BCAT Certified Organization Levels for Home Care

Initial Application Form

Mansbach Health Tools, LLC (MHT) provides a pathway for providers of Home Care services to achieve excellence and mastery in the provision of memory care to their clients using the BCAT Approach. MHT recognizes three certification levels:

- *Bronze* – a commitment to quality and integration of the BCAT Approach to memory care
- *Silver* – demonstrated excellence in applying the BCAT Approach to memory care
- *Gold* – demonstrated mastery in applying the BCAT Approach to memory care

To apply for a BCAT Certified level: 1. Complete this application on a computer as it is a fillable pdf form. 2. Submit it to Kristen Clark at Mansbach Health Tools, LLC at kclark@thebcat.com. It can also be mailed to Kristen at: 7067 Columbia Gateway Drive Suite 180 Columbia, MD 21046.

Section I: IDENTIFYING INFORMATION

Name of Organization: ____

Address: ____

Phone: ______________________________________ Fax: ______________________________

Website: ____

Names of Primary Officers:

Name	Title	Email	Phone(s)

Please provide the contact information of the *primary* person who will be working directly with MHT on certification.

Name: ____ Title: __________________

Email: ____ Phone: ________________

SECTION II: BCAT CERTIFICATION LEVEL

Indicate which certificate level you are applying for:

Bronze Silver Gold

SECTION III: BACKGROUND OF THE ORGANIZATION

1. Please check the box which indicates the number of years the organization has been providing Home Care services.

	<5 years		6 – 10 years		11 – 15 years		15+ years

2. Please check the box(es) which indicate the services the organization provides.

Companion Services	Personal/ADL Care	Housekeeping/ Laundry	Transportation
Hospice	Skilled Nursing	Skilled Physical Therapy	Skilled Occupational Therapy
Skilled Speech Therapy	Restorative Nursing	Restorative PT/OT/SLP	Medical Social Work Services
Other (Please describe):			

3. Please check the box(es) that indicate the employment status of your staff. Additionally, please select the box that identifies the total number in each category. If you select both employees and contractors, please explain below.

Status	**<20**	**20-99**	**100-249**	**250-999**	**1000-2499**	**2500-4999**	**≥5000**
Full-time Employees							
Part-time Employees							
1099 Contractors							
Description of Employment Status:							

4. Please indicate the geographic area(s) in which your organization provides care.

   ____

5. Please identify the pre-hire expectations the organization has for employees by checking the appropriate box(es):

Initial Interview	Second Interview
Require Resume	Require Letters of Recommendation
National Criminal Background Check	Other: ___________________________________

6. Please check the box(es) to indicate the payer groups the organization serves.

Private Pay	Commercial Insurance	Medicare	Medicaid
Long-Term Care Insurance	Veterans (VA)		
Other (Please describe):			

7. If your organization is Medicare and/or Medicaid certified, please indicate the year(s) when the initial certification was approved. Medicare: _______________ Medicaid: _________________

8. Is your organization licensed by the state?

Yes	Which one(s)?
No	

9. Please describe any other certifications the organization maintains. (e.g., NAHC, JCAHO)

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SECTION IV: QUALITY INDICATORS

1. Do you provide literature explaining your services to potential clients?

Yes	What literature?
No	

2. Do you furnish clients with a “Patient Bill of Rights” or similar document?

Yes	Which?
No	

3. Do you require specific qualifications, certifications, experience, or prior training before you hire staff?

Yes	Which one(s)?
No	

4. How do you train staff?

Internal In-person Group Courses	Self-Paced Reading Modules	External In-person Group Courses	Digital Classes
Internet Courses	Internal One to One Courses	External One to One Courses	Hands On Demonstration
Other (Please describe):			

5. How many hours of training do you provide *before* staff begin working with clients?

    ____

6. How many hours of annual training are required of staff as part of their ongoing education?

    ____

7. Do you have an Employee Manual or written policies and procedures shared with staff?

Yes	Explain how it's provided:
No	

8. Are your staff bonded or insured?

Yes	Company or Employee Provided?
No	

9. Do you conduct a home visit before starting care in the home?

Yes	Who conducts the visit?
No	

10. Are nurses or therapists required to evaluate client's needs prior to care?

Yes	Explain:
No	

11. Do nurses or therapists consult with clients' physicians and healthcare providers?

Yes	Explain:
No	

12. Do nurses or therapists routinely consult with family members?

Yes	Explain:
No	

13. Do you include the client/family in developing the plan of care?

Yes	Explain:
No	

14. Is the client's course of treatment or care documented and updated, detailing specific tasks to be carried out by all staff who participate in care?

Yes	Explain:
No	

15. Do you educate family members regarding the care you provide?

Yes	Explain:
No	

16. Do staff directly involved in care have an assigned supervisor?

Yes	How is one assigned?
No	

17. How do you resolve and follow-up disagreements, complaints, and disputes with the client and family?

18. How do you ensure client confidentiality?

19. Are you currently using memory or cognitive screening tools or tests? If yes, please provide detail.

Yes	Explain:
No	

20. Are you currently using memory or cognitive enhancing activities? If yes, please provide detail.

Yes	Explain:
No	

SECTION V: ACKNOWLEDGEMENTS

By signing below, I certify the responses in this application are true and accurately represent the actual policies, procedures, and practices in the organization.

Print Name: ____ Date:__________________________

Signature: ____ Title: __________________________

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MHT reviews applications on a rolling basis (first come, first serve). We are currently able to review and respond to applications within 30-days of receiving submissions.