Snoqualmie Indian Tribe
Tribal Healthcare Program-In Home Care
Facility Provider Application

Application

The Snoqualmie Indian Tribe's Tribal Healthcare program provides financial assistance to help qualified Tribal Members with obtaining In-Home Care.

Caregiving Providers must be a state licensed agency, bonded and insured business, with certified/licensed Caregivers or the Caregiver must be an active state-certified Certified Nursing Assistant (CNA) or similar healthcare professional. All Caregivers must pass a criminal background check prior to approval for this program.

All payments for In-Home Care are paid directly to the facility provider. Changes in facility circumstances must be reported immediately to Snoqualmie Indian Tribe Tribal Healthcare Program. Changes include:

1. Change in Caregiver: new position or staff who could have access to the Tribal Member.
2. Change/update in certification status: copy of new certifications must be provided upon any change or renewal.
3. Change in care provided: changes in hours provided or termination of services.

Vendor needed documents checklist: All items will need to be provided to obtain certification within the Snoqualmie Indian Tribes in-home care program.

_____ Application

_____ State Credentials _____ CPR & First Aid cards for care-giver

_____ Department of Health license _____ W-9

_____ Background check forms or approval sheets for all staff providing care to Tribal Member.

_____ Copy of facility insurance.

_____ Policies and contract/agreement for services being rendered.

Snoqualmie Indian Tribe
Tribal Healthcare Program-In Home Care
Facility Provider Application

*Date:*_____

Provider (Vendor) Information

Vendor Name: _____

Primary Contact: _____

Assigned Caregiver_____

Current Address: _____

Mailing Address (if different): _____

Business Phone: _____ Phone (Primary contact number): _____

Email: _____

License number: _____

Expiration date: _____

Tax ID number: _____

Rates and Fees

Indicate the billing rate for In-home at your facility (Max of 40 hours per week):

$_____ Hourly Rate $_____ Weekly Rate $_____ Monthly Rate

Indicate the billing rate for additional charges the agency may have (i.e. Hour overages, additional charges associated with transportation, etc.):

$_____ Additional Charges: _____

$_____ Additional Charges: _____

Safety standards & statement

Initial next to each safety standard:

____ Provider will not apply, nor allow anyone else in the facility apply, corporal punishment to any Tribal Member in their care.
____ Provider agrees to be trained in CPR and basic first aid and maintain a current status during the duration of the in-home care.
____ Provider ensures that all medications will be provided based on recommended/ prescribed dosages and timeframes.
____ Provider will practice proper hand washing habits before working with a Tribal Member.
____ Provider will not smoke nor allow others to smoke during the period when in home care is being provided.
____ Provider will be made aware of at least two unobstructed exits to outside of the building.
____ Provider understands that they are required to submit all documentation and be certified by the Snoqualmie Tribe prior to any payments being issued.

Knowingly and willingly giving false or fraudulent information on the application for the Snoqualmie Tribe Tribal Healthcare Program will be grounds for immediate termination of the program.

Signature:_____Date:_____

Applications can be scanned, emailed, or mailed to:

Snoqualmie Indian Tribe
ATTN: General Resources –Tribal Healthcare
Mail: P.O. 969, Snoqualmie, WA 98065
Email: generalresources@snoqualmietribe.us