# AREA AGENCY ON AGING OF NORTHWEST MICHIGAN

**Michigan Department of Health and Human Services**

MI Choice Waiver, Care Management and Caregiver Respite Program

## FY 2021/FY 2022

## Provider Purchase of Service Agreement Face Sheet

**Date Completed: _____**

**Provider Name: _____ Provider No.: _____**

**EIN #: _____ NPI #: _____ SSN#: _____**
*(Enter all that apply)*

**Physical Address:** **Street Address: _____**

**City: _____ State: ____ Zip +4: _____**

**Mailing Address:** **Street Address: _____**
*(If different)*

**City: _____ State: ____ Zip +4: _____**

**Owner/Director:** **Name: _____**

**Contact #: _____ Email: _____**

**Manager/Supervisor:** **Name: _____**

**Contact #: _____ Email: _____**

**Referrals / Scheduling:** **Name(s):_____**

**Contact #: _____ Email: _____**

**Fax: _____**

**Additional Emails to be copied on Program/ Management Issues:**

**Additional Emails to be copied on Weekly Scheduling Email: (Does not apply to AFC homes)**

**Additional Contact Information (Optional): _____**

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