



## Arizona Non-Medical Home Care Association (AzNHA)

### Application for Membership Packet Mail-in Check-off Sheet

Please use this list to verify that you have included all the necessary forms and they are correctly completed, and the additional paper work and documentation required by AzNHA to complete the Application process. You need to include the following in the packet you mail to AzNHA:

1. The completed, signed and dated original of the Association's Application for Membership. Please be sure to answer all the questions.
2. The completed, signed and dated original of the Association's Credentialing Standards Agreement.
3. A copy of your proof of insurance coverage for Professional/General Liability and Fidelity/Theft bond for caregiver employees. This is easily obtained from your insurance agent and is usually in the form of an ACCORD Proof of Insurance form.
4. A copy of your proof of workers' compensation insurance coverage. This is easily obtained from your workers' compensation carrier.
5. A copy from the Arizona Corporations Commission that your business is in good standing with the State of Arizona. Go to the following link to get a copy of your company's status: <http://starpas.azcc.gov/scripts/cgiip.exe/WService=wsbroker1/main.p>
6. Be sure to include a check for the annual dues, made out to the Arizona Non-Medical Home Care Association. That covers AzNHA's membership and processing fees. Membership is for one year and is from the date of the application to the next year and renews on the anniversary date of the application, and every year thereafter on the Member's application date.

If you have any question or issues regarding completing AzNHA's Application Packet for Membership, please feel free to call Don Irish, Executive Director at (602)295-8468.

Please mail the completed Application Packet to: Arizona Non-Medical home Care Association, PO Box 31687, Mesa AZ 85275.



## Arizona Non-Medical Home Care Association (AzNHA)

### Application for Membership

Date: \_\_\_\_\_  Application for Membership  Current Membership Change of Information

**A. Identification**

1. Registered/Corporate/Business Name: \_\_\_\_\_
2. DBA's or Name Known to Customers: \_\_\_\_\_
3. Street Address: \_\_\_\_\_
4. City/State/Zip: \_\_\_\_\_
5. Telephone Number: Area Code/Number: \_\_\_\_\_
6. After Hours Number: Area Code /Number: \_\_\_\_\_
7. Fax Number: Area Code /Number: \_\_\_\_\_
8. E-mail Address: \_\_\_\_\_
9. Web Page Address: \_\_\_\_\_
10. Name of counties in which business has an office: \_\_\_\_\_
11. Names of counties in which services are provided: \_\_\_\_\_

**B. Ownership**

Ownership Code

1. Fill in the code, which corresponds, to the type of entity legally responsible for operating the business.



- |                                    |                               |                               |
|------------------------------------|-------------------------------|-------------------------------|
| GOVERNMENTAL                       | NON GOVERNMENTAL, NONPROFIT   | NON GOVERNMENTAL, FOR PROFIT  |
| 11. State                          | 20. Church Related            | 23. Individual                |
| 12. County                         | 21. Nonprofit Corporation     | 24. Partnership               |
| 13. City                           | 22. Other Nonprofit Ownership | 25. Corporation               |
| 14. City-County                    | OTHER                         | 26. Group                     |
| 15. Hospital District or Authority | 27. Tribal                    | 28. Limited Liability Company |
| 19. Federal                        |                               | 29. Business Trust            |

2. State License # \_\_\_\_\_

\*Federal ID # \_\_\_\_\_ \*State Tax ID # \_\_\_\_\_

\*Confidential Business Information: The Association considers an Applicant's and Member's Federal Tax ID number and/or their State Employer Tax ID number to be confidential. All Members' confidential information is used for verification purposes only and will be maintained in a secure location and will



not be available for public preview.

3. All Applicants:

Please provide the names, titles and addresses of all officers, directors, owners and managerial employees, the percent of ownership if proprietary. Attach an additional sheet if necessary.

Names of Officers, Directors, Owners, and Managerial Employees	Title (President, Director, Partner, Stockholder, etc.)	Address (Street, City, Zip)	Percent of Ownership (if Proprietary)

4. If a corporation or LLC, give the date and State of incorporation. \_\_\_\_\_

Attach a Certificate of Good Standing for the corporation or LLC to do business in the State of Arizona from the Arizona Corporations Commission. [Available through the Arizona Corporations Commission on the web at <http://corporations.azcc.gov/certgoodstanding.htm>

5. How long have the owners's of the business owned and operated a Non-Medical Home Care business?

\_\_\_\_\_

6. List the name of the corporation's or LLC's Agent(s):

\_\_\_\_\_

7. List other office locations. (Use additional sheets if necessary.)

DBA's or Name Known to

Customers: \_\_\_\_\_

Street Address:

\_\_\_\_\_

City/State/Zip:

\_\_\_\_\_

Telephone Number:      Area Code/Number: \_\_\_\_\_

After Hours Number:      Area Code /Number:

\_\_\_\_\_

Fax Number:      Area Code /Number:

\_\_\_\_\_



E-mail Address: \_\_\_\_\_

Web Page Address: \_\_\_\_\_

8. Have any of the company's or business organization's Officers, Directors, Owners, or Managerial Employees ever been convicted of any criminal offense, other than a minor traffic violation? Yes \_\_\_\_ No \_\_\_\_ If Yes, please name the person and their position and

explain: \_\_\_\_\_

9. Are any Officers, Directors, Owners, or Managerial Employees licensed or certified in any capacity of health or home care? (Use an additional sheet if necessary) Yes \_\_\_\_ No \_\_\_\_

Person's Name:

Name of license/certification \_\_\_\_\_ Date of expiration \_\_\_\_\_

Issuing state \_\_\_\_\_ License/Certification number \_\_\_\_\_

10. Have any Officers, Directors, Owners, or Managerial Employees had their license/certification ever revoked or suspended or any other disciplinary action taken against them by a licensing body? Yes \_\_\_\_ No \_\_\_\_

If yes, give name(s) state reason(s), date of revocation or suspension and date of reinstatement. (Attach additional pages if necessary) \_\_\_\_\_

11. Have the owners or principals of the Applicant business been involved, had interest in, or owned a Non-Medical Home Care business, or other Health Care business, that has either shut down its operations or went out of business? Yes \_\_\_\_ No \_\_\_\_ If Yes, please attach a letter explaining the dates of operation, circumstances of the business going out of business, and the individuals on this application involvement and position in said business.

12. Scheduled Hours of Operation

Office:

Hours: \_\_\_\_\_

Days: \_\_\_\_\_

Service Hours - Days/Evenings/Nights: \_\_\_\_\_

Weekends: \_\_\_\_\_

Other (explain): \_\_\_\_\_

Office Staff Availability: \_\_\_\_\_



**C. Membership Category**

Membership shall consist of any sole proprietorships, partnerships, corporations, companies, associations, or other form of business endeavor of good character and outstanding business and professional reputation engaged in the non-medical home care industry in Arizona may be business members. Please choose the one category for which you are applying for membership.

- Business Members** - Those businesses, sole proprietorships, partnerships, corporations, companies, associations, or other forms of business endeavor who are actively engaged in providing non-medical home care services. These members are voting members of the Association.
  
- Associate Members** - Those who are engaged in the non-medical home care industry as a part of providing other medical, palliative, or other services. These individuals will not be voting members of the association; except that any Associate Member elected to the Board of Directors will have voting privileges at any meeting of the Board of Directors.
  - (1) Licensed Home Health Care Agencies;
  - (2) Hospice Agencies;
  - (3) Other: \_\_\_\_\_.

**D. Applicant's Home Care Services Offered**

	<b>Homemaker Services</b>
Yes _____ No _____	<b>Housekeeping or Home Management</b>
Yes _____ No _____	Light house cleaning
Yes _____ No _____	Sweeping, vacuuming, mopping
Yes _____ No _____	Laundry
Yes _____ No _____	Ironing
Yes _____ No _____	Washing dishes and utensils
Yes _____ No _____	Bagging garbage and taking it out
Yes _____ No _____	Making beds and changing linens
Yes _____ No _____	Assisting client organizing household routines
Yes _____ No _____	Assisting with reading and writing tasks as requested
Yes _____ No _____	Other housekeeping tasks: _____
Yes _____ No _____	Other housekeeping tasks: _____
Yes _____ No _____	<b>Meal Preparation</b>
Yes _____ No _____	



Yes _____ No _____	Assisting with menu planning where appropriate
Yes _____ No _____	Preparing and serving meals using sanitary meal preparation practices
	<b>Transportation/Shopping</b>
Yes _____ No _____	Accompanying a client on trips to obtain health care services or other necessary items or
Yes _____ No _____	services.
	Caregiver drives client's vehicle for such trips.
	Caregiver drives personal vehicle for such trips.

Yes _____ No _____	<b>Home Care Aide Tasks (Hands-on assistance)</b>
	• Bathing/Showering/Bed Baths
	• Dressing/Undressing
	• Personal Hygiene
	• Toileting/Peri Care
	• Transfers
	• Ambulation
	• Medication monitoring
	<b>Home Care Aide Tasks (Limited Hands-on assistance)</b>
Yes _____ No _____	• Bathing/Showering/Bed Baths
	• Dressing/Undressing
	• Personal Hygiene
	• Toileting/Peri Care
	• Transfers
	• Ambulation
	• Medication monitoring
	<b>Home Care Aide Tasks (No Hands-on assistance)</b>
	• Bathing/Showering/Bed Baths
	• Dressing/Undressing



Yes _____ No _____	<ul style="list-style-type: none"> <li>• Personal Hygiene</li> <li>• Toileting/Peri Care</li> <li>• Transfers</li> <li>• Ambulation</li> <li>• Medication monitoring</li> </ul>
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**Other Home Care Services offered by Applicant**

Yes _____ No _____	Registered Nursing Services
Yes _____ No _____	Licensed Practical Nursing Services
Yes _____ No _____	Medical Social Services
Yes _____ No _____	Nutritional Services by a Dietitian
Yes _____ No _____	Occupational Therapy
Yes _____ No _____	Physical Therapy
Yes _____ No _____	Speech Therapy
Yes _____ No _____	Respiratory Therapy
Yes _____ No _____	Hospice
Yes _____ No _____	Medical Equipment
Yes _____ No _____	Other:

**Applicant's Employment Information and Practices**

Please attach a brief statement outlining and explaining, as necessary, the business's hiring practices policies for its Caregiver employees. Please have this document signed by an officer of the corporation or principal of the business verifying the accuracy of such.



1. Please attach evidence of current workers' compensation coverage as required by the State of Arizona. Arizona law requires that all Arizona employers with one or more employees maintain workers' compensation insurance. (Applicants must submit a certificate of insurance from their workers' compensation provider showing home care workers are covered, not just an application or a certificate showing coverage for employees, etc.)

Yes _____ No _____	Does the business maintain a liability insurance policy that covers the actions of all employees? Please attach a Certificate of Liability Insurance detailing the amounts of coverage and the types of coverage and expiration dates of said coverage.
Yes _____ No _____	Does the business maintain a Bond Against Theft or Dishonesty Bond that covers the actions of all employees, including Caregiver employees? Please attach evidence of this Bond indicating amounts of coverage and expiration dates of said coverage.
Yes _____ No _____	Does the Applicant classify its Caregivers as "Employees?" (If so, the business maintains a payroll process which includes reporting of employment, wages, collecting state and federal withholding payroll taxes, and the payment of these taxes and all other state and federal payroll taxes to the appropriate governmental institutions.)
Yes _____ No _____	Are the Caregivers working for the Applicant considered private contractors or self employed individuals?
Yes _____ No _____	Are private contractors or self-employed individuals ever referred to clients or potential clients by the Applicant?
Yes _____ No _____	Does the business have and perform criminal background checks for all individuals who have direct contact with clients in their homes or in the community?
Yes _____ No _____	Does the Applicant have and perform criminal background checks for all managerial officials, supervisors, office personnel and volunteers?
Yes _____ No _____	Does the Applicant operate the business from a commercial office space, in a commercially zoned area or from a private residence zoned for commercial use?
Yes _____ No _____	Does the Applicant enter into a written service agreement with each client to provide home care services, signed by the client's financially responsible person and by the company or business organization?
Yes _____ No _____	Does the Applicant have an abuse prevention plan for each vulnerable adult receiving services from your company?
Yes _____ No _____	Does the Applicant require your Caregivers to have clean driving records and provide a copy



	of the Caregiver's DMV driving record?
Yes ____ No ____	Does the business obtain at least two positive references from two previous employers in the past five years for each Caregiver applicant?
Yes ____ No ____	Does the Applicant validate home making and home care skills of Caregivers through demonstration and written questionnaires?
Yes ____ No ____	Does the Applicant require all caregivers to read and write English?
Yes ____ No ____	Does the Applicant require its Caregivers to maintain current CPR and First Aide certification and have policies in place to ensure these are updated on a timely basis?
Yes ____ No ____	Does a Staff Person of the Applicant conduct a face to face interviews with Caregiver applicants, in English, that covers employment history, experience, training issues, skill knowledge, and employment preferences?
Yes ____ No ____	Have all personnel in the Applicant's business, who require direct contact with clients, had tuberculosis screening performed at least annually?
Yes ____ No ____	Has every individual who provides direct care or manages services in the Applicant's business been oriented to the home care duties and skill requirements necessary in order for him or her to perform his or her duties as a care provider?
Yes ____ No ____	The Applicant has a client problem resolution and/or client complaint process policy in place that promptly addresses and resolves problems, issues or conflicts?
Yes ____ No ____	Does the Applicant drug test all new employees?
Yes ____ No ____	Does the Applicant have an establish on-going policy and practice that randomly drug tests current employees?

**Applicant's Client/Consumer Information and Practices**

Yes ____ No ____	Does the Applicant perform any type of evaluation or assessment prior to providing care for a client?
Yes ____ No ____	Does the Applicant charge a prospective client a fee for any type of evaluation or assessment prior to providing care for a client? If Yes, please explain the business's policy on this. In addition, please indicate the amount charged for this service.



Yes _____ No _____	Does the Applicant require a deposit from the customer in order to perform services? a. If Yes, what is that fee or how is the fee determined? What is the policy of collecting (such as: up-front) and returning unused portions of this deposit to the client?
Yes _____ No _____ Yes _____ No _____ Yes _____ No _____ Yes _____ No _____ Yes _____ No _____ Yes _____ No _____ Yes _____ No _____	Does the Applicant have any of the following fees: a. Set-up/Start-up fees? Amount Charged: \$ _____ b. Administrative fees? Amount Charged: \$ _____ c. Cancellation fees? Amount Charged: \$ _____ d. Client Visit fees? Amount Charged: \$ _____ e. Managerial fees? Amount Charged: \$ _____ f. Other fees? Type/Name: _____ Amount Charged: \$ _____ g. Other fees? Type/Name: _____ Amount Charged: \$ _____
Yes _____ No _____	Does the Applicant have a minimum amount of hours, whether per day, per week, or per month, or minimum charge that is required before for the business will provide services? If Yes, what are those minimum hours and/or minimum charges?
Yes _____ No _____	Does the Applicant have a business policy on a client canceling services? Please indicate issues such as amount of notice required, any penalties, and etc.?

**G. Privacy and Disclosure Policy Acknowledgments**

**Non-Confidential Business Information:** Since the Arizona Non-Medical Home Care Association Members or users of our Web Site are doing so in their capacity as employees or companies, or consumers; certain



business information we collect from Applicants and Members is considered public information by the Association (rather than information about you individually, such as your personal or financial information, etc.). For these purposes, we have defined "Non-Confidential Business Information" as any information for public preview that identifies, or may identify, a company, its business practices, policies and procedures, its employees, or an individual contact at a company or that allows others to contact a company or an individual contact at a company that is **not** considered by the Association to be "Confidential Business Information".

**Confidential Business Information:** The Association considers an Applicant's and a Member's Federal Tax ID number and/or their State Employer ID number to be confidential. All Applicant's and Members' confidential information is used for verification purposes only and will be maintained in a secure location and will not be available for public preview.

**Member's Profile:** We also collect Business Information when you complete and submit an Application for process by the Association. This information includes company name and contact information and certain other information about you and/or your business and the services your business may provide. We use this information in accordance with this policy to identify you, your business, and to process your Application. In addition, this Business Information is used to create a "Member's Profile" that is posted on the Association's Web Site and available for the public to review.

**Release Statement:** I, the undersigned, grant the Arizona Non-Medical Home Care Association (the "Association"), and/or its authorized agents, the rights to use the Non-Confidential Business Information contained herein, as defined above, for informational, publicity, or promotional purposes without prior notification. I understand that this Business Information may appear in printed materials published by the Association, on the Association's web site, in the Association's presentations or exhibits, in newspapers or magazines, or on television. I agree to hold the Association and its Members harmless from all claims related to the Association's or its agents' use of this Non-Confidential Business Information for these purposes. I also agree that the Association is under no obligation to me or any other party to use this Non-Confidential Business Information. By my signature below, I represent that I have read and fully understand this Application for Membership Form.

**Application Verification Statement** I hereby authorize the Arizona Non-Medical Home Care Association, its agents, officers, directors, staff, or private investigators, to make inquiries, either by written communication, telephone, computer, in person or otherwise, to any current or former business associate, governmental



agency, educational institution, military establishment, relative or any other persons or entities knowledgeable of backgrounds of the individuals listed on this Application as to their prior history, without limitation, their: Criminal history, business records or personal background; Corporate directorship/ownership, interest in business(es), nature of business of business dealings; Prior claims, lawsuits, settlements; Educational background, licenses, and certifications, work experience, nature of duties, performance levels; Reliability, responsibility, honesty, integrity, civility, and any other measures of their character or personality.

In consideration of the furnishing of any such information by any party contacted by or on behalf of Arizona Non-Medical Home Care Association, I and the business entity I represent, specifically waive any confidential relationship or privacy right which may exist for my (our) benefit and completely release the Arizona Non-Medical Home Care Association, and the part(ies) contacted from any responsibility or liability for damages or other injuries which may occur as a result of the release or disclosure of this information. I, and the business entity I represent, agree to indemnify and hold harmless anyone involved with the conduction of this investigation of my, or the business entity's, background from any and all liabilities or claims in connection therewith. Photo static, faxed or any other copy of this instrument bearing my signature shall be equally legally valid as the original.

**H. Applicant Verification**

Are you interested in linking your website to Arizona Non-Medical home Care Association's website?

Yes \_\_\_\_\_ No \_\_\_\_\_

As a member your link is free and we make the link. Our web site address is: <http://.aznha.org>

I certify that to the best of my knowledge, that the information provided herein is accurate and complete. I further agree, in the event the business I represent become Member's of the Association that all disputes and claims, individual or severable, involving this Membership will be submitted to the Association's Board of Directors for final resolution. The decision rendered by the Board of Directors regarding any Member dispute or claim is binding, final, and cannot be appealed.

My company's current annual financial participation in the work of the ANMHCA is \$150.00 in non-refundable annual dues, and a\$100.00 non-refundable processing fee. (This Membership is renewable annually, unless it is terminated by action of the Board of Directors.) Enclosed is the \$ \_\_\_\_\_ , annual dues made payable to "Arizona Non-Medical Home Care Association."



Signature of Authorized Agent: \_\_\_\_\_

Name (please print or type): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_