Affinity Nonprofits

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Home Healthcare Supplemental Application

Applicant: _____

Type of Operations (check **all** that apply):

☐ Home Health Care ☐ Medical Staffing/Nurse Registry ☐ Medical Equipment Supplier

☐ Other (specify)_____

Please indicate percentage of time spent in the following work locations (total **must** equal 100%)

Patient Private Home	_____%	Hospital Staffing	
Assisted Living/ RCFE	_____%	Operating Room	_____%
Nursing Home	_____%	Emergency Room	_____%
Institutional Hospice	_____%	Labor & Delivery	_____%
Ambulatory Surgery Center	_____%	Neonatal (NICU)	_____%
Adult Day Care	_____%	Adult Intensive Care Unit	_____%
Clinic	_____%	Pediatric Intensive Care Unit	_____%
Physician's Office	_____%	Group Home/Congregate	_____%
Other (Specify where)	_____%	Other Hospital (Specify where)	_____%
_____		_____	

Percentage of Types of Services Provided (total **must** equal 100%)

Personal Care Chore or Companion	_____%	Respiratory Therapy	_____%
Rehabilitation – including Physical, Occupational, or Speech Therapy	_____%	Radiation Therapy Child care or babysitting	_____% _____%
Infusion Therapy	_____%	Skilled Nursing Care	_____%
Hospice – In Home	_____%	Pediatric Care** see below	_____%
Supplemental Staffing	_____%	Complex Wound Care	_____%
Obstetrical Services	_____%	Medical Equipment Supplier	_____%
Chemotherapy	_____%	In Home Dialysis	_____%
Cardiac Care	_____%	GTube feedings	_____%

Does the applicant provide care or treatment to ventilator or tracheotomy patients? ☐ Yes ☐ No

If yes, please advise the percent of services _____%

Does the applicant employ relatives of the patient as their care provider? ☐ Yes ☐ No

If yes, what percentage of your staff is related to patients? _____%

Does the applicant perform any permanent placements of staff? ☐ Yes ☐ No

If yes, please indicate: percent of permanent placements _____% and temporary placements _____%

What is the total estimated annual care provider payroll, including payments to contractors? $ _____

** If Pediatric Care is provided:

Please advise what specific type of care is provided: _____

Is a parent/guardian ALWAYS present in the home during care? ☐ Yes ☐ No

Are there medically fragile pediatric clients? ☐ Yes ☐ No

_____	_____	_____
Date Signed	Signature of Applicant	Name and Title