GOVERNMENT OF BERMUDA

Ministry of Health

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:**

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GOVERNMENT OF BERMUDA

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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GOVERNMENT OF BERMUDA

Ministry of Health
Health Insurance Department

ELECTRONIC PAYMENT AGREEMENT FORM

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.gov.bm/department/health-insurance

**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.