

APPLICATION FOR THE HOME CARE REGISTRY - AGENCY

AGENCY NAME: **DATE:**

Address:

Phone: Alt. Phone: E-mail:

Agency Owner Name:

Agency Manager Name(if different than owner):

Is your agency licensed and bonded? Yes No

Is your agency licensed by the State of Maryland, Department of Health and Mental Hygiene, as a Nursing Staff Agency? Yes No If yes, license # _____

Is your agency licensed by the State of Maryland, Department of Health and Mental Hygiene, as a Nursing Referral Service Agency? Yes No If yes, license # _____

Do you have at least one Registered Nurse on staff that performs initial assessments and creates a plan of care with the client and/or caregivers? Yes No

Does your agency accept medical insurance as payment for services? Yes No

Does the agency have experience working with individuals who are or have:

Blind Deaf Incontinent Alzheimer/Dementia Younger Persons with Disabilities

Indicate if you are willing to perform the following duties - please check all that apply:

<input type="checkbox"/> Companion Care	<input type="checkbox"/> 24 hour care	<input type="checkbox"/> Light Cleaning	<input type="checkbox"/> Transportation
<input type="checkbox"/> Lifting	<input type="checkbox"/> Heavy Cleaning	<input type="checkbox"/> Toileting	<input type="checkbox"/> Reading Mail
<input type="checkbox"/> Meal Preparation	<input type="checkbox"/> Grooming	<input type="checkbox"/> Shopping	<input type="checkbox"/> Medication
<input type="checkbox"/> Overnight Care	<input type="checkbox"/> Laundry	Other: _____	<input type="checkbox"/> Reminders

Special Training, License(s)
and Certificate(s):

List languages spoken
by staff:

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Days/Hours
Available:

I hereby authorize the Office on Aging to publish my agency's name and the information on the Home Care Registry for use by private citizens who may be interested in utilizing the services of my agency. I understand that neither Howard County Government nor the Office on Aging endorse any one agency. This information is published as a courtesy for Howard County residents and does not constitute a guarantee of referrals to the agency.

Name:

Phone:

Signature:

Date:

Please complete and return by mail, e-mail or fax to:

Maryland Access Point
Office on Aging
6751 Columbia Gateway Dr. 2nd Floor
Columbia, MD 21046
Attention: Pam Bilal
pbilal@howardcountymd.gov
410-313-5970 (fax)

Please direct any questions to: Pam Bilal 410-313-6029 (office)

Rev 3/10/16