VetAssist®
Exclusive to the VETERANS HOME CARE Family

AGENCY PROFILE

Date

VHC Regional Manager

State of Registration

(Note: If separate entities, please complete a separate agency profiles form for each location)

Provider Information Needed

Agency Legal Name

Agency DBA Name

Address

City

State

Zip Code

Email Address

Phone Number

Fax

Tax ID #

Areas of Coverage

Counties

Business Entity

☐ Limited Liability Company ☐ S Corporation ☐ C Corporation ☐ Other: _____

Primary Contact

Title

(If multiple contacts attach list)

Phone/ Ext.

Fax

Cell

Email Address

Website

Employee Background Screening

Employee Background Screening

☐ Yes ☐ No

Employee Drug Testing

☐ Yes ☐ No

Home/Day Care Pay Rate

Home/Day Care Private Pay Rate:

$ _____ /hr.

Home/Day Care Medicaid Rate:

$ _____ /hr.

What is the Medicaid rate for home care or day care in your area?

$ _____ /hr.

Business Type

☐ Home Care Agency ☐ Home Care Registry ☐ Adult Day Care ☐ Assisted Living Facility

☐ Skilled Nursing Facility ☐ Other: _____

Business License

☐ Yes ☐ No If YES / State: _____

Year Established: _____

Services Provided (homemaker, companion, personal care, skilled care transportation, etc)

1

2

3

4

5

6

Types of Insurance your Company carries

☐ Workers Compensation Insurance ☐ General Liability Insurance ☐ Professional Liability Insurance

Methods of Payment

Received (Check the next to each that apply)

☐ Private Pay ☐ Medicaid ☐ Long Term

Care Insurance

☐ Private Insurance ☐ Medicare ☐ VA Health Care System ☐ Other

If other, please list

How many active clients to you have?

☐ 0 ☐ 1 to 10 ☐ 11 to 24 ☐ 25 to 49 ☐ 50 to 99 ☐ 100 or more

Do you have a dedicated employee for marketing (community liaison)?

☐ Yes ☐ No If YES , how many?: _____

How did you hear about us?