AREA AGENCY ON AGING OF NORTHWEST MICHIGAN

Michigan Department of Health and Human Services

MI Choice Waiver & Bureau of Aging, Community Living & Supports Programs

FY 2023 - FY 2025
Provider Agreement Information Sheet

Provider Name: _____

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 Contacts & Information:

Date Completed: