# FY24 NOI APPLICATION

## NOTIFICATION OF INTENT TO CONTRACT

Updated: 9/2023

**I. CORPORATE INFORMATION:** «IsNewProv» New NOI Applicant «IsExistingProv» Existing NOI Provider

**Provider Name** «ProvName»

**"Doing Business As" (D/B/A)** «ProvDba» «ProvDbaNa» **NA**

**Address** «Address» «City» «State» «Zip» **Street City/Town State Zip**

**Contact** «LastName» «FirstName» «Title» **Telephone** «Phone»
Last Name First Name Title

**Email address** «Email» **Fax** «Fax»

**State where organized/incorporated** «OrgState» **Date** «OrgDate» **FEIN** «Fein»
**Federal Employer ID Number**

**Business Type:** «btBizCorp» Business Corp. «btForeignCorp» Foreign Corp. «btLLC» Limited Liability Company
(Check one) «btProCorp» Professional Corp. «btLtd» Limited Partnership «btLLP» Limited Liability Partnership
«btNa» **NA** «btNonprofit» Non-Profit Corp. «btBizTrust» Business Trust «btSole» Sole Proprietorship

**List # of current FTE (full time equivalent) homemakers** «FteHome»**;**
**List # of current FTE personal care homemakers** «FtePersonal»

**As of today's date, the Commonwealth of Massachusetts Supplier Diversity Office (SDO) formerly (SOMWBA) has certified my company as a** (check all that apply or skip to Section II: Assurances & Certifications)
«Mbe» Minority-owned business or non-profit organization (MBE) – «MbeCert» SDO certification letter attached
«Wbe» Woman-owned business or non-profit organization (WBE) – «WbeCert» SDO certification letter attached

## II. ASSURANCES & CERTIFICATIONS:

By submitting this completed document to the *Executive Office of Elder Affairs*, I certify (check all that applies):

«as1» My Company has filed papers with the Secretary of State's Office in order to conduct business within the Commonwealth of Massachusetts;5
«as2» Neither I nor my company is currently under Federal or State debarment;
«as3» I have purchased liability insurance to protect my company – «as3file» Certificate of Insurance attached;
«as5» I have secured all licenses, certifications, permits and accreditation required of my business at this time; and
«as6» My company's Unit Rate submission includes an *average employee compensation* amount equal to, or greater than that mandated by the Executive Office of Elder Affairs (e.g., **at least $19.00 per hour for FY 2022**), and defined in Rate Calculation Instructions posted on www.800AgeInfo.com.

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Provider Authorized Signature Printed Name Title Date

## III. UNIT RATE CALCULATION:

**To be completed at this time only by New Providers and Providers not currently under Contract with one or more ASAPs for the provision of homemaker/personal care homemaker services.**

## Calculation of Average (hourly) Employee Compensation

| | | | |
|---|---|---|---|
| Base Wages | $ «rtBase» | Health/Life Insurance | $ «rtLife» |
| Travel Stipend | $ «rtTravel» | Training Wages | $ «rtTraining» |
| Holiday Pay | $ «rtHoliday» | Transportation Expense | $ «rtTrans» |
| Sick Pay | $ «rtSick» | Bereavement Pay | $ «rtBereave» |
| Personal Days Pay | $ «rtPersonal» | Annuity Pension | $ «rtAnnuity» |
| Vacation Pay | $ «rtVacation» | Day Care | $ «rtDaycare» |
| | | **TOTAL Hourly Average** | **$ «rtTotal»** |

## Calculation of Hourly Unit Rate

| | |
|---|---|
| **1. AVERAGE HOURLY COMPENSATION**<br>*(Transfer the TOTAL from above—**not less than $19.00**)* | **$** «rtTotalCompRate» |
| **2. HOURLY ADMINISTRATIVE OVERHEAD**<br>*(Including all costs associated with statutory fringe)* | **$** «rtAdminOverhead» |
| **3. HOURLY UNIT RATE**<br>*(The sum of lines 1 and 2, above)* | **$** «rtTotalUnitRate» |

# Administrative Overview

**Complete this form and retain the original at your agency.** Please answer each of the following questions as completely and as accurately as possible. Be **specific** in your responses; provide **details**. This Overview, inclusive of any Attachment, cannot exceed twenty (20) pages with a font size of 10.

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# TECHNICAL QUALIFICATIONS

## SERVICE CAPABILITY

1. List all ASAPs with whom you seek to contract during the next state fiscal year:

| | **ASAP** |
|---|---|
| «TableStart:Asaps»«isChecked» | «asapName»«TableEnd:Asaps» |

2. List the **specific towns/communities** per ASAP that you can serve, i.e., have worker availability. Specify any evening and/or weekend or other serviceability limitations per town/community.

| **ASAP** | **Town** | **Limitations** |
|---|---|---|
| «TableStart:tq2»«tq2asap» | «tq2town» | «tq2limitations»«TableEnd:tq2» |

3. Does your main office operate Monday through Friday, 9:00am-5:00pm, as required by ASAPs?

«tq3»

4. Identify all satellite offices by address, contact person, phone number, cities/towns served, and hours of operation. «tq4na» **NA**

| **Address** | **Phone** | **Hours** | **Contact** | **Cities/Towns Served** |
|---|---|---|---|---|
| «TableStart:tq4»«tq4address» «tq4city», MA «tq4zip» | «tq4phone» | «tq4hours» | «tq4contact» | «tq4towns» «TableEnd:tq4» |

5. Are any of your services subcontracted to other companies or individuals? If yes, identify subcontractor (s) by name, address, service(s) and percentage of ASAP business referred to each. *Provider Agreement* requires the Provider secure written approval from an ASAP prior to subcontracting out any service. «tq5na» **NA**

| **Organization** | **Address** | **Services** | **Percentage** |
|---|---|---|---|
| «TableStart:tq5»«tq5org» | «tq5address» «tq5city», «tq5st» «tq5zip» | «tq5services» | «tq5percent» «TableEnd:tq5» |

6. Describe your company's in-house capacity to provide translation for clients when needed? «tq6na» **NA**

| **Language(s)** | **# Admin Staff** | **# Direct Staff** |
|---|---|---|
| «TableStart:tq6»«tq6languages» | «tq6adminstaff» | «tq6directstaff»«TableEnd:tq6» |

7. If you have no in-house translation capacity, describe your procedure for serving clients who have limited English-speaking ability. «tq7file» **Procedure Attached**

«tq7»

8. Indicate by address which office maintains the following records:

| | **Address** | **City/Town** | **State** | **Zip** | **Phone #** |
|---|---|---|---|---|---|
| a. Client | «tq8aaddress» | «tq8acity» | «tq8ast» | «tq8azip» | «tq8aphone» |
| b. Personnel | «tq8baddress» | «tq8bcity» | «tq8bst» | «tq8bzip» | «tq8bphone» |
| c. Fiscal | «tq8caddress» | «tq8ccity» | «tq8cst» | «tq8czip» | «tq8cphone» |

9. Describe your procedure for ensuring 24-hour service, 7 days week. Define early morning, evening and weekend coverage, including wage differentials/incentives offered. Address staffing coverage on legal holidays. «tq9file» **Policy Attached**

«tq9»

10. Describe your procedures for handling client emergencies, including instructions to staff when a client does not answer the door. Include plan for accessing emergency medical services and contacting provider supervisors as well as your system for ensuring compliance with reporting incident to ASAP. «tq10file» **Policy Attached**

«tq10»

11. Describe your procedures for handling weather-related emergency situations. «tq11file» **Policy Attached**

«tq11»

## CLIENT/SERVICE COORDINATION

1. Describe procedures for ensuring adequate and timely communication between your company, your field staff and the ASAP Case Manager(s). Discuss how these procedures may differ for clustered sites.

«csc1»

2. Describe procedures for staff supervision and for ensuring staff reliability (attendance, promptness) and what arrangements you have in place to provide back-up staff to serve clients when necessary.

«csc2»

a. What is the average number of homemaker/personal care personnel that each supervisor has? «csc2a»

b. Specify the credentials for your direct care supervisors that comply with the requirements outlined in the Qualifications and Supervision sections of the Homemaker Standards, including the RN Supervisory requirement for Personal Care. «csc2b»

c. What is the average number of clients that each homemaker/personal care personnel has? «csc2c»

3. How would you ensure that a substitute worker knows exactly what services are needed by each client?

«csc3»

4. What is your company's maximum number of days between receipt of a service referral and date of service initiation per ASAP area?

«csc4»

5. How do you track/monitor service delivery to guarantee that the client receives the services and hours listed on the initial Service Authorization?

«csc5»

6. Describe in detail your company's quality assurance plan and process, including the name and title of the person overseeing quality assurance. «csc6file» **Plan & process Attached**

«csc6»

7. Describe how your company monitors subcontractors for quality assurance, if applicable. «csc7file» **Procedure Attached**

«csc7»

8. How will your company work with the ASAP Case Manager(s)--and site coordinator(s), if applicable—to assure quality in service delivery?

«csc8»

9. How will your company maintain quality control in client services?

«csc9»

10. Describe your procedures for managing the delivery of services to clustered sites. «csc10file» **Procedure Attached**

«csc10»

11. How would residents of a service cluster know when their homemaking tasks are to be performed?

«csc11»

12. What procedures do you use to verify to the ASAP that all assigned tasks for clustered clients have been completed? «csc12file» **Procedure Attached**

«csc12»

## CLIENT TRACKING

1. Describe your Case Record System. What specific information is documented in client case records?

«ct1»

2. How often are client records updated and by whom?

«ct2»

3. Is access to client data restricted? If YES, please describe and identify all who have access to client data (by job title/function). «ct3file» **Policy Attached**

«ct3»

4. How is client confidentiality maintained during day-to-day operations? «ct4file» **Procedure Attached**

«ct4»

# ADMINISTRATION and STAFFING

## STAFFING STRUCTURE

1. Identify (by name, title, and phone #) staff responsible for the following:

| | Name | Title | Phone# |
|---|---|---|---|
| a. Contracts | «st1aname» | «st1atitle» | «st1aphone» |
| b. Intakes | «st1bname» | «st1btitle» | «st1bphone» |
| c. Scheduling | «st1cname» | «st1ctitle» | «st1cphone» |
| d. Client Issues/Complaints | «st1dname» | «st1dtitle» | «st1dphone» |
| e. Finance/Invoices | «st1ename» | «st1etitle» | «st1ephone» |

2. Describe your company's staffing structure by identifying each direct care and supervisory job title, number of FTEs currently employed in each, and minimum qualifications for each job.

**Direct Care:**

| Title | FTEs | Minimum Qualifications |
|---|---|---|
| «TableStart:st2dc»«st2dctitle» | «st2dcfte» | «st2dcminqual»«TableEnd:st2dc» |

**Supervisory:**

| Title | FTEs | Minimum Qualifications |
|---|---|---|
| «TableStart:st2sv»«st2svtitle» | «st2svfte» | «st2svminqual»«TableEnd:st2sv» |

## HIRING and EQUAL OPPORTUNITY

1. Describe your company's recruiting, screening, and hiring policies and procedures, including your procedure for contacting the registry maintained by DPH before hiring to determine if there is a sanction, finding or adjudicated finding of a violation. «ee1file» **Policy/Procedure Attached**

«ee1»

2. Describe your CORI procedures. How do you make individual determinations based upon findings of CORI checks? «ee2file» **Procedure Attached**

«ee2»

3. How do policies and procedures ensure equal opportunity in hiring? «ee3file» **Policy/Procedure Attached**

«ee3»

4. How are employees informed of these policies and procedures?

«ee4»

5. Companies who received **less than** $50,000 in business during the last full fiscal year OR who anticipate receiving **less than** $50,000 in business over the next full fiscal year, check NA and go to Question #6; for all others indicate whether you have an affirmative action plan and identify by name and job title your Affirmative Action Officer. Also specify whether full or part time.: «ee5na» **NA**

«ee5»

6. Describe your company's procedure for handling employee grievances. «ee6file» **Procedure Attached**

«ee6»

## STAFF SUPERVISION

1. Describe your training program for homemakers/personal care homemakers. Specify how your agency ensures that homemakers/personal care homemakers complete a training program as described in the Training and In-Service Education section of the Homemaker Standards. The Mass Council's training Curriculum (or its equivalent) is referenced throughout this section.

«ss1»

2. How is supervisory review documented?

«ss2»

3. Describe your procedure for ensuring uninterrupted service/client coverage in the event of an unforeseen staff shortage.

«ss3»

4. Describe in detail your company's policies and procedures for client complaint resolution, including how you reconcile "client" complaints (a) about a specific employee, (b) about your agency? «ss4file» **Policy/Procedure Attached**

«ss4»

5. How do you track client complaints, their resolution, and the provision of feedback to the ASAP? «ss5file» **Procedure Attached**

«ss5»

6. Describe how your agency ensures compliance with reporting allegations of loss or theft of, or damage to, a consumer's property, including reporting allegations to DPH as well as reporting incidents to the ASAP. «ss6file» **Procedure Attached**

«ss6»

7. How much liability insurance does your agency maintain? Identify the insurance company by name and address.

| **Amount** | **Insurance Company** | **Street Address** | **City/Town** | **State** | **Zip Code** |
|---|---|---|---|---|---|
| «ss7amt» | «ss7company» | «ss7address» | «ss7city» | «ss7st» | «ss7zip» |

8. Describe your agency's Money Management policy that prohibits the handling of consumer's money unless the ASAP has established special arrangements. «ss8file» **Policy Attached**

«ss8»

9. How is direct care staff supervised on a day-to-day basis? Address time records, management of sick time and vacation schedules, the assignment of staff caseloads, and the process for conducting staff evaluations, etc.

«ss9»

10. If you are a new provider list three business references. Include the organizations name, address, phone, fax and contact person. «ss10na» **NA**

| Organization | Address | Phone | Fax | Contact |
|---|---|---|---|---|
| a. «ss10aorg» | «ss10aaddr»<br>«ss10acity», «ss10ast» «ss10azip» | «ss10aphone» | «ss10afax» | «ss10acontact» |
| b. «ss10borg» | «ss10baddr»<br>«ss10bcity», «ss10bst» «ss10bzip» | «ss10bphone» | «ss10bfax» | «ss10bcontact» |
| c. «ss10corg» | «ss10caddr»<br>«ss10ccity», «ss10cst» «ss10czip» | «ss10cphone» | «ss10cfax» | «ss10ccontact» |

## BILLING VERIFICATION

1. How do you verify services delivered to services authorized to services billed? «bv1file» **Procedure Attached**

«bv1»

2. What documentation is kept on file to support billings submitted to an ASAP?

«bv2»

## POLICIES AND PROCEDURES-

Indicate with a check that your company has on file a current policy/procedure/certification for:

| | Yes | No | NA |
|---|---|---|---|
| Affirmative Action Plan | **«pp1y»** | **«pp1n»** | **«pp1na»** |
| Client Privacy & Confidentiality | **«pp2y»** | **«pp2n»** | |
| Confidentiality of HIV/AIDs status | **«pp3y»** | **«pp3n»** | |
| CORI: Criminal Offender Record Information | **«pp4y»** | **«pp4n»** | |
| Infection Control Plan | **«pp5y»** | **«pp5n»** | |
| Job Descriptions for all staff positions | **«pp6y»** | **«pp6n»** | |
| Personnel Policies for all staff | **«pp7y»** | **«pp7n»** | |
| The Commonwealth of Massachusetts Supplier Diversity Office (SDO) formerly (SOMWBA) Certification | **«pp8y»** | **«pp8n»** | **«pp8na»** |
| Uniform Financial Report | **«pp9y»** | **«pp9n»** | **«pp9na»** |

**Indicate with a check that your company complies with: For all compliances listed- delete "NA" response.**

| | Yes | No | NA |
|---|---|---|---|
| Americans with Disabilities Act<br>(42 USC 12112(a) et seq., 28 CFR Part 35<br>(Prohibits discrimination based on disability.)<br>(Promotes equal opportunity in employment & service delivery.) | «cw1y» | «cw1n» | |
| EOEA-PI-03-17 (Clients As Research Projects) | «cw2y» | «cw2n» | |
| HIPAA: Health Insurance Portability and<br>Accountability Act of 1966<br>(Protection of client privacy & confidentiality) | «cw3y» | «cw3n» | |
| Massachusetts General Law c.151B sec.4,<br>subsections 1, 1A and 1B<br>(Prohibits discrimination in employment on the basis<br>of race, color, religious creed, national origin,<br>sex, sexual orientation, ancestry, age.) | «cw4y» | «cw4n» | |
| Massachusetts General Law c.151B sec.4, subsection 10<br>(Prohibits discrimination in service delivery for recipients<br>of federal, state or local public assistance or housing subsidies.) | «cw5y» | «cw5n» | |
| M.G.L. c149, s24A<br>(Prohibits discrimination in employment based on age) | «cw6y» | «cw6n» | |
| OSHA Safety Standards | «cw7y» | «cw7n» | |
| Section 504 of the Rehabilitation Act of 1973 (29 USC s.794)<br>(Prohibits discrimination in employment & service delivery<br>against qualified handicapped persons.) | «cw8y» | «cw8n» | |
| Title VII of the Civil Rights Act of 1964<br>(42 USC s.2000e-2(a)(1) and (2), et seq.)<br>(Prohibits discrimination in employment on the basis<br>of race, color, sex, religion, national origin.) | «cw9y» | «cw9n» | |
| Title VI of the Civil Rights Act of 1964 (42 USC s.2000d, et seq.)<br>(Prohibits discrimination in service delivery on the basis of race,<br>color, or national origin in programs receiving federal financial assistance.) | «cw10y» | «cw10n» | |