



Health Related Social Needs (HRSN) Provider Application

Before applying, please:

- Read the Provider Application Details, Insurance Requirements, and Sample Contract for the service you are interested in contracting for.
- Be prepared to provide copies of or enter data specific to your qualifications, as indicated in the Provider Application Details and in Section 3 below.
- Complete a [Background Check Authorization Form](#) and have confirmation code available.

Please reach out to the HRSN team with questions at HRSN@dshs.wa.gov.

Section 1. Business Information			
Business Name			
DBA (Doing Business As), as applicable			
Contract Signatory Name	Phone Number	Email Address	
Type of organization (check all that apply) <input type="checkbox"/> Nonprofit <input type="checkbox"/> For-profit <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Small business <input type="checkbox"/> Government <input type="checkbox"/> Tribe			
Your identified primary business and contact details will be displayed on the HRSN Provider Directory.			
List the email address and phone number you wish to display and for staff / clients to contact.			
<ul style="list-style-type: none"> • If you are a sole proprietor using your home address and do not wish to have it published on the HRSN Provider Directory, please indicate so by checking this box <input type="checkbox"/>. <p>Be sure to include the main email address and phone number you wish to display and staff / clients to contact you.</p>			
Primary Street Address	City	State	Zip Code
Program Contact Name	Phone Number	Preferred Contact Method	
Email Address			
Website Address			
<p>* Do you hold a current or have you held a DSHS Contract(s) in the past five (5) years?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Contract purpose Contract number Is your business enrolled in ProviderOne? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you billed ProviderOne? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Background Check: If you answer yes to the following question, you will be required to participate in a federal fingerprint background check.

Has the contract signatory lived outside the State of Washington in the last three years?

Yes No

If yes, list specific name(s) of the individual(s):

Section 2. Service Information

Services

Please check the service(s) you are interested in contracting for and provide all service-specific required information and documentation as indicated in the Provider Application details and sample contract.

- Nutrition Support Service – Nutrition Counseling
- Nutrition Support Service – Nutrition Education
- Nutrition Support Service – Medically Tailored Meals
- Nutrition Support Service – Pantry Stocking
- Nutrition Support Service – Short-Term Grocery Provisions
- Nutrition Support Service – Fruit and Vegetable Provisions
- Home Accessibility – Accessibility Modifications
 - RV repair specialty
- Home Accessibility – Remediations
 - RV repair specialty
- Home Accessibility – Adaptation Devices
- Housing – Storage
- Housing – Moving Services

Service Area

Please select statewide if you are serving all of Washington State's 39 counties, otherwise select the counties you are able to serve.

Statewide (all 39 counties)

Specific counties:

- | | | |
|--|--|---|
| <input type="checkbox"/> Adams County | <input type="checkbox"/> Grays Harbor County | <input type="checkbox"/> San Juan County |
| <input type="checkbox"/> Asotin County | <input type="checkbox"/> Island County | <input type="checkbox"/> Skagit County |
| <input type="checkbox"/> Benton County | <input type="checkbox"/> Jefferson County | <input type="checkbox"/> Skamania County |
| <input type="checkbox"/> Chelan County | <input type="checkbox"/> King County | <input type="checkbox"/> Snohomish County |
| <input type="checkbox"/> Clallam County | <input type="checkbox"/> Kitsap County | <input type="checkbox"/> Spokane County |
| <input type="checkbox"/> Clark County | <input type="checkbox"/> Kittitas County | <input type="checkbox"/> Stevens County |
| <input type="checkbox"/> Columbia County | <input type="checkbox"/> Klickitat County | <input type="checkbox"/> Thurston County |
| <input type="checkbox"/> Colville Federated Tribes | <input type="checkbox"/> Lewis County | <input type="checkbox"/> Wahkiakum County |
| <input type="checkbox"/> Cowlitz County | <input type="checkbox"/> Lincoln County | <input type="checkbox"/> Walla Walla County |
| <input type="checkbox"/> Douglas County | <input type="checkbox"/> Mason County | <input type="checkbox"/> Whatcom County |
| <input type="checkbox"/> Ferry County | <input type="checkbox"/> Okanogan County | <input type="checkbox"/> Whitman County |
| <input type="checkbox"/> Franklin County | <input type="checkbox"/> Pacific County | <input type="checkbox"/> Yakima County |
| <input type="checkbox"/> Garfield County | <input type="checkbox"/> Pend Oreille County | <input type="checkbox"/> Yakama Nation |
| <input type="checkbox"/> Grant Count | <input type="checkbox"/> Pierce County | |

Languages spoken by client facing staff or subcontractors: Check all that apply. Information provided here will help inform clients and staff for appropriate choice and referral purpose, as applicable.

- | | | | |
|--|--------------------------------------|--|---|
| <input type="checkbox"/> English | <input type="checkbox"/> German | <input type="checkbox"/> Oromo | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Amharic | <input type="checkbox"/> Hindi | <input type="checkbox"/> Pilipino / Filipino | <input type="checkbox"/> Tamil |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Hmong | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Telugu |
| <input type="checkbox"/> Burmese | <input type="checkbox"/> Japanese | <input type="checkbox"/> Punjabi | <input type="checkbox"/> Thai |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Karen | <input type="checkbox"/> Romanian | <input type="checkbox"/> Tigrinya |
| <input type="checkbox"/> Chinese (Simplified) | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | <input type="checkbox"/> Ukrainian |
| <input type="checkbox"/> Chinese (Traditional) | <input type="checkbox"/> Lao | <input type="checkbox"/> Samoan | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Chuukese | <input type="checkbox"/> Marshallese | <input type="checkbox"/> Somali | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Mixteco | <input type="checkbox"/> Spanish | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> French | <input type="checkbox"/> Nepali | <input type="checkbox"/> Swahili | |

Community

Is your organization considered 'By and For'? By-and-For Organizations are operated by and for the communities they serve. Their primary mission and history are serving a specific community. They are culturally based, directed, and substantially controlled by individuals from the population they serve. At the core of their programs, these organizations embody the community's central cultural values.

- Yes No

Please indicate if there are culturally specific communities your organization is uniquely equipped to serve.

Section 3. Attachments

Attach all documents listed below to prove general and specific provider qualifications are met. Documents may be submitted together as a single attachment or as separate attachments. Please ensure all attachments are included for a complete application.

- Completed [Contractor Intake, DSHS 27-043](#), and Required Attachments
 - Form W-9 – request or taxpayer identification number and certification
 - 501(c) status documentation, as applicable
 - List of partners, members, directors, officers, and board members, as applicable
 - WA State Master Business License or proof of exemption
 - List of state contracts that have been terminated for default, including a brief explanation
 - Additional addresses, as applicable
 - Additional staff, as applicable
 - Certificate of Insurance
 - If requesting a small business waiver, signed [Small Business Self-Certification Statement, DSHS 27-234](#), or OMWBE certification
 - Completed [Medicaid Provider Disclosure Statement, DSHS 27-094](#)
 - Completed [Background Check Authorization Form](#)* and name, date of birth, and background check confirmation number for the contract signatory

Contract signatory: Name	DOB	Confirmation Number
--------------------------	-----	---------------------
- * A paper form is available upon request if you are unable to complete it online
- Total program operating budget, including all anticipated revenue sources

- Brief narrative describing type and years of experience providing service(s) related to what you are applying for
- Evidence showing a history of responsible financial stewardship and integrity using **one** of the following:
 - Most recent audit report
 - Most recent financial review
 - Request to waive this requirement, including justification
- Organizational chart or staffing plan, including applicable credentials and a list of subcontractors, as applicable
- Completed [Request for Approval to Subcontract, DSHS 17-265](#), as applicable
- Additional information depending on specific services applying for:

MTMs

- Rate
 - List of associated costs
 - Approximate breakdown of each
- List of medical conditions for which meals are tailored to
- Menu / meal options
- Indicate whether meals are fresh, frozen, or shelf-stable
- Indicate area from which foods are sourced
- Method and frequency of delivery
- Nutrition Plan template
- RD / RDN certification or PCP documentation, as applicable
- Indicate whether RD / RDN students (interns) will be utilized
- What is your estimated capacity (i.e. how many clients do you anticipate being able to serve)?
 - Are there any limits in the number of clients you may be able to serve? If yes, explain.

Nutrition Counseling and Nutrition Education

- Rate
 - List of associated costs
 - Approximate breakdown of each
- Examples of educational materials, including in languages other than English, as applicable
- Nutrition Counseling Goal Plan template, as applicable
- Indicate how services will be delivered (in person, telephone, mail, etc.)
- RD / RDN certification, qualified health care professional or CHW documentation, as applicable
- Indicate whether RD / RDN students (interns) will be utilized to perform any of the work; if so, specify the work to be performed
- What is your estimated capacity (i.e. how many clients do you anticipate being able to serve)?
 - Are there any limits in the number of clients you may be able to serve? If yes, explain.

Pantry Stocking, Short-Term Grocery Provisions, Fruit and Vegetable Provisions

- Rate
 - List of associated costs

- Approximate breakdown of each
- Rate should include food and administrative costs
- NOTE: If you hold a Community Choice Guide or Support Housing Provider contract, a rate is not necessary as this will be negotiated upon contract execution.
- List of foods included in each unit, as applicable
- Indicate whether food is fresh, canned or frozen
- Indicate whether clients will have choice about what foods are provided
- Method and frequency of delivery
- What is your estimated capacity (i.e. how many clients do you anticipate being able to serve)?
 - Are there any limits in the number of clients you may be able to serve? If yes, explain.

Accessibility Modifications and Remediations

- Rate
 - Labor costs
- License(s) and/or certifications(s), as applicable
- List of specialties and/or limitations, as applicable
- List of supervisory and labor personnel
- What is your estimated capacity (i.e. how many clients do you anticipate being able to serve)?
 - Are there any limits in the number of clients you may be able to serve? If yes, explain.

Adaptation Devices

- Rate
 - List of associated administrative costs
- Indicate what devices you can provide
- Indicate how devices will be delivered and installed, as applicable
- What is your estimated capacity (i.e. how many clients do you anticipate being able to serve)?
 - Are there any limits in the number of clients you may be able to serve? If yes, explain.

Storage

- Rates
 - List of associated costs
- Size of storage facilities
- Indicate whether facilities are:
 - Heated
 - Within a secure area
- Rental / lease agreement
- Protocol and procedures when an eviction is deemed necessary
- What is your estimated capacity (i.e. how many clients do you anticipate being able to serve)?
 - Are there any limits in the number of clients you may be able to serve? If yes, explain.

Moving Services

- Rates
 - List of associated costs
- Washington Utilities and Transportation Commission (WUTC) registration
- Certifications(s), as applicable

- List of supervisory and labor personnel
- What is your estimated capacity (i.e. how many clients do you anticipate being able to serve)?
 - Are there any limits in the number of clients you may be able to serve? If yes, explain.

Section 4. Attestations

By checking the following boxes and submitting this form, I attest that each of the following statements is true. Each of these may be reviewed upon monitoring. If a statement is not true, please attach a corresponding explanation and documentation.

- Contractor has no multiple cases of lost litigation related to service provision to medically frail and/or functionally disabled persons.
- Contractor staff, including those with unsupervised access to clients and those with a controlling interest in the organization, have no findings of abuse, neglect, exploitation, abandonment nor has the organization had any government issued license revoked or denied related to the care of medically frail and/or functionally disabled persons suspended or revoked in any state.
- Contractor and subcontractor employees and volunteers who may have unsupervised contact with vulnerable adults, including those delivering goods or services to a vulnerable adult's home, must pass a criminal history background check, which must be conducted by the organization every two years and kept in personal files. The criminal history background check must at least include Washington State Patrol criminal conviction records.
- Contractor has no history of significant deficiencies as evidenced by monitoring, licensing reports, or surveys.
- Contractor has policies and procedures meeting the requirements of mandatory reporting procedures, as described in chapter [74.34 RCW](#)

Section 5. Certification

By signing and submitting this form, I certify, under penalty of perjury as provided by the laws of the State of Washington, that all the foregoing statements and attachments are true and correct, that I meet all program, state and local requirements for the services provided. I will notify DSHS immediately of any changes.

Full Name

Title

Signature

Date