**Application form to become an Approved Provider of Care for Edinburgh Health and Social Care Partnership**

**SECTION A - GENERAL INFORMATION**

**A.1** Full name, address and website of the organisation applying to be included on the Approved Providers List:

|  |  |
| --- | --- |
| Company Name |  |
| Address |  |
| Town / City |  |
| Postcode |  |
| Website |  |

**A.2** Name, position, telephone number and email address of the main contact for this organisation:

|  |  |
| --- | --- |
| Name |  |
| Position |  |
| Telephone Number |  |
| Email |  |

**A.3** Current legal status of the organisation and any registration numbers if applicable:

|  |  |
| --- | --- |
| Type of Organisation |  |
| Company Number |  |
| Charity Number |  |
| Other |  |
| VAT registration number |  |

**A.4** Size of your organisation; if you are a National organisation, please complete for your Edinburgh office. If you do not have provision currently in Edinburgh please complete field detailing provision outside of Edinburgh.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of FTE Staff Employed |  | No of carers: |  | No of non care staff |  |
| What is the current volume of service delivery in Edinburgh |  |
| If provision is outside Edinburgh please detail location(s) and volume of provision | Location(s) |  | Volume |  |

**A.5** What client group do you provide care services for? (Please tick/detail all that apply)

|  |  |
| --- | --- |
| Older Adults (65 yrs or over)  |  |
| Adults (under 65 yrs) |  |
| Client Group Specialism if any – please specify |  |

**A6**  What geographical area do you plan to provide support in? (Please tick all that apply)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **North East** |  | **North West** |  | **South East** |  | **South West** |  | **City-wide** |  |
| Older Adults (65 yrs or over)  |  | Older Adults (65 yrs or over)  |  | Older Adults (65 yrs or over)  |  | Older Adults (65 yrs or over)  |  | Older Adults (65 yrs or over)  |  |
| Adults (under 65 yrs) |  | Adults (under 65 yrs) |  | Adults (under 65 yrs) |  | Adults (under 65 yrs) |  | Adults (under 65 yrs) |  |

**SECTION B – TECHNICAL AND PROFESSIONAL INFORMATION**

**B.1** Please provide Care Inspectorate (CI) registration numbers for service provision. (*Organisations offering personal care must have such services appropriately registered with the Care Inspectorate)*.

|  |  |
| --- | --- |
| CI Registration Name and Number for all **Edinburgh based service** care services  |  |
| Date(s) of most recent inspection of Edinburgh based care services |  | CI Grades |  |

Where an Edinburgh Based service is yet to be inspected by the Care Inspectorate a reference should be provided reflecting the Organisation’s ability to provide a Care service to an acceptable standard - this may be from an existing or previous Commissioning Authority. Where the service is in receipt of a Care Inspectorate Grade 2 or less any application linked to that registration will not be progressed as that service will not meet the required quality standards.

For Organisations whose services are registered with the Care Inspectorate but provide a service outside of Edinburgh you should submit a separate sheet detailing dates of inspections and grades. Similarly, where/if provision is based in England you should submit detail of all Care Quality Commission ratings which were achieved and dates of most recent inspections.

**B.2** Have the owners/directors/senior staff of your organisation ever held similar roles within any previous care provision organisations. Please detail below

|  |  |  |
| --- | --- | --- |
|  | **Name** | **Similar roles (if any) held within other organisations to include name of previous organisation, role type, duration role held for, Care Inspectorate Grades (or CQC ratings) at time of involvement. (should cover up to the last 5 years)** |
| Owner (s) |  |  |
| Director (s) |  |  |
| Registered manager |  |  |

**B.2(i)** Has the owner or any member of its supervisory/management body:

- been the subject of a conviction by final judgement within the last five years? Please detail

- been the subject of bankruptcy or insolvency proceedings. Please detail

**B.3** Please provide details of the Insurances held by your organisation

|  |  |
| --- | --- |
| **Type of Insurance** | **Level of Cover £** |
| Public Liability (minimum £5m) |  |
| Employers’ Liability (minimum £10m) |  |
| Professional Indemnity (Please indicate level) |  |

**B.4** The following policies/procedures are an essential requirement for Approved Providers. Please confirm they are currently in place

|  |  |
| --- | --- |
| **Policy / Procedure** |  **(Y/N)** |
| Medication Policy |  |
| Recruitment & Selection  |  |
| Adult Support & Protection |  |
| Procedure relating to No Entry/Access to client’s home |  |
| Business Continuity / Emergency Plan |  |
| Data Protection  |  |
| Complaints Handling Procedure |  |
| Manual Handling |  |

**B.5** Care Staff

|  |  |
| --- | --- |
| **Staff Employment Terms and Conditions** | **Y/ N** |
| Are Contract employment terms of staff inclusive of options for *both* Guaranteed contracted hours and Zero contracted hours where the staff member has option to choose |  |
| Are all carers currently members of the PVG Scheme which is managed by Disclosure Scotland  |  |

**SECTION C – FINANCIAL INFORMATION**

**C.1** Please submit audited accounts covering the last three years OR reasons why there are no available accounts eg start-up company

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Confirm accounts attached | **YES**  |  | **NO** |  |
| Reasons why accounts are unavailable |  |

**C.2**Hourly rate

|  |  |
| --- | --- |
| What is your proposed hourly rate  | £ |
| Any additional comments: |

**C.3** Scottish Living Wage

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please confirm you are a Scottish Living Wage employer (Please Tick) | YES |  | NO |  |

**SECTION D – DECLARATION**

|  |
| --- |
| When you have completed the application, please read and sign the section below. |
| I/We certify that the information supplied is accurate to the best of my/our knowledge and I/we understand that false information could result in my/our exclusion from further consideration.I/We hereby apply for inclusion on the Approved Provider List (APL) and am/are prepared to answer any questions or supply any additional information as requested.I/We understand that if successful we will follow appropriate policies and procedures and comply with Edinburgh Health and Social Care Partnership’s monitoring requirements.I/We understand that being awarded APL status is not intended to be and shall not constitute a recommendation or award for services by Edinburgh Health and Social Care Partnership.I/We understand that inclusion on the APL does not guarantee any business through Edinburgh Health and Social Care Partnership Signed:For and on behalf of:Date: |
| The undertaking should be signed by the partner/director in his/her own name and on behalf of the organisation. |

**Data Retention and Storage**

The Council retains information and manages records in line with its Data Retention Schedule and Records Management Policy. This ensures information is not held unnecessarily and also ensures compliance with legislation and best practice, including the Freedom of Information (Scotland) Act 2002 and the Data Protection Act 1998 in addition to any relevant EU regulations such as General Data Protection Regulation 2018 (GDPR).