APPLICANT INFORMATION	
PROVIDER NAME	EIN OR SOCIAL SECURITY NUMBER
PHONE	EMAIL
This business is: 1. ☐ Sole Proprietor ☐ For Profit Corporation ☐Non-Profit Corporation ☐ Non-Profit 501c(3) ☐ Partnership ☐ Government	

BUSINESS LOCATION	
1. MAILING ADDRESS (NO. & STREET)	P.O. BOX
CITY	STATE ZIP CODE

OWNERSHIP INFORMATION - This is Required if a Corporation or Business (list the individual owners/Use additional sheet if necessary)

Owner's Name	Date of Ownership	% Owned	Owner's Social Security No.
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IMPORTANT: FACSIMILE SIGNATURES WILL NOT BE ACCEPTED – PLEASE MAIL FORM TO REGION IV AAA

Owner/Administrator Signature	Date	Business or individual Criminal Convictions relating to Titles XVIII, XIX, or XX? ☐ No ☐ Yes
Name (PRINT)	Title:	

MEDICAL ASSISTANCE (MEDICAID) PROVIDER PAYMENT AGREEMENT CONDITIONS

1. All information furnished on this payment agreement form is true and complete.
2. I consent that, upon request and a reasonable time and place, I will permit authorized agents of the State of Michigan or the federal government to inspect, and copy, and records related to my delivery of goods or services to, or on behalf of, a participant under the Medicaid Program.
3. I am not currently suspended, terminated, or excluded from any state Medicaid Program or by the U.S. Department of Health and Human Services.
4. I agree to accept the Michigan Medicaid payment from Region IV Area Agency on Aging as payment in full for the services rendered. I will not seek nor accept additional or supplemental payment from the participant, his/her family, or representative(s).
5. I may be prosecuted under applicable federal or state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data, other acts of misrepresentation, or conspiracy engaged therein.

6. I agree to comply with the MDCH's policies and procedures for the Home and Community Based Services for the Elderly and Disabled contained in manuals, manual updates, provider bulletins, and other program notifications.

As a condition of receiving payment from the Michigan Medicaid Program for services provided to an eligible participant, I certify and/or agree to all of the conditions listed above. I certify that the above signatory has the authority to execute this agreement.

Replaces Form No. DCH-1625