Benevilla

C.A.R.E.S. Preferred Partners

Partnership Application

Company Information

Company Name: _____ Years in Service: _____

Address: _____
Street Address

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Category for application:

☐Fiduciary ☐Geriatric Management ☐Hospice ☐Home Care ☐Placement ☐Memory/SNF ☐AL/IL ☐Home Health

How did you hear about the partnership? _____

Who Do We Contact? (can be same person)

Referrals/Communication:

Name: _____ Title: _____

Email: _____ Phone: _____

Billing/Invoices:

Name: _____ Title: _____

Email: _____ Phone: _____

Marketing/Promotions:

Name: _____ Title: _____

Email: _____ Phone: _____

References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Partnership Questions

1. What interests you most about the Preferred Partners Program?

2. Do you currently have a relationship with Benevilla or other non-profit organizations?

3. Please provide us with your organization's Mission, Vision, and Core Values.

4. (Facilities and Hospice Only) Please attach your organization's most recent state survey. (Must be no older than 3 years)

5. Is your company a part of any other partnership/memberships?

6. Please explain in detail how your organization is giving back to the community in terms of education, volunteering, assistance, or support?

7. How does your organization encourage diversity, inclusivity, and cultural awareness?

8. Do you require your staff to have a Level 1 fingerprint clearance card?

☐Yes ☐ No Explain:

9. What do you feel your organization can bring to the partnership and what do you think sets you apart from others in your category?

10. On a scale of 1-10 (1=minimal participation and 10= maximum participation), If approved for the partnership how would you gage your level of anticipated participation in the partnership program? Ex: attending monthly partner meetings, responding to communications and event participation.

11. (Non-Medical Home Care Only) Are you a current member of the Arizona In Home Care Association (AZNHA)?

12. How does your organization address complaints or concerns regarding services provided or quality of care?

13. Please provide us a detailed example of how your company provides person-centered care.

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to program acceptance, I fully understand that false or misleading information in my application may result in removal from the program with no refund.

Signature: _____ Date: _____