APPLICATION FOR NAHC PRIVATE DUTY HOME CARE CERTIFICATION AND ATTESTATION

AGENCY CORPORATE NAME

D/B/A (IF ANY)

ADDRESS

FEDERAL TAX ID # STATE UNEMPLOYMENT TAX ID #

PHONE

WEBSITE (IF APPLICABLE)

By signing below, I hereby certify that, to the best of my knowledge and belief and after a diligent and comprehensive review, all information provided in this application is accurate. In addition, based on my review of this application, my knowledge of the agency and inquiry of staff of the agency, this organization is in compliance with all of required standards, and the documentation provided in support of this application are true, correct, & complete & will remain in full compliance throughout any period of certification. I understand The National Association for Home Care & Hospice (NAHC) relies on the truthfulness of this certification in granting certification, and that any falsification or inaccuracy in the information provided may be grounds for revocation of the certification and associated benefits. I further agree if for any reason my organization ceases to be certified by the NAHC Private Duty Home Care Program, I will immediately cease use of the NAHC Private Duty Home Care Program name and/or logo in any format.

NAME OF OFFICER OR DIRECTOR

TITLE

EMAIL

ATTESTATION & APPLICATION SIGNATURE DATE