Cabinet for Health and Family Services
Office of Inspector General

Application for Certification to Operate a Personal Services Agency

OIG-1180, September 2021

906 KAR 1:180

Division of Health Care Use Only

Date Received: _____ *(month, day, year)*

Date Approved: _____ *(month, day, year)*

- All questions on this application must be answered completely in printed or typed script. Supporting documentation must be attached. An incomplete or illegible application will be returned without being processed.
- A non-refundable application fee in the amount of $500 for initial application, $350 for annual recertification, or $350 for reporting a change in an ownership interest of more than 25% of the personal services agency must accompany this application. No certificate and/or approval shall be issued without receipt of this fee.
- **Return the application, required documents, and a non-refundable certification fee payable to the Kentucky State Treasurer to: Office of Inspector General, Division of Health Care, 275 East Main Street, 5EA, Frankfort, Kentucky 40621**

Please Type or Print Legibly

SECTION 1-TYPE OF APPLICATION

☐ Initial Certification

☐ *Please check if you are a new business that has three (3) or fewer employees and intends to hire additional employees within ninety (90) calendar days of the date of application.*

☐ Annual Recertification

☐ Change of Ownership *(Submit a bill of sale or comparable document, which includes the corporation/owner(s) names(s) and buyer/seller signature(s) and effective date of the transaction. A change of ownership must be reported within 30 calendar days of the effective date of the transaction. Complete the remaining sections of this application.)*

SECTION 2- IDENTIFYING INFORMATION

A. Parent Personal Services Agency Location

Name of Agency

Street Address (number and street) P.O. Box

City County State Zip Code

Telephone Number Fax Number

B. Mailing Address *(if different from agency's location)*

Street Address (number and street) P.O. Box

City County Zip Code

Agency's Office Hours (e.g. 8:00a.m.- 4:30p.m.)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

E-mail Address: Web Address:

C. Branch offices operated under this certification

Please list below each of the parent personal services agency's branch offices.

If a branch office's hours of operation are different from those of the parent personal services agency, please attach a separate page documenting the branch office's business hours.

Address (street address/city/zip)	County	Telephone Number

SECTION 3- OWNERSHIP

A. Ownership and Controlling Interest *(If the "doing business as" name is different from the name of the owner, e.g. corporation, limited liability company, partnership, etc., submit a "Certificate of Assumed Business Name" document from the Kentucky Secretary of State that lists the name of the direct owner's corporation, etc., and the "doing business as" name (d/b/a). You must register the direct owner's corporation name etc and the d/b/a name with the Secretary of State.)*

(List names and addresses of individuals or organizations having direct or indirect ownership in the applicant entity.)

Name	**Business Address**

B. Type of Entity

For Profit	NonProfit	Government
◯ Individual	◯ Church Related	◯ State
◯ Partnership	◯ Individual	◯ County
◯ Corporation	◯ Partnership	◯ City
◯ Limited Liability Company	◯ Corporation	◯ City/County
◯ Sole Proprietorship	◯ Limited Liability Company	◯ Federal
◯ Other (specify below)	◯ Other (specify below)	◯ Other (specify below)
_____	_____	_____

C. Directors/Officers/Partners/Managing Agents/Managing Employees

List all individuals associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, president, vice president, secretary, treasurer, CEO, CPO, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company.

Name	Title-Position (list if owner, i.e. president/owner)	Business Address (street address/city/state/zip)

SECTION 4- STAFFING

A. Manager:

Last Name | First Name | Initial

B. Alternate Manager:

Last Name | First Name | Initial

SECTION 5- SIGNATURE OF AUTHORIZED PERSONAL SERVICES AGENCY REPRESENTATIVES

I have reviewed the Personal Services Agency administrative regulation (906 KAR 1:180) and state laws (KRS 216.710-KRS 216.716). As an applicant, I believe that the Personal Services Agency is capable of and agrees to comply with the conditions set forth in 906 KAR 1:180 and KRS 216.710- 216.716.

I certify that all services provided by the Personal Services Agency, and its branches if applicable, will be restricted to those services allowable under KRS 216.710(9)(a) as follows:

"Personal services" means:

1. *Assisting with a client's ambulation and activities of daily living as defined in KRS 194A.700;*
2. *Facilitating the self-administration of medications if such medications are prepared or directed by a licensed health-care professional or the client's designated representative;*
3. *Providing services which may be referred to as attendant care, in-home companion, sitter and respite care services, and homemaker services when provided in conjunction with other personal services; and*
4. *Providing services that enable the client to live safely, comfortably, and independently.*

I understand that any change of status (change of ownership, name, location, opening or closing a branch) must be reported to the Office of Inspector General within 30 calendar days after the effective date of the change.

I certify that the Personal Services Agency will serve clients equally, without regard to race, color, religion, or national origin.

I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application may result in the denial or revocation of certification.

Names and signatures of authorized representatives:

Name of Owner /President/Chairperson/CEO/ (type or print)

Signature of Owner/President/Chairperson/CEO | Date

Name of Personal Services Agency Manager (type or print)

Signature of Personal Services Agency Manager | Date

SECTION 6- POLICIES AND DOCUMENTATION

POLICIES AND DOCUMENTATION TO BE SUBMITTED WITH THE INITIAL CERTIFICATION APPLICATION OR CHANGE OF OWNERSHIP.

RE-SUBMISSION OF THESE POLICIES AND DOCUMENTS IS NOT REQUIRED AS PART OF THE ANNUAL RECERTIFICATION APPLICATION UNLESS THEY ARE DIFFERENT FROM THE ORIGINAL DOCUMENTS SUBMITTED AT THE TIME OF INITIAL CERTIFICATION.

In addition to documentation required by Section 3.A of this application, please submit the following:

1. Copy of the manager's responsibilities for day to day operations.
2. List containing the following information for each personal services agency manager and employee who provides direct services to clients. *(An "employee" includes an individual who is directly employed by the personal services agency, an agent of the personal services agency, an independent contractor who has a contractual arrangement with the agency to provide personal services, or a person who is referred by another person or other agency that has an ownership or financial interest that is realized from the delivery of personal services rendered by the individual for whom the referral is made):*
   a. Name of employee;
   b. Date of initial hire;
   c. Date of criminal record check;
   d. Date of documentation showing the employee is not listed on the nurse aide and home health aide abuse registry;
   e. Date of documentation showing the employee is not listed on the caregiver misconduct registry;
   f. Date of substance abuse test;
   g. Date of documentation showing the employee is free of active tuberculosis;
   h. Date of evaluation to determine employee competency;
   i. Date employee received training and topics covered in training; and
   j. No later than 90 days from the most recent effective date of 906 KAR 1:180, date that each direct-care staff member who provides services to a client that exhibits symptoms of Alzheimer's disease or other dementia successfully completed at least six (6) hours of initial and three (3) hours of annual training in dementia care pursuant to the requirements established by KRS 216.713(3).

   An entity granted provisional certification shall, no later than fourteen (14) calendar days prior to expiration of the 90-day provisional certificate, submit the employee information required by 2.a. through j. for each employee hired by the agency after submission of this application.

   NOTE: The Office of Inspector General may request a random sample of employee records in which the personal services agency would be required to submit actual copies of an employee's criminal record check or other documentation necessary to verify compliance with 906 KAR 1:180 and KRS 216.712.
3. Documentation on how the personal services agency will evaluate an employee's competence to provide direct personal care services to a client.
4. Copy of the personal services agency's Service Agreement.
5. Copy of the personal services agency's Client Rights Statement.
6. Policy for investigating any grievance made by a client or the client's designated representative.
7. In the event of a change of ownership, a bill of sale or comparable document that includes the corporation/owner(s) names(s) and buyer/seller signature(s) and effective date of the transaction.

SECTION 7- CERTIFICATION FEE

Return the application, required documents, and a non-refundable certification fee payable to the Kentucky State Treasurer to:

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Division of Health Care
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Frankfort, Kentucky 40621

Fee Schedule: $500 for initial certification.
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