National Institute for Home Care Accreditation, Inc.
Standards of Accreditation© Program

APPLICATION

Organization:____

Contact Name ____

Address ____
Street Suite #

____
City State Zip

Telephone: __________________________ Ext.: ____________

Web-Site: ____________________ Email address: ____________________

Name and Title of Organization Administrator: ________________________
Name Title

1. Has the organization ever been denied accreditation, or had its accreditation revoked or been placed in a provisional status?

☐ No ☐ Yes, please provide details.

2. Has the organization ever been convicted, censured, sanctioned, or discharged by any law enforcement, regulatory, licensing or other government oversight body, or been the subject of any investigation or enforcement action conducted by any state or federal regulatory agency?

☐ No ☐ Yes, please provide an explanation.

3. Has any current employee (licensed, certified or otherwise), owner or governing authority member, or a past employee or governing authority member ever been convicted, censured, sanctioned, or discharged by any law enforcement, regulatory, licensing or other government oversight body, or been the subject of any investigation or enforcement activity conducted by any state or federal regulatory agency?

☐ No ☐ Yes, please enclose an explanation.

4. <u>The organization must meet the following four conditions to apply for accreditation:</u>

4.1. Service must be directly provided by the organization. Does the organization provide direct home care services?

☐ Yes, how many hours in the past last twelve months? ____________ Hours ☐ No

4.2. The organization must directly employ the Direct Care employee. *(Organizations, which serve as a registry, placement agencies, job list or do not directly employ the Direct Care Staff are not eligible for accreditation)*

How many Direct Care Employee are employed? Full time______ Part time_______

4.3 The organization must be in operation for at least six (6) months and one (1) year at the completion of the accreditation process.

Date business started ______________________________

(A copy of the Article of Incorporation or other official documents must be attached to this application)

4.4. Has the organization handled the required minimum of five (5) cases, with three (3) currently active cases?

☐ Yes. How many cases does the organization currently have? _______ ☐ No

---

Service Usage and Organizational Data

1. Population of total service area ___________________
2. What percentage of the service area is: Over age 65 _______ Minority ________
3. How many branch offices do you have, not counting the main office? _______
4. Do you have another national accreditation? ☐ No ☐ Yes, who

   ____
5. Is the organization Medicare certified: ☐Yes ☐ No
6. Is the organization Medicaid approved: ☐Yes ☐ No
7. Is the organization Licensed: ☐Yes ***(attach a copy of license)*** ☐ No

   ☐ No licensed required
8. Service provided for last year with complete figure. Please specify year.

	Units		**Cases**	
Year: 20___	**Number**	**% of total**	**Number**	**% of total**
a. Age 60 +				
b. Age 18-59				
c. Families with children				
d. Other:				
TOTAL				

9. Please provide the following information from the most recent completed fiscal year:

    a. **Total Gross Revenue** $________________________________

DISCLAIMER:

THE NATIONAL INSTITUTE FOR HOME CARE ACCREDITATION, INC (NIHCA), RESERVES THE RIGHT, IN ITS SOLE DISCRETION, WITHOUT EXPLANATION OR REASON, TO REFUSE TO CONSIDER OR PROVIDE AN APPLICATION FOR ACCREDITATION TO ANY ORGANIZATION, AND TO WITHHOLD, DENY OR DISCONTINUE ACCREDITATION TO ANY ORGANIZATION.

CERTIFICATION

▶ I have read the above Disclaimer and further understand that this Application is not a contract or guarantee of accreditation. I certify that the information provided herein is complete and accurate to the best of my knowledge, and I realize that my application for accreditation may be denied, or that my accreditation may be revoked or discontinued if any of the information provided herein is false.

____

Applicant's Signature **Date**