Resource Directory Participant Application Aging & Disability Resource Center

Please make copies for additional site information if needed.

Name of Program/Site _____

AKA _____

Address _____

City, State, Zip _____

Phone # _____ TDD/TTY _____ Fax _____

Contact Name _____ Phone # _____

Email Address _____ Website Address _____

License Type _____ License # _____ Date _____

Administrative (Operating) Agency _____

Address (if different from Site) _____

Person in Charge _____ Title _____

Phone # _____ Email Address _____

Office Hours & Days of Operation _____ Other Hours _____

Service Delivery Area (by county) _____

Ages Served _____ Languages Spoken _____

Program Accessibility ☐ Wheelchair Access ☐ Accessible Parking ☐ Other _____

Fees/Charges: Suggested Donation of $ _____

☐ Sliding fee $_____ per ☐ hour ☐ day ☐ month ☐ week ☐ Other _____

Method of Payment Accepted: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Payment Plan

☐ Veteran's Administration Contract ☐ Other _____

Documents Required: ☐ physicians order ☐ photo ID ☐ DD-214 ☐ insurance information

☐ application ☐ income verification ☐ birth certificate ☐ RN assessment ☐ proof of residency

☐ Social Security Card ☐ other: _____

Please describe the eligibility requirements for your programs (Target Population, age, income, disability, etc.):

Intake Procedure (call for appointment, complete on-line application, needs assessment, etc.):

Please print a narrative describing your program and the services you provide. Feel free to use additional paper if more space is needed. Please include program publications, if available.

Medicaid Providers: (Direct Care Workers=DCW) **Complete this section, if applicable.**

No. of years providing personal assistance or attendant services _____
No of years serving Medicaid enrollees _____

Total no. of DCW/Employees _____ Avg. longevity of DCW in months ____ Avg. hourly wage _____

Are DCW bonded or provider has liability coverage? ☐ Yes ☐ No

Is health insurance or other benefits offered? ☐ Yes ☐ No

Does provider complete a background check for DCW/employees? ☐ Yes ☐ No If yes, check all that apply:

☐ MT Name-Based (Public Record) ☐ Western Identification Network (WIN Check)/Fingerprint. (Covers Alaska, MT, WY, ID, WA, OR, NV and UT).

☐ Federal Finger Print/FBI (Requires Statutory Authority) ☐ MT DOJ Driving Record

☐ Self-direct program allowing consumers to recruit, select, train and dismiss direct care workers

Assisted Living Facilities: Complete this section, if applicable.

Do you have a secure facility? ☐ Yes ☐ No

Do you have a bed category **B** endorsement? ☐ Yes ☐ No

Do you have a category **C** endorsement? ☐ Yes ☐ No

Total number of beds _____ How many beds are in a secure unit? _____

Long Term Care Facilities: Complete this section, if applicable.

Does your facility have a distinct secured or locked unit? ☐ Yes ☐ No If yes, how many beds _____

Does your facility serve individuals who need a ventilator? ☐ Yes ☐ No

Does your facility provide any specialized rehabilitation services? ☐ Yes ☐ No If yes, please indicate which of the following: ☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy

Does your facility offer specialized services to residents with Alzheimer's /dementia? ☐ Yes ☐ No

Person completing this form? _____ Title _____

Phone _____ Email _____

We make every effort to update your information on an annual basis. Whom should we contact for future updates? _____

Phone _____ Email _____

_____ _____ _____

Signature Title Date

Please return completed form to:

State Office on Aging
Department of Public Health & Human Services (DPHHS)
PO Box 4210
Helena, MT 59604-4210

Attn: Kerrie Reidelbach (406) 444-7788 – kreidelbach@mt.gov