MAP- 4100P (Rev. 01/2000)

PERSONAL CARE ASSISTANCE WAIVER SERVICES
PROVIDER INFORMATION AND SERVICES

PROVIDER NUMBER: ____________________

AGENCY NAME: ____________________

AGENCY ADDRESS: ____________________
STREET OR P.O. BOX
____
CITY, STATE, ZIP CODE

FROM THE FOLLOWING LIST, PLEASE CHECK EACH SERVICE FOR WHICH YOU WILL BE SUBMITTING CLAIMS:

1. ______ Case Management
(If this item is checked, this provider may bill for **no** other services)

2. ______ Personal Care Assistance/ *Business Agent Function
(*Payroll and accounting function for paying the personal care assistant)

3. ______ Personal Care Program Coordination

By signing below I, ______________________ (Authorized Representative), certify that this agency is capable of and agrees to comply with the conditions for participation established in the Personal Care Assistance Services Waiver and regulation 907 KAR 1:090. In addition, I certify that all staff shall meet all training requirements prior to the provision of services.

______________________ SIGNATURE OF AUTHORIZED REPRESENTATIVE / TITLE

______________________ DATE