy) of any mini mental status exam and score:
Are there any concerns regarding the person's behaviors when interacting with others or potential care givers?
Are there any advanced directives in place? Y N. Comments:

Please note which activities of daily living person may need assistance with:
Bathing; Dressing; Toileting; Walking 10 steps or more; Transferring self from chair to bed, etc.
Eating
DIET or fluid restrictions
Wound care
Other education/supports needed:

Additional Comments

Signed _____ Date (dd/mm/yy): ☐☐/☐☐/☐☐

Sample Client and Caregiving Provider Contract

This is an <u>example</u> of a written agreement between a client (policyholder) and their personal home care provider. It is a guide to assist in the development of an agreement that is appropriate for you and your care provider.

When developing an agreement, ensure it includes any details that are verbally agreed upon during the hiring process. Ensure two copies of the agreement are made: one for the client and one for the provider.

Name of care giving Provider: _____

Phone (home): _____

(cell): _____

Name of Client (*person receiving care*): _____

Name of Responsible Party (*for payment and oversight, if not the client*): _____

Type of caregiving to be provided (personal caregiving, skilled caregiving or if both specify how many hours of each) _____

The reimbursement rate we are agreeing to is:
Hourly _
weekly
Amount expected to be covered by Personal H<u>ome Care Benefit:</u>

Amount expected to pai<u>d by Client:</u>

Pay period *(e.g. every Friday, last Friday of the month, etc.):* _____

Caregiver sick days or time off.
To be certain the client will have care when needed, advance notice is required. Notice will be given by the caregiver to the client /responsible person in advance for vacation or days off.
Specify how much time in advance:

When caregiver is ill and unable to provide care on a scheduled day then he/she will contact client/responsible person as soon as known.

Schedule (fill in hours on days expected)

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
morning							
afternoon							
evening							
night							

Start Date; Total weekly hours:

Vacation days or weeks when caregiver not available (unpaid):

Holiday day regular pay? Y* N

If yes Client responsible to pay.

Check all expected to be provided	Caregiving Duties	Frequency	Comments
	Health monitoring or health related care as needed:		
	Observe taking or reminding to take medications on time		
	Assist in measuring and following diet or fluid restrictions		
	Assist in measuring and logging BP, weights, blood glucose, etc.		
	For person who is bed bound- • Assist with turning and positioning every 2 hours		
	• Provide range of motion exercises		
	• Protective skin care		
	Other – Please list		
	Personal care -assist with:		
	• getting in/out of bed, in and out of chair		
	• standing, walking or exercise		
	• bathing or showering		
	• grooming and dressing		
	• toileting		
	• eating		
	Daily living care needs		
	Prepare and serve meals		
	Clean sink, stove, counters, refrigerators		
	Wash, dry and store dishes and utensils		
	Clean bathroom sink, tub, toilet, and surfaces		
	Empty and take out trash		
	Make bed		
	Change bed linens		
	Wash, dry and fold clothing and linens		
	Clear, dust and organize surfaces throughout home		
	Vacuum carpets		
	Sweep floors		
	Wet or dry mop in rooms you use		
	Assist w/ grocery shopping		
	Prepare list		
	Store items as requested		
	Run errands		

Check all expected to be provided	Caregiving Duties	Frequency	Comments
	Transportation		
	Take to social activities		
	Take to doctor's appointments		
	Take to other activities		
	Social Activities		
	Reading to client		
	Playing games with client		
	Visiting relatives/friends		
	Other (list below):		
	Other Tasks (list below):		

Client Benefits provided to Caregiver:*(tick the box as required)*

Self-employed persons are responsible to pay their own payroll tax, social insurance pension and health insurance unless otherwise agreed to as described below:

☐ The care provider is responsible for insurance and tax obligations

☐ The client is responsible for provider's insurance and tax obligations

☐ The client and care provider will share the cost of the obligations: Client pays: _____ Provider pays: _____

Benefits that Client Provides to caregiver:

Meals provided: Meals to be eaten with client or Meal break times: _____

Use of client's belongings such as phone, TV, car, etc.: _____

Visitors allowed in what circumstances: _____

Sleeping or live-in arrangement: _____

Other: _____

_____

Caregiver Signature: _____ Date: _____

Client (or Responsible Person) Signature: _____ Date: _____

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Ageing and Disability Forms

Ageing and Disability Services and Health Insurance Department

Self-Employed Home Care Provider Application Form

Self-Employed Home Care Provider Application Form

Section A: Applicant Information

i. Provider Type:

☐ Personal Caregiver (CG) ☐ Nursing Associate (NA or Geriatric Aide/Nursing Assistant) ☐ Nurse (RN)

☐ Personal Caregiver to a family member/friend (CG) (tick if you are only providing care under this circumstance)

ii. Provider Contact Details:

Name:			
	Last Name	*First Name*	*Middle Name(s)*
Previous Name(s) (if applicable):			
Date of Birth:		**Gender:**	☐ Male ☐ Female
Immigration Status	☐ Bermudian ☐ Spouse of Bermudian ☐ Permanent Resident Certificate Holder ☐ Work Permit Holder (must submit copy of work permit with application) ☐ Other (please specify)_____		
Home Address:			
House Name:			
House/Apartment/Unit #	*Street Name*		
Parish	*Postal Code*		
Telephone:		**Cell:**	**Email**

Section B: Screening Questions If you answer yes to any of the following questions provide an explanation on a separate sheet of paper and submit with this application

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 be a caregiver?	YES ☐	NO ☐

Section C: Application Submission and Document Requirements	
All applications must have:	1. A completed and signed application form 2. Copy of a photo ID 3. All required documentation according to type of provider as listed below 4. HID Electronic Payment form – must be completed by all providers to be paid by the Future Care or HIP Personal Home Care Benefit. 5. OPTIONAL: Home Care Provider Information for Public Listing- complete to have your information listed on www.helpingservices@gov.bm to assist the public in finding services.
C 2. Documentation required by provider type being applied for:	
Personal Caregiver *	1. Current CPR and First Aid Certification – Photocopy of current training certificate 2. Bda Police Service Record Check – issued within the last 24 months 3. Medical Certificate for Home Care Providers – completed by your GP/doctor indicating mental and physical fitness to provide care 4. Home Care Provider Personal Reference Questionnaire – to be completed, signed and submitted in a sealed envelope by one reference. 5. Resume – on a separate piece of paper outline previous work experience *Registered medical professionals applying as personal caregivers can provide evidence of active registration status and items 2, 3 and 4 listed in the skilled caregiver qualifications below.
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. Bda Police Services Record Check –issued within the last 24 months 4. Medical Certificate for Home Care Providers – from your GP/doctor indicating mental and physical fitness to provide care
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. Bda Police Services Record Check- issued within the last 24 months 4. Medical Certificate for Home Care Providers – Completed by your GP/doctor indicating mental and physical fitness to provide care

Section D: Declaration Statement Check each box after reading and sign below

By my signature:

☐ I agree the information in this application and the information 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 my registration.

☐ I understand registration with Ageing and Disability Services (ADS) is required for private caregivers delivering home care services to clients that are paid for, in part 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)

☐ I understand my application for registration as a caregiving provider in the community, if approved, may be suspended or revoked at any time there is significant concern, evidence, or allegation regarding fraudulent activities, abuse or neglect.

☐ I understand this registration is valid for 2 years only and will require re-registration.

☐ I agree to notify Ageing and Disability Services of any changes to the information provided in this registration form.

☐ I agree for Ageing and Disability Services and/or MOH to contact relevant persons (including but not limited to regulatory and government entities) to verify the information provided in this application.

☐ I understand that the Health Insurance Department will issue electronic versions of their Explanation of Payments Statement for any claims submitted to them, for providers with email addresses. Notifications will be emailed to the Provider Contact and email address mentioned in Section A. ii.

_____
Printed Name of Applicant

_____ _____
Signature of Applicant Date

Incomplete applications will not be reviewed.

Completed applications are mailed/delivered to: Ageing and Disability Services,
Ministry of Health, Ground floor
25 Church St. Hamilton, HM12; 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 be shared with the Bermuda Health Council and other Governmental agencies for the same purposes.

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Ministry of Health

HOME CARE PROVIDER PERSONAL REFERENCE QUESTIONAIRE

This reference is required by Ageing and Disability Services for home care provider applications. It is to be completed by the person providing the reference, not the applicant. Rate the applicant based on your experience and interactions. Complete and submit in sealed envelope to ensure confidentiality.

Your Name: _____ **Occupation:** _____

Address: _____ **Phone Number:** _____

Name of Applicant (person you are providing a reference for): _____

1. How do you know the applicant? ☐ Friend ☐ Acquaintance ☐ Former Employer ☐ Neighbor ☐ Care Recipient ☐ Other _____
2. How long have you known the applicant? _____
3. When was the last time you had contact with the applicant? _____

Respond to all questions by checking which response best describes your experience with this applicant.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4. Applicant gets along well with others.					
5. Applicant handles stressful situations well.					
6. I have trust the applicant would keep private information confidential.					
7. I believe the applicant is honest and trustworthy.					
8. I have not witnessed any displays of prejudice.					
9. The applicant loses his/her temper easily.					
10. I do not have any knowledge of the applicant's use or involvement with illegal drugs or narcotics.					
11. I believe the applicant is reliable.					
12. I would recommend the applicant as a caregiver.					

COMMENTS:

Signature_____ Date_____

Ministry of Health
25 Continental Building, Hamilton HM 12
292-7802, ads@gov.bm

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Ministry of Health

MEDICAL CERTIFICATE FOR HOME CARE PROVIDERS

This certificate is to establish that the person named below is in good physical and mental condition as to not adversely affect the health or safety of those they care for as a care provider.

PATIENT INFORMATION and AUTHORIZATION (To be completed by the PATIENT)

Name:	**Date of Birth:**
I authorize the release of this medical information to my potential employer and Ministry of Health to ensure compliance with Ageing and Disability Services home care provider registration requirements.	
Signature:	**Date:**

MEDICAL INFORMATION (To be completed by PHYSICAN)

1. **Check to indicate if your patient is:** *If any are unchecked provide an explanation in comments section*	☐ Free from communicable diseases ☐ Free from substance abuse ☐ Mentally fit and capable of caring for vulnerable persons
2. **Does your patient have the physical capacity to perform the functions of their care role?** *If any are unchecked provide an explanation in comments section*	Yes : ☐ able to lift and carry 10 pounds or more, ☐ assist another with mobility such as: getting up and down stairs, in and out of chair or bed if needed, and ☐ drive a car **No,** please specify:
3. **Check to Indicate patient's current immunization status** *This is to help identify who may be at risk based on immunization status.*	☐ Influenza vaccine Date:_____ ☐ Measles, Mumps, Rubella Date:_____ ☐ Varicella (chickenpox): Date:_____ ☐ Polio: Date_____ ☐ Hepatitis B: Date_____ ☐ Tetanus, Diphtheria, Pertussis Date:_____ ☐ Other (see Adult Immunization Schedule)_____
Comments	
Date:	**Physician Signature:**
Contact Number:	**Print Name:**

Ministry of Health
25 Continental Building, Hamilton HM 12
292-7802, ads@gov.bm

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Ministry of Health
Health Insurance Department

HOME CARE PROVIDER INFORMATION FOR PUBLIC LISTING

Only to be completed to have information posted on the public listing.

Name of Care Provider: _____

Phone: _____ **Email:** _____

CHECK ALL BOXES THAT APPLY

TYPE OF CARE PROVIDER:	☐ Personal Caregiver Skilled Caregiver: ☐ NA ☐ RN	**AVAILABILITY:**	☐ Full time ☐ Part time ☐ Days ☐ Eves ☐ Nights ☐ Weekends
CARE EXPERIENCE:	☐ Diabetes ☐ Stroke ☐ Dementia ☐ Learning Disabilities ☐ Assisting in mobility transfers ☐ Use of mechanical lift	**CARE TRAINING:**	☐ Diabetes ☐ Stroke ☐ Dementia ☐ Learning Disabilities ☐ Assisting in mobility transfers ☐ Use of mechanical lift
TRANSPORTATION: *to and from medical appointments, grocery shopping, going to social /recreational activities*	☐ Not available ☐ With client's car ☐ With my car ☐ By bus		

By signing this form I agree that:

- The information provided is true and accurate.
- My information may be posted on the public listing for persons searching for a home care provider.
- The public posting is for 6 months and if I wish to renew my listing I will need to complete a new form and submit it to ADS.
- I may be removed from the public listing at any time if my registration as a home care provider lapses, is suspended or revoked.

Signature_____ **Date**_____

Ministry of Health
25 Continental Building, Hamilton HM 12
292-7802, ads@gov.bm

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Home Care Agency Application Form

Section A: Applicant Information			
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:**	

Employee Information and Documentation- 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, and indication if a work permit holder. 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.
3. Copies of work permit for all work permit holders.

Provider type	Employee name, DOB, job title, contact info, start date of employment	Work Permit holder	
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No

Section B: Application Submission and Document Requirements	
Applications must have:	1. A completed and signed application form 2. Copy of a photo ID 3. Required documentation for each type of care provider employed by the Agency must be available upon request by Ageing and Disability Services. 4. A signed and submitted declaration for each employee. 5. HID Electronic Payment form – must be completed by all Agencies to be paid by the Future Care or HIP Personal Home Care Benefit. 6. OPTIONAL: Home Care Provider Information for Public Listing- complete to have your information listed on www.helpingservices@gov.bm to assist the public in finding services.
Documentation required by Caregiving Provider Type you are applying for:	
Personal Caregiver *	1. Current CPR and First Aid Certification – Photocopy of current training certificate 2. Bda Police Service Record Check – issued within the last 24 months 3. Medical Certificate for Home Care Providers – completed by your GP/doctor indicating mental and physical fitness to provide care 4. Home Care Provider Personal Reference Questionnaire – to be completed, signed and submitted in a sealed envelope by one reference. 5. Resume – on a separate piece of paper outline previous work experience *Registered medical professionals applying as personal caregivers can provide evidence of active registration status and items 2, 3 and 4 listed in the skilled caregiver qualifications below.
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. Bda Police Services Record Check –issued within the last 24 months 4. Medical Certificate for Home Care Providers – from your GP/doctor indicating mental and physical fitness to provide care
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. Bda Police Services Record Check- issued within the last 24 months 4. Medical Certificate for Home Care Providers – Completed by your GP/doctor indicating mental and physical fitness to provide care

Incomplete applications will not be reviewed.

Completed applications are mailed/delivered to: ads@gov.bm
Ageing and Disability Services,
Ministry of Health, Ground floor, 25 Church St. Hamilton, HM12

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 (Home Care Agency Owner) Check each box after reading and sign below

By my signature:

☐ I agree the information in this application and the information 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 my registration.

☐ I understand registration with Ageing and Disability Services (ADS) is required for private caregivers delivering home care services to clients that are paid for, in part 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)

☐ I understand my application for registration as a caregiving provider in the community, if approved, may be suspended or revoked at any time there is significant concern, evidence, or allegation regarding fraudulent activities, abuse or neglect.

☐ I understand this registration is valid for 2 years only and will require re-registration.

☐ I agree to notify Ageing and Disability Services of any changes to the information provided in this registration form, including changes in the submitted employee listing.

☐ I agree for Ageing and Disability Services and/or MOH to contact relevant persons (including but not limited to regulatory and government entities) to verify the information provided in this application.

☐ I understand that the Health Insurance Department will issue electronic versions of their Explanation of Payments Statement for any claims submitted to them, for providers with email addresses. Notifications will be emailed to the agency email address mentioned in Section A. ii.

Signature **Date**

Print Name

(Blank page for printing)

Name of Employee: _____

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.			
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 F: Declaration Statement (Employee) Check each box after reading and sign below

By my signature:

☐ I agree the information in this application and the information 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 my registration.

☐ I understand registration with Ageing and Disability Services (ADS) is required for private caregivers delivering home care services to clients that are paid for, in part 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)

☐ I understand my application for registration as a caregiving provider in the community, if approved, may be suspended or revoked at any time there is significant concern, evidence, or allegation regarding fraudulent activities, abuse or neglect.

☐ I understand this registration is valid for 2 years only and will require re-registration.

☐ I agree to notify Ageing and Disability Services of any changes to the information provided in this registration form.

☐ I agree for Ageing and Disability Services and/or MOH to contact relevant persons (including but not limited to regulatory and government entities) to verify the information provided in this application.

☐ I understand that the Health Insurance Department will issue electronic versions of their Explanation of Payments Statement for any claims submitted to them, for providers with email addresses. Notifications will be emailed to the agency email address mentioned in Section A. ii.

_____ _____

Signature of Applicant Date

(Blank page for printing)

GOVERNMENT OF BERMUDA

Ministry of Health

HOME CARE PROVIDER PERSONAL REFERENCE QUESTIONAIRE

This reference is required by Ageing and Disability Services for home care provider applications. It is to be completed by the person providing the reference, not the applicant. Rate the applicant based on your experience and interactions. Complete and submit in sealed envelope to ensure confidentiality.

Your Name: _____ **Occupation:** _____

Address: _____ **Phone Number:** _____

Name of Applicant (person you are providing a reference for): _____

1. How do you know the applicant? ☐ Friend ☐ Acquaintance ☐ Former Employer ☐ Neighbor ☐ Care Recipient ☐ Other _____
2. How long have you known the applicant? _____
3. When was the last time you had contact with the applicant? _____

Respond to all questions by checking which response best describes your experience with this applicant.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4. Applicant gets along well with others.					
5. Applicant handles stressful situations well.					
6. I have trust the applicant would keep private information confidential.					
7. I believe the applicant is honest and trustworthy.					
8. I have not witnessed any displays of prejudice.					
9. The applicant loses his/her temper easily.					
10. I do not have any knowledge of the applicant's use or involvement with illegal drugs or narcotics.					
11. I believe the applicant is reliable.					
12. I would recommend the applicant as a caregiver.					

COMMENTS:

Signature_____ Date_____

Home Care Agency Application form V03.00 01 December 2018

GOVERNMENT OF BERMUDA

Ministry of Health

MEDICAL CERTIFICATE FOR HOME CARE PROVIDERS

This certificate is to establish that the person named below is in good physical and mental condition as to not adversely affect the health or safety of those they care for as a care provider.

PATIENT INFORMATION and AUTHORIZATION (To be completed by the PATIENT)

Name:	Date of Birth:
I authorize the release of this medical information to my potential employer and Ministry of Health to ensure compliance with Ageing and Disability Services home care provider registration requirements.	
Signature:	Date:

MEDICAL INFORMATION (To be completed by PHYSICAN)

1. **Check to indicate if your patient is:** *If any are unchecked provide an explanation in comments section*	☐ Free from communicable diseases ☐ Free from substance abuse ☐ Mentally fit and capable of caring for vulnerable persons
2. **Does your patient have the physical capacity to perform the functions of their care role?** *If any are unchecked provide an explanation in comments section*	Yes : ☐ able to lift and carry 10 pounds or more, ☐ assist another with mobility such as: getting up and down stairs, in and out of chair or bed if needed, and ☐ drive a car No, please specify:
3. **Check to indicate patient's current immunization status** *This is to help identify who may be at risk based on immunization status.*	☐ Influenza vaccine, Date:_____ ☐ Measles, Mumps, Rubella, Date:_____ ☐ Varicella (chickenpox): Date:_____ ☐ Polio: Date_____ ☐ Hepatitis B: Date_____ ☐ Tetanus, Diphtheria, Pertussis Date:_____ ☐ Other (see Adult Immunization Schedule)
Comments	
Date:	**Physician Signature:**
Contact Number:	**Print Name:**

GOVERNMENT OF BERMUDA

Ministry of Health

Care Provider Information for Public Listing

Only to be completed to have information posted on the public listing

Name of Care Provider: _____

Phone: _____ **Email:** _____

CHECK ALL BOXES THAT APPLY

TYPE OF CARE PROVIDER:	☐ Personal Caregiver Skilled Caregiver: ☐ NA ☐ RN	**AVAILABILITY:**	☐ Full time ☐ Part time ☐ Days ☐ Evenings ☐ Nights ☐ Weekends
CARE EXPERIENCE:	☐ Diabetes ☐ Stroke ☐ Dementia ☐ Learning Disabilities ☐ Assisting in mobility transfers ☐ Use of mechanical lift	**CARE TRAINING:**	☐ Diabetes ☐ Stroke ☐ Dementia ☐ Learning Disabilities ☐ Assisting in mobility transfers ☐ Use of mechanical lift
TRANSPORTATION: *to and from medical appointments, grocery shopping, going to social /recreational activities*	☐ Not available ☐ With client's car ☐ With my car ☐ By bus		

By signing this form I agree that:

- The information provided is true and accurate.
- My information may be posted on the public listing for persons searching for a home care provider.
- The public posting is for 6 months and if I wish to renew my listing I will need to complete a new form and submit it to ADS.
- I may be removed from the public listing at any time if my registration as a home care provider lapses, is suspended or revoked.

Signature_____ **Date**_____

ELECTRONIC PAYMENT AGREEMENT FORM

GOVERNMENT OF BERMUDA
Ministry of Health

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.

****Please indicate if this is a:** ☐ **New Agreement** ☐ **Update to Existing Agreement**

Provider or Company Details	
**Provider (Individual or Company) Name:	
**Contact/Accounting Officer: (if different from above)	

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

Bank Details	
**Name on Bank Account:	
**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.hip.gov.bm

**Bank Name:	
**Bank Address:	
Swift or ABA Address: (** to be completed for banks located outside of Bermuda)	
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:** _____

TITLE: _____

(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.

Personal Home Care Services Claim Form

GOVERNMENT OF BERMUDA
Health Insurance Department

Personal Home Care Services - Claim Form

Basic Guidelines for this Form:

- This Claim Form must be submitted to Health Insurance Department (HID);
- Only Caregivers registered with ADS may be reimbursed for this benefit by HID; and only as the level of service provider(s) they are registered for.
- Reimbursement is limited to level of care the HID policyholder is approved for, and not according to caregiver qualifications.
- Benefit does not cover caregiving when policyholder is admitted or in hospital;
- Caregivers are employed by policyholder, not HID.

Policyholder's Name (First Name, Middle Initial, Last Name):	HID Policy ID:	Date of Birth (mm/dd/yyyy):
Provider to be Paid (Agency or Individual Caregiver Name):	Care Provider Name (If different from Provider to be Paid):	

Caregivers can only charge for the services that they are registered for: **Personal Caregiver (CG, NA, RN): G0156** **Adult Day Care (AD): S5101 (half day or 4 hours)** **Skilled Caregiver (NA, RN): S9122** **S5102 (full day)** **Registered Nurse (RN): S9124**	**Place of Service:** ☐ (12) Home ☐ (32) Nursing Home (for day care) ☐ (33) Rest Home (for day care)

Date (mm/dd/yyyy)	CPT Code	Start Time	End Time	Total Hours (Full hours only)	Hourly Charge	Charges (Total Hours x Hourly Charge)

Policyholder or Responsible Person Signature: **"I confirm receipt and authorize payment of medical benefits to the undersigned provider/caregiver for the service(s) described above."**

Signed: Date (mm/dd/yyyy):

Care Provider's Signature: Date (mm/dd/yyyy):

Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.gov.bm **Email:** hidclaims@gov.bm