

Provider Identification

Name		Date of Birth
Social Security Number	FTIN	

I (my agency) am (is) willing and able to assist nursing facility residents (hereinafter referred to as client) to move to a more independent living arrangement of his/her choice by helping to obtain necessary items and services as authorized by DHHS.

Provider Standards

I CERTIFY that I or my organization/agency-

- Am 19 or older
- Am (or someone from my organization/agency is) physically capable of providing services and willing to provide a physician's verification statement if requested by staff.
- Understand and support client choice in selecting items and services to assist the client to move to a more independent setting.
- Have (has) experience in carrying out activities related to locating housing and setting up a household.
- Agree to use universal precautions.
- Will exercise reasonable caution and care in the use and placement of client's personal possessions, appliances, and furnishings.
- If transporting the client to look for housing or other transition needs will meet applicable licensing, insurance and safety laws and regulations and will meet the transportation provider standards in 471 NAC, Chapter 27.
- Am able to recognize distress and/or signs of illness and will report all changes in client functioning to the Services Coordinator and/or to the Nursing Facility staff:
- Will bill and submit only one billing request and receipts for the total amount of allowable and authorized services and expenses incurred and provided.
- Will provide a detailed listing of the dates and activities performed.
- Will report any changes in my/our circumstances and ability to deliver this service to the Services Coordinator.

Comments

Signatures and Date

I have read and understand the above standards as explained by the DHHS representative. I certify that I will meet the above standards while providing Home Again Service(s). If I represent an agency, I certify that agency employees will meet these standards while providing Home Again Service(s).

Provider/Agency Representative Signature

Date

I have explained the above standards to this provider and she/he or the agency meet all the standards to provide Home Again Service.

Signature of Authorized Representative - Nebraska Department of Health and Human Services

Date

