HEALTH SERVICE PROVIDER APPLICATION

Legal name of company: ____

Name of company if different from legal name: ____

Owner or contact person and his/her title: ____

Contact Phone: ___________________________Email: ___________________________________

Mailing Address: ____

City: ______________________________ State: ____________________ Zip Code: ________

How long has your agency been serving Johnson County? ________________________

Does your agency supply literature explaining services, eligibility requirements, fees and funding sources? Please attach literature or explanation.

Is your agency Medicare or Medicaid certified?

Medicare? Y / N
Medicaid? Y / N

Do you do background checks on your all your workers?

a) Criminal? Y / N
b) Child & Dependent Adult Abuse? Y / N
c) Sex offender registry? Y / N
d) Other ____________________________

7. Please provide:

- Copies of current licenses, certifications and accreditations
- Copy of current Certificate of Insurance coverage for your company
- Three professional references from doctors, discharge planners, social workers, patients or their family members. References will be contacted by a TRAIL representative.

References:

Name: ____

Professional relationship: ____

Preferred contact information (phone/email/address): __________________________

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Name: ____

Professional relationship: ____

Preferred contact information (phone/email/address): __________________________

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Name: ____

Professional relationship: ____

Preferred contact information (phone/email/address): __________________________

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Company representative signature Date

Unless otherwise instructed, please return this form to *maggie.a.elliott@gmail.com* or mail to TRAIL of Johnson County, 308 East Burlington Street #196, Iowa City, IA 52240.