GOVERNMENT OF BERMUDA

Ageing and Disability Services and Health Insurance Department

Self-Employed Caregiver Application Form

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)

Guidance:
Applications must have:

1. A completed and signed application form
2. Required documents (see section B).
3. Providers to be paid by the Future Care or HIP Personal Home Care Benefit must complete the 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, 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 be shared with the Bermuda Health Council and other Governmental agencies for the same purposes.

Self Employed Caregiver Provider Application

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 (if non-Bermudian)**:**	☐ Spouse of Bermudian ☐ Work Permit Holder ☐ Permanent Resident Certificate Holder ☐ Other (please specify): _____		
Home Address:			
House Name:			
House/Apartment/Unit #	*Street Name*		
Parish	*Postal Code*		

Telephone:		**Cell:**		**Email**	

Section B: Provider Requirements- Submit the approved documentation indicated by each requirement for your provider type.

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 *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. 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
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: References for personal caregiver

Submit a written statement from the 2 references listed below. References cannot be from family members.

Name		**Name**	
Address		**Address**	
Contact	Telephone: Email:	**Contact**	Telephone: Email:

Section D: 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 E: Access to information

1.	ADS can share my contact information with people looking for caregivers. If yes, indicate current availability (e.g. Time of day/days of week): _____	YES ☐	NO ☐

Section F: Declaration Statement

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 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 HID 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

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.