# **New Jersey Department of Human Services**

## **Division of Aging Services**

**Provider Application Section III: Services**

**HOMECARE SERVICES**

***Read carefully the description of services and requirements.***

***If you do not qualify, please do not apply.***

**Definition:**

Homecare Services includes assistance with eating, bathing, dressing, personal hygiene, and the activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed-making, dusting, and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual’s family. Homecare providers must meet state standards for this service.

# **Billing Codes:**

***JACC*** ***Service/Unit Rates Per Unit Limitations***

J1200 1 hour weekday $25.16 Per ISA

 weekend or holiday

J1205 RN initial assessment $35.00 Per ISA, initial only

J1290 RN reassessment $35.00 Per ISA

J1295 1 hour weekday $26.16 Per ISA

 weekend/holiday

**HOMECARE SERVICES PROVIDER QUALIFICATIONS**

The applicant must submit evidence that it meets **all** items within the following section(s).

Please check off **ONE** section in which you are applying

Section 1[ ]  Section 2[ ]

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| **Section 1** |

|  |  |
| --- | --- |
| 1.a |[ ]  Medicare Certified Home Health Agency licensed by NJ DOH, per N.J.A.C. 8:42\* |
| 1.b |[ ]  Evidence of Liability Insurance and Worker’s Compensation Coverage |

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| **Section 2** |

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| 2.a |[ ]  Homecare Agency with Health Care Service Firm License from theNJ DL&PS, per N.J.A.C.13:45B\* |
| 2.b |[ ]  Accredited by National Home Caring Council, Commission on Accreditation for Home Care Inc., The Joint Commission and/or the Community Health Accreditation Program |
| 2.c |[ ]  Evidence of Liability Insurance and Worker’s Compensation Coverage |

\*Submit photocopy as evidence.

**Check all evidence submitted with application.**

Incomplete applications and / or applications submitted without required

documentation and evidence will be returned.

**CERTIFICATION**

For the purpose of establishing eligibility to receive direct payment for services to recipients under the New Jersey JACC Program, I certify that the information furnished on this application is true, accurate, and complete. I am aware that if any of the statements made by me in this application are willfully false, I am subject to punishment, including but not limited to disqualification from the New Jersey JACC Program. I agree to notify the new Jersey Department of Human Services, Division of Aging Services of any changes in the information contained in this application.

Name and Title of Applicant Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_