

**NOTIFICATION OF DISTRICT INTEREST TO CONTRACT FOR THE PROVISION OF PERSONAL CARE SERVICES**

Completion of this form by the social services district indicates district interest in contracting for the provision of personal care services with the identified licensed home care agency (LHCSA) or certified home health agency (CHHA).

District: \_\_\_\_\_

Name and Title of Contact Person Completing form: \_\_\_\_\_

Telephone Number of Contact Person: (\_\_\_\_) \_\_\_\_\_

Fax Number of Contact Person: (\_\_\_\_) \_\_\_\_\_

Signature of Authorizing Representative: \_\_\_\_\_

Date of Completion: \_\_\_\_\_

-----

Name of Provider Agency: \_\_\_\_\_

Address of Agency: \_\_\_\_\_

Telephone Number of Agency: (\_\_\_\_) \_\_\_\_\_

Fax Number of Agency: (\_\_\_\_) \_\_\_\_\_

Name(s) of Authorized Representative(s): \_\_\_\_\_

MMIS Identification Number: \_\_\_\_\_

Date of Department of Health Approval for Personal Care Aide or Home Health Aide Training Plan: \_\_\_\_\_

(District should request and **maintain** a copy of the Training Plan Approval in their files.)

The Provider agency will be providing nursing assessments: YES NO

The Provider agency will be providing nursing supervision: YES NO

The Provider agency will be providing PCS through a Shared Aide Model: YES NO

The Provider agency will be providing PCS through a  
Consumer Directed Model: YES NO

The Provider Agency will be providing Personal Emergency  
Response Services (PERS): YES NO

The Provider Agency will be providing PCS through a  
Limited License Home Care Services Agency: YES NO

Rationale for expansion of PCS contracts: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_. (District should indicate need for  
expansion of PCS providers.)

**RETURN COMPLETED FORM TO:** Carl M. Dembrosky  
Director  
Bureau of Long Term Care Reimbursement  
Corning Tower - ESP  
9th Floor - Room 943  
Albany, New York 12237