INITIAL AGENCY CONTACT FORM

Instructions: Complete all information requested below and return with your application.

Application Type:

- ☐ Home Health Agency
- ☐ Emergency Response/Medication Dispenser System
- ☐ Personal Care Agency
- ☐ Fiscal Intermediary
- ☐ Adult Day Care
- ☐ Home Delivered Meals
- ☐ Assisted Living Facility
- ☐ Specialized Medical Equipment/Assistive Tech.
- ☐ Nursing Care Facility
- ☐ Environmental Adaptation
- ☐ Other:

Agency Information:

Full Agency Name:
Phone:
Physical Address: City: State: Zip:
Mailing Address: City: State: Zip:
Fax:
Agency Web Address:

Executive Director/Administrator (person authorized to sign contract):

Name: Phone: Extension:
Address: City: State: Zip:
Fax: Email Address:

Only indicate one case manager contact unless you have multiple sites

Case Manager: (person the case manager will contact to start services):

Name: Phone: Extension:
Address: City: State: Zip:
Fax: Email Address:

Case Manager: (person the case manager will contact to start services):

Name: Phone: Extension:
Address: City: State: Zip:
Fax: Email Address:

Billing Contact: (person who will complete provider billing spreadsheet(s):

Name: Phone: Extension:
Address: City: State: Zip:
Fax: Email Address:

Person completing this form:

Name: Phone: Extension:
Address: City: State: Zip:
Fax: Email Address:

Providers must take reasonable steps to ensure contact information is kept up to date and current at all times to ensure timely correspondence of billing, case manager referrals and correspondence regarding insurance and/or license requirements. Failing to update could result in contract termination, decrease in new client referrals and late or no payment.