HEALTHTRUST
Workforce Solutions

Community Liaison Tier 2

Name: _____

Community Liaisons are not permitted to provide hands-on care to any patients.*

Description
I request to provide services that require access to a patient care areas. The services I provide may have indirect impact on patients which may require supervision from a member of the clinical staff of the facility (i.e. Case Management) during any service at the facility. The services provided may also include contact with the patient or patient's representative. Services I am requesting to provide include the following (*Check all that are being requested*): ☐ Deliver marketing materials to a patient care setting ☐ Explain about facility/agency services and expectations with the patient which may also include the patient's family ☐ Assess patient's eligibility, which may require access to patient's chart

Please select your type of company:

	Hospice		Long-term Acute Care
	Long-term Nursing		Home Services
	Rehab		Skilled Nursing Facility

I am requesting approval to provide services in the following patient care area(s).
You may add other areas once you begin the credentialing process.
Areas are not tied to the Tier

	Rehabilitation Unit
	Intensive Care Unit
	Emergency Department
	Hospice

NOTE: Education is highest level of completed academic education. This should be confirmed on your background check.
By signing below, I attest that at no time I am involved with discharge planning.

Applicant Signature:_____ **Date:** _____

Company Name: _____

5-15-18