REGION IV
Area Agency on Aging, Inc.
SPECIALISTS IN AGING

PROVIDER DEMOGRAPHICS & RATES

Provider Legal Name: _____

d/b/a (if applicable):_____

EIN:_____

NPI:_____

Corporate Address:_____ City/State/Zip Code +4:_____

Local Address (if different from above):_____

Administrator Contact: _____

Title:_____

E-Mail:_____

Phone:_____

Fax:_____

Scheduling Contact: _____

E-Mail:_____

Phone:_____

Fax:_____

Billing Contact: _____

E-Mail:_____

Phone:_____

Fax:_____

Type of Business (check one): ☐Public ☐Private Non-Profit ☐Private for Profit
Tax Status (check one): ☐Sole Proprietor ☐Partnership ☐Corporation
Minority Owned: ☐Yes ☐No
Number of years in business (must be in business for a minimum of one year): ___
Number of staff: Admin: ___ Clerical:___ Direct Service Workers:___
Persons providing service will be (check all that apply): ☐Applicant Only ☐Employees ☐Subcontractors
Service Area (check all that apply): ☐Berrien ☐Cass ☐Van Buren
Are you a provider for another AAA region? ☐Yes ☐No If yes, list region(s):_____
Check the priority service levels you are willing to accept:

☐ **Priority 1A*** - Provider MUST provide back-up workers if regularly scheduled worker(s) not available
☐ **Priority 1B* -** Provider MUST assist participant in activating their Back-Up Plan if unable to provide worker(s) as scheduled
☐ **Priority 1C* -** AFC/HFA MUST provide back-up workers if regularly scheduled worker(s) not available

SERVICE & RATE INFORMATION FOR (Provider Name): _____

Service (Indicate the services to be provided)	Unit Rate	Capacity (units per week)
☐Adult Day Health	Full Day w/o Trans.: _____ Full Day w/ Trans.: _____ Half Day w/o Trans.: _____ Half Day w/ Trans.: _____	_____ _____ _____ _____
☐Chore Services **	Per ¼ Hour: _____ Per Service (if applicable): Case-by-Case	_____ _____
☐Community Health Worker **	Per ¼ Hour: _____	_____
☐Community Living Supports/Personal Care (In-Home) **	Per ¼ Hour: _____	_____
☐Community Living Supports/Personal Care (AFC/HFA) **	Per Hour: _____	_____
☐Congregate Meals	Per Meal: _____	_____
☐Fiscal Intermediary Services	Initial Enrollment: _____ Monthly Fee: _____	_____
☐Home Delivered Meals **	Hot/Frozen: _____ Pureed: _____ Liquid: _____ Gluten Free/Renal: _____	_____ _____ _____ _____
☐Home Modifications/Repairs	Per Service: Case-by-Case	_____
☐Homemaker Services **	Per ¼ Hour: _____	_____
☐Community Transportation (Transportation Company)	Per Ride: Case-by-Case	_____
☐Community Transportation (In-Home Agency)	Per Mile: $ .50 Per Hour: CLS Rate	_____
☐Nursing Services/Medication Mgmt. **	LPN Per ¼ Hour: _____ RN Per ¼ Hour: _____	_____ _____
☐Personal Emergency Response Systems (Monthly Charges) **	Install: No Charge 1st Button: _____ 2nd Button: _____ Cellular: _____ Landline: _____	_____

	Satellite: _____ Fall Detection Pendant: _____	
☐Private Duty Nursing **	LPN Per ¼ Hour: _____ RN Per ¼ Hour: _____	_____
☐Respite (In-Home) **	Per ¼ Hour: _____	_____
☐Respite (Out-of-Home) **	Per Diem: _____	_____

*See Minimum Operating Standards for MI Choice Services for detailed explanation of Service Level Needs

**Providers of these services must comply with the In-Service Training requirements per the MDHHS Minimum Operating Standards for MI Choice Services.

Provider Signature: _____ **Date:** _____

Region IV AAA Approval: _____ **Date:** _____

Region IV AAA Rate Effective Date: _____