Area Agency on Aging of Northwest Michigan
Dignity. Independence. Choice.

PROVIDER NETWORK
PURCHASE OF SERVICE AGREEMENT
APPLICATION

1. Legal Name of Applicant _____

   Doing Business As, if applicable _____
2. Federal Tax ID Number _____
3. NPI Number (if used) _____
4. Business Address

   Name: _____

   Street: _____

   City, State, Zip: _____

   Phone #: _____

   Fax #: _____

   Email: _____

   Website: _____

   Mailing Address (if different than physical address):

   _____
5. Which of the following insurances does your agency carry? *(check applicable boxes)*

   A. General Liability ☐
   B. Facility/Property Insurance ☐
   C. No-Fault Auto Insurance ☐
   D. Professional Liability ☐
   E. Malpractice ☐
   F. Workers' Compensation ☐
   G. Unemployment Insurance ☐
   H. Fidelity Bonding ☐
   I. Cyber Security ☐
   J. Other _____

   At the time of agreement, applicants will be required to provide Certificates of Insurance listing AAANM as "Certificate Holder" and/or as Additional Insured.
6. Provider for another MI Choice Waiver program? Yes ☐ No ☐

   If yes, please indicate which agency/agencies:

   _____
7. Michigan Medicaid Provider Agreement/CHAMPS? Yes ☐ No ☐

   Provider ID# _____
8. Medicare Certified Home Health Agency? Yes ☐ No ☐

9. Ownership (check appropriate category)

   Private- For Profit ☐ Public/Government ☐

   Private- Non Profit ☐ Other (describe) ☐ _____

10. Legal Structure (check appropriate category)

    Sole Proprietorship ☐ Partnership ☐ Corporation ☐

    Corporation Type: LLC ☐ S Corp ☐ C Corp ☐ Non-Profit ☐

11. Minority Owned and/or Operated Yes ☐ No ☐

12. Services interested in providing for AAANM MI Choice Waiver and/or Health Services/Bureau of Aging Community Living & Supports (ACLS) programs:

    _____

    _____

13. If providing In-Home Care (Community Living Supports and/or Respite Care), do you utilize Electronic Visit Verification (EVV)? Yes ☐ No ☐

14. Provider services clients: 18+ years of age ☐ 60+ years of age ☐

15. Staffing available (check all that apply):

    Weekdays ☐ Evenings ☐ Weekends ☐ Holidays ☐

16. Counties service coverage will be available:

    Antrim ☐ Gr Traverse ☐ Manistee ☐

    Benzie ☐ Kalkaska ☐ Missaukee ☐

    Charlevoix ☐ Leelanau ☐ Wexford ☐

    Emmet ☐

17. Service Provision Experience _____ Years or _____ Months

18. Key Personnel:

    A. CEO/President _____

       Phone _____ Email_____

    B. Administrator/Manager _____

       Phone _____ Email_____

    C. Service Referral Contact (with title) _____

       Phone _____ Email_____

    D. Agreement Contact (with title) _____

       Phone _____ Email_____

19. Persons providing service will be:

    Applicant (individual) ☐ Agency Employees ☐ Sub-contractor(s) ☐

    Note: If subcontractors are used, AAANM will require a copy of the subcontract for review prior to issuing a purchase of service agreement.

20. Please attach/submit the following documents:
    A. Statement of purpose and/or description of services provided
    B. Promotional materials for agency/business (brochures, annual reports, etc.)
    C. Organizational Chart
    D. Licenses or certificates of personnel, business
    E. Insurance verifications (see #5)
    F. References that relate directly to the services being proposed.
    G. Please indicate policies/procedures that are available upon request:

☐	Client confidentiality	☐	Personnel orientation & training
☐	Client grievances & appeals	☐	Personnel supervision & evaluation
☐	Client feedback/evaluation	☐	Personnel background checks
☐	Emergency procedures	☐	Medication administration

Statement of Understanding

The applicant affirms that the information contained in this application is true to the best of their knowledge. The applicant assures that their agency currently provides the services for which it is proposing. The Applicant also affirms that they are aware of the applicable service standards and that services are required to be provided in compliance with the applicable standards.

_____
Signature of Authorized Individual

_____
Title

_____
Date

_____ _____
Telephone Number Email Address