



WA Cares Fund Provider Application for Registration



Before you apply, please:

- Read the Provider Application Details and Sample Contract for your [Service / Provider Type](#). Providers should be prepared to provide copies of or enter data specific to their qualifications, as documented on the Provider Application Details documents.
- Verify [DSHS Insurance Requirements](#) indicated in your specific contract; and
- Ensure you have completed your [Background Check Authorization](#) and have your confirmation code ready for the application.

For additional information on the WA Cares Fund program, click [here](#).

Section 1. Contractor Name or Business Organization Information		* Required
Contractor Name*		
Facility Name (required for facility-based providers)		
DBA (Doing Business As)		
Service Area		
Please select statewide if you are serving <u>all</u> of Washington State's 39 counties, otherwise select the counties you plan to serve.		
<input type="checkbox"/> 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 Confederated 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	

*** Do you hold a current DSHS Contract?** Yes No

If yes, attach a brief explanation.

Languages Spoken: * Check all that apply.

- | | | | |
|--|--------------------------------------|--|---|
| <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 | |

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

Do you currently, or have you lived outside Washington in the last three years? Yes No

Are you currently categorized as a "High Risk" Medicaid provider as determined by the Health Care Authority? Yes No

Do you hold 5% or higher interest with a contracted Medicaid provider who falls in the High-Risk Category, as determined by the Health Care Authority? Yes No

Section 2. Service Information and Requirements

*** Required**

Please review and provide all service-specific required information and documentation. You can find requirements for your service type on our <https://wacaresfund.wa.gov/providers/toolkit> in the application details.

- Adaptive Equipment and Technology – Medical Equipment and Supplies
- Adaptive Equipment and Technology – Specialized Equipment and Supplies
- Adaptive Equipment and Technology – Assistive Technology Goods
- Adaptive Equipment and Technology – Assistive Technology Services
- Adaptive Equipment and Technology – Vehicle Modifications
- Adult Day Services - Adult Day Care and Respite
- Adult Day Services - Adult Day Health
- Adult Family Home
- Adult Family Home - Respite
- Adult Family Home - Private Duty Nursing
- Assisted Living Services
- Assisted Living Services - Respite
- Assisted Living Services – Memory Care
- Care Transition Coordination
- Dementia and Behavioral Support – Medical Provider
- Dementia and Behavioral Support – Non-Medical Provider
- Home Safety Evaluation

- Education and Consultation – Medical Provider
- Education and Consultation – Non-Medical Provider
- Environmental Modifications
- Home-Delivered Meals
- Housework and Errands
- In-home personal care and Respite - Home Care Agency
- Nursing Home Services
- Nursing Home Services - Respite
- Personal emergency response systems (PERS)
- Professional nursing services - Skilled Nursing
- Professional nursing services – Private Duty Nursing
- Professional nursing services - Nurse Delegation
- Transportation
- Yardwork and Snow Removal

Select Business Organization Type: *

Choose an item.

Taxpayer Identification Number (TIN) Type: * Please mark and provide either Social Security Number (SSN) or Employer Identification Number (EIN).

- Social Security Number (SSN):
- Employer Identification Number (EIN):

Do you have a Unique Entity Identifier (UEI)? * Yes No

If you checked yes, please enter the UEI Number:

Have you had any State contract terminated for default? * Yes No

Current DSHS Employee(s): *

- Yes No Are you or any member of your staff a current employee of DSHS? If yes, attach a brief explanation, describing you or your employees' duties as a DSHS employee.

Conditions / Clauses / Waivers: *

- Yes No Does your business require its employees to sign or agree to, as a condition of employment, mandatory individual arbitration clauses or class or collective action waivers?

Fiscal Year: *

- Yes No Does your fiscal year end the same as the calendar year (January 1 through December 31)?

Section 3. Contractor Primary Address*** Required**

Your identified primary business or facility address and contact details will be displayed on the WA Cares Provider Directory.

Please list the main email address and phone number you wish to display and beneficiaries to contact in that field.

- If you are a sole proprietor using your home address and do not wish to have it published on the WA Cares Provider search:
 - Enter your address below as well as in Section Six: Additional Information under "Additional Address Description 1".
 - Select "Facility Address" under "Additional Address Description 1" and enter "Private Address" under "Additional Street Address 1" and the rest of the fields as normal.
 - Please include the main email address and phone number you wish to display and beneficiaries to contact in that field.

Primary Street Address*	City*	State*	Zip Code*
		WA	
County*	Phone Number*	Preferred Contact Method*	
Email Address*			

Section 4. Contractor Ownership Type*** Required**

Please indicate if your business is any of the following:

Micro / Mini / Small Business: * Yes No

If you identify as a small business or select yes above, complete and submit the Small Business Self-Certification Statement. <https://www.dshs.wa.gov/sites/default/files/forms/pdf/27-234.pdf>

Veteran-Owned Business: * Yes No

If yes, are you: Certified / Not Certified.

Certified Disadvantaged Business Entity: * Yes No

If yes, are you: Certified / Not Certified.

Section 5. Contractor Primary Contract Person*** Required**

Please ensure primary contact person is authorized to sign the contract or an agency owner. If the individual who is authorized to sign the contract is not the agency owner, please enter the name of the agency owner as an additional staff person.

Primary Contact Person: *

If not agency owner, list agency owner as additional staff.

- | | |
|---|---|
| <input type="checkbox"/> Owner | <input type="checkbox"/> Elected Official |
| <input type="checkbox"/> Office or Board Member | <input type="checkbox"/> Other (please identify): |
| <input type="checkbox"/> Partner | |
| <input type="checkbox"/> Staff Member | |

Section 6. WA Cares Provider Search

Please enter the contact information you would like to be displayed on the WA Cares Provider Search website.

If you are a sole proprietor using your home address and do not wish to have it published on the WA Cares Provider search, please re-enter your address under Provider Search Street Address and enter "Private Address".

Provider Directory Street Address:

Provider Directory City, State, Zip Code:

Provider Directory County:

Provider Directory Phone Number:

Provider Directory Fax Number:

Provider Directory Email Address:

Provider Directory Website:

Section 7. Additional Information

If you are a sole proprietor using your home address and do not wish to have it published on the WA Cares Provider Search, please re-enter your address under "Additional Address Description 1" and select "Facility Address" under "Additional Address Description 1" and enter "Private Address" under "Additional Street Description 1" and the rest of the fields are normal.

Additional Address Description 1:

If your facility address is different from contractor address, please enter it here:

Additional Address Description 2:

Additional Staff: Any additional staff designate4d as authorized to sign contracts will be required to undergo a background check.

Staff Person 1 is a(n): **Choose an item.**

Full Name:

Staff Person 2 is a(n): **Choose an item.**

Full Name:

Section 8. Contractor Certification

*** Required**

Include all additional documents that show all general and specific provider qualifications are met, including Washington licenses, endorsements, certifications, and/or credentials, as required by law.

* In addition to this application, the applicant must submit evidence of minimum qualifications as documented in the Provider Application Detail documents in the [Provider Toolkit](#).

Attached Supporting Documentation Checklist

- Copy of your **signed** W-9 – You may need to also include your Taxpayer Identification Number and Certification.
- Copy of statement showing non-profit 501(c) status (if applicable)
- List of partners, members, directors, officers, and board members (not applicable to sole proprietors)
- Copy of your Washington State Master Business License or proof of exemption
- List of any contracts you have had with the state that have been terminated for default, including a brief explanation (if applicable)
- List of Additional Addresses (if applicable)
- List of Additional Staff (if applicable)
- Copy of your Certificate of Insurance / Insurance Statement and evidence that DSHS is added as an additional insured on the policy (if applicable)
- Current rate sheet or pricing guide for services provided

I certify, under penalty of perjury as provided by the laws of the State of Washington, that all the foregoing statements are true and correct, that I meet all program, state and local requirements for the services I offer, and that I will notify DSHS of any changes in any statement.

Full Name

Title

Signature

Date