HOP RFP Timeline
2026-2027 Cycle

9/30/2025	HOP Provider RFP information and Application Available on our website
11/03/2025	ALL HOP Applications must be submitted to Clermont Senior Services by 4:30pm
11/04/2025	Begin Review of Applications
11/12/2025	Send HOP Agreements to qualified providers
12/08/2025	Signed Agreements due back to Clermont Senior Services
01/01/2026	New HOP agreements go into effect

Due Date

Applications must be either hand delivered, sent via any method which produces a return receipt, or emailed to eschacht@clermontseniors.com (must have original signature on application.) If hand delivered applications must be submitted in a sealed envelope plainly marked CSS-HOP Application on the outside.

Applications must be received by:

Wednesday, November 3, 2025
No later than 4:30pm

Send/Delivered Application to:

Emily Schacht, Supportive Services Director
2085 James E. Sauls, Sr. Drive
Batavia, Ohio 45103

CSS reserves the right to reject any application

Terms/Definitions

The following terms and abbreviations will be used throughout the Application and Information Packet.

CSS: Clermont Senior Services
HOP: Home Options Program
PY: Program Year
RFS: Request for Service
RFP: Request for Proposal

Information Regarding Rate Calculations

All Applicants desiring to provide any of the following services in Clermont County are required to complete and submit a separate rate for each service they anticipate providing with their application.

Homemaker Service
Personal Care Service
Respite Care Services

HOP reserves the right to adjust rates or establish ceilings.

Applicants submitting an application with a requested rate higher than the established ceiling rate will be extended an Agreement/Contract* at the ceiling rate. Applicants submitting a requested rate equal to or lower than the established ceiling rate will be extended a contract at the rate requested in their application. (* Applicants must be approved and certified before a Service Agreement can be issued.)

Please note that the term of this Agreement will be for two years. Remember the rate you request on the Application has a direct impact on the ceiling rate established by HOP!

Service Referral and Award

- Only Providers who have specified that they will serve the customer's zip code will be presented for consideration.
- Any provider that has been placed on "hold" will not appear on the referral list or offered the referral.
- If Homemaker, Personal Care Services, and Respite are to be offered, the referral will be based on the cost of the services that has the greater number of units.

All Applicants must provide

- HOP Application for Service Provider Certification
- Application HOP Rate Sheet
- Insurance Declaration
- Workers' Compensation Certificate
- Copy of Registration/Certificate of Good Standing from the Ohio Secretary of State Office.

All New Applicants must provide

- Statement of Ownership (list of all persons with 5% or more ownership)
- List of the names/addresses of governing body.
- Statement of purpose/description of specific services provided
- Table of Organization (T.O.) identifying lines of administration, advisory, contractual and supervisory authority to the direct care level.

For the above, please refer to the application attachment requirement, number 14, 15, and 16 on the HOP Application for Service Provider Certification for further information and suggested documentation.

- Articles of Incorporation
- IRS 501(3) (c) determination letter
- CPA management letter
- Personnel Policy
- Discrimination Policy/Affirmation Action Plan

Existing Provider Applicants

- New information *in the case of any changes* relative to information required of new applicants

INSTRUCTION FOR COMPLETING THE CSS HOP APPLICATION

PLEASE TYPE OR PRINT AII INFORMATION EXCEPT SIGNATURE

I. IDENTIFYING INFORMATION

1. **Legal Name of Applicant: Enter your full legal name.** Except for Sole Proprietor applicants, the legal name must match the legal name attached to your Federal Tax ID Number.
2. **Federal Tax Identification Number:** Please enter your Employer Identification Number (EIN) if you are required to have an EIN by the Internal Revenue Service Instructions for Employer Identification Number.
3. **Doing Business As (dba),** if applicable: If your agency or business uses a name that is different from your legal name, please enter.
4. **Sites Doing Business in This Service Area:** Please enter the following for the locations where you do business:
    - Administrator/Director
    - Street
    - City, State, and Zip Code
    - Area Code and Phone Number
    - FAX number. If available, where materials can be FAXED to you
    - E-Mail Address
    - Intake/scheduler (if applicable)
5. **Medicare Certified Home Health Agency?** Please check “yes” if your agency is Medicare certified. Or “no” if you are not. If you checked “yes”, Please enter your Provider Number.
6. **Medicaid Certified Home Health Agency?** Please check “yes” if your agency is Medicaid certified, or “no” if you are not. If you checked “yes”, Please enter your Provider Number.
7. **PASSPORT/MyCare Ohio Certification?** Please check “yes” or “no”.
8. **Are employees bonded?** Please check “yes” or “no”.
9. **Days of Operation/ Hours of Operation**
10. **Accredited:** JCAHO, CHAPS, Other? Please check “yes” or “no”.
11. **Ownership**: Please check the option that best describes ownership of your business.
12. **Legal Structure**: Please check the option that best describes your legal structure.
13. **Name, Title, Address and Phone of Individual Authorized to Sign Provider Agreement.**

II. STATEMENT OF UNDERSTANDING

The signature, title and date indicate that the applicant attests to the statements to which the signature is attached.

III. APPLICATION ATTACHMENTS

Submit only if new provider or if change in ownership since last application. Please mark each attachment with the Item Number and Submit with Application.

14. The **Item Numbers** refer to the Conditions of Participation that require the material to be submitted.
15. The **Description** refers to the material that must be included as an application attachment.
16. **Suggested Documentation** refers to the type of material that will fulfill the description in Item #15.

IV. SERVICES APPLYING TO PROVIDE

Type of Service: Homemaker Service, Personal Care Service, and Respite Service.
Service Delivery Area: **PLEASE INCLUDE ZIP CODES OF AREAS YOU WILL SERVICE**. It will be assumed you will provide service throughout the entire County if no areas are designated.
Rate: Enter your expected rate of reimbursement, for each service.

V. PROVIDER INFORMATION FORM

This form is intended to update information maintained and utilized by Clermont Senior Services staff for your agency. **Please keep in mind, especially with regard to Referrals for Service, this information may be critical to your agency's ability to receive and accept referrals, and to be awarded services.**

HOP APPLICATION FOR SERVICE PROVIDER CERTIFICATION

Contract Year 2026-2027

IDENTIFYING INFORMATION

1. Legal Name of Applicant:			2. Federal Tax ID #:
3. Doing Business As (d.b.a.) if applicable:			
4. Sites Doing business in this service area:			
	Site #1:	Site #2:	Site #3:
Admin./Director:			
Street Address:			
City, State and Zip:			
Phone Number:			
Fax Number:			
Email address:			
Intake/Scheduler:			

5. Medicare Home Health Agency? ☐ Yes Provider #: ☐ No ☐ N/A

6. Medicaid Home Health Agency? ☐ Yes Provider #: ☐ No ☐ N/A

7. Current Passport Provider? ☐ Yes Provider #: ☐ No ☐ N/A

8. Are employees bonded? ☐ Yes ☐ No

9. Days of Operation? ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

Hours of Operation?

10. Accredited?
JCAHO ☐ Yes ☐ No ☐ N/A
CHAPS ☐ Yes ☐ No ☐ N/A
OTHER ☐ Yes ☐ No ☐ N/A Name:

11. Ownership: ☐ Private ☐ Private/Non-Profit ☐ Public/Government ☐ Charitable/Religious ☐ Publicly Traded ☐ Other

12. Legal Structure ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Non-Profit Corporation ☐ Voluntary Corporation ☐ S Corporation

13. Name, Title, Address, and Phone # of individual authorized to sign Provider Agreement:

Name: Title:

Address: Phone #:

STATEMENT OF UNDERSTANDING

The applicant affirms that the information contained in this application is true to the best of their knowledge and belief. The applicant assures that it currently provides the services for which it is applying. The applicant also affirms that the Conditions of Participation and all applicable Service Specifications have been read and are understood. The undersigned further understands that implementation of and adherence to the Conditions of Participation and Service Specifications in the delivery of authorized services will be binding in accordance with the provider agreement in order to receive reimbursement for services delivered and to maintain provider certification.

Signature:	**Title:**
Printed Name:	**Date:**

APPLICATION ATTACHMENTS

Every application must include copies of **each** of the following items as attachments to the application submitted to Clermont Senior Services. These items shall be marked with the application attachment number. The item numbers refer to the Conditions of Participation. **Attachments required only if new provider or if change in ownership since last application.**

14. **ITEM #**	15. **DESCRIPTION**	16. **SUGGESTED DOCUMENTATION**
COP 1.1	Statement of ownership.	A list of all persons with 5% or more ownership.
COP 1.1	List of the names and addresses of the governing body.	**Not applicable to individual owner/operator** Board of Directors roster.
COP 1.2	Statement of purpose/description of specific services provided.	Corporations: As stated in Articles of Incorporation Others: Description of programs or services offered.
COP 1.3	Table of organization (T.O.) identifying lines of administrative, advisory, contractual and supervisory authority to the direct care level.	**Not applicable to individual owner/operator.** Printed or written table of organization. Corporations & multi-location business T.O. must show placement of corporate and regional offices. T.O. must clearly show placement of the services to be provided for HOP.

CLERMONT COUNTY HOME OPTIONS PROGRAM
RATE SHEET FOR 2026-2027

TYPE OF SERVICE	SERVICE DELIVERY AREA Be specific with zip codes	REQUESTED RATE
Homemaker Services		**/hour**
Personal Care Services		**/hour**
Respite Services		**/hour**

Clermont Senior Services, Inc.

Provider Information Form (PIF)

THIS FORM IS INTENDED TO UPDATE INFORMATION MAINTAINED AND UTILIZED BY CLERMONT SENIOR SERVICES, INC. STAFF FOR YOUR AGENCY. Please keep in mind, especially with regard to Referrals for Service, this information may be critical to your agency's ability to receive and accept referrals and be awarded services. **Report all changes to eschacht@clermontseniors.com**

Legal Name:	
Doing Business As (DBA):	
Main Office Street Address:	**Primary Business Phone:**
Main Office City, State, Zip:	**Primary Business Fax:**
Agency Website:	

ADMINISTATOR	
Name & Title:	**Phone #:**
E-Mail:	Fax #:

REFERRALS	
Name & Title:	**Phone #:**
E-Mail:	**Fax #:**

SCHEDULING	
Name & Title:	**Phone #:**
E-Mail:	Fax #:

BILLING	
Name & Title:	**Phone #:**
E-Mail:	**Fax #:**

AUDIT CONTACT (Individual Authorized to Set-Up/Oversee Audit)	
Name & Title:	**Phone #:**
E-Mail:	**Fax #:**

PROBLEM RESOLUTIONS	
Name & Title:	**Phone #:**
E-Mail:	**Fax #:**

Notes: