Michigan Department of Community Health
Medical Assistance Home Help Provider Agreement

Instructions for Completing the Home Help Provider Agreement

SECTION 1: TO BE COMPLETED BY INDIVIDUAL HOME HELP PROVIDERS NOT AFFILIATED WITH AN AGENCY.

1. **HOME HELP PROVIDER NAME:** Enter the first, middle initial and last name of the Home Help provider applicant.
2. **PROVIDER SSN:** Enter the Social Security Number of the provider applicant.
3. **DATE OF BIRTH:** Enter the birth date of the provider applicant (MM/DD/YYYY).
4. **PROVIDER ADDRESS:** Enter the full street address of the provider applicant including street number, street, and, if applicable, apartment or lot number.
5. **TELEPHONE NUMBER & E-MAIL ADDRESS:** a. Enter the current telephone number, including area code, to reach the provider applicant. b. Enter the current e-mail address (optional).
6. **P.O. BOX NUMBER:** Enter the Post Office Box number (where applicable).
7. **CITY:** Enter the city where the provider applicant resides.
8. **STATE:** Enter the state where the provider applicant resides.
9. **ZIP CODE:** Enter the corresponding zip code for the provider applicant's address.

SECTION 2: TO BE COMPLETED BY AGENCIES PROVIDING HOME HELP SERVICES.

10. **AGENCY PROVIDER NAME:** Enter the complete name of the agency provider.
11. **TAX ID NUMBER:** Enter the IRS Tax ID number for the agency.
12. **AGENCY PROVIDER ADDRESS:** Enter the full street address of the agency, including street number, street, and, if applicable, suite or unit number.
13. **AGENCY TELEPHONE NUMBER:** Enter the phone number where the authorized representative of the provider agency can be reached.
14. **P.O. BOX NUMBER:** Enter the Post Office Box number (where applicable).
15. **CITY:** Enter the city where agency provider is located.
16. **STATE:** Enter the state where agency provider is located.
17. **ZIP CODE:** Enter the corresponding zip code for agency provider's address.
18. **CONTACT PERSON & E-MAIL ADDRESS:** a. Enter the name of the agency owner or other authorized representative. b. Enter the current e-mail address (optional).
19. **OWNER NAME(S):** Enter the name(s) of any person owning at least a 5% share of the provider agency. (Attach additional pages if needed.)

SECTION 3: TO BE COMPLETED BY BOTH INDIVIDUAL AND AGENCY PROVIDERS.

20. The provider applicant must provide proper disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (Title XIX) and other State Health Care Programs (Title V, Title XX, and Title XXI). Proper disclosure includes i.e., nature of the crime, court where the conviction was entered, date the conviction was recorded, and date the sentence was completed.
21. Home Help Provider Applicant must re-enter the Individual applicant's Social Security Number or the IRS Tax ID number for the agency.
22. The Home Help Provider Applicant must indicate by checking the appropriate box, if they are in agreement with the terms and conditions of the application. All Agreements must be signed.

Michigan Department of Community Health

Medical Assistance Home Help Provider Agreement

(FOR OFFICIAL USE ONLY)	
PROVIDER ID NUMBER	PROVIDER TYPE 01

SECTION 1 (INDIVIDUAL PROVIDERS ONLY)

As an individual provider of Home Help services, I agree that the beneficiary is considered the employer. I will not be employed by the Department of Community Health (DCH), the Department of Human Services (DHS), or the State of Michigan.

1. INDIVIDUAL HOME HELP PROVIDER NAME (FIRST, MI, LAST)	2. PROVIDER SSN (Required) - -	3. DATE OF BIRTH / /
4. PROVIDER ADDRESS (NO. AND STREET, APARTMENT OR LOT NO)	5. A. TELEPHONE NUMBER ( ) -	5. B. E-MAIL ADDRESS (optional)
6. P.O. BOX NO.	7. CITY	8. STATE / 9. ZIP CODE

SECTION 2 (AGENCY PROVIDERS ONLY)

As a Home Help provider agency, I agree that the agency contract is with the beneficiary. The agency contract is not with the Department of Community Health (DCH), the Department of Human Services (DHS), or the State of Michigan.

10. AGENCY PROVIDER NAME		11. TAX ID NO. (Required for Agencies)	
12. AGENCY PROVIDER ADDRESS (NO. AND STREET, SUITE NO)		13. AGENCY TELEPHONE NUMBER ( ) -	
14. P.O. BOX NO.	15. CITY	16. STATE	17. ZIP CODE
18. A. CONTACT PERSON (AGENCY OWNER OR AUTHORIZED REPRESENTATIVE)		18. B. E-MAIL ADDRESS (optional)	
19. A. OWNER NAME(S):	EFFECTIVE	% OWNED	OWNER SSN - -
B. OWNER NAME	EFFECTIVE	% OWNED	OWNER SSN - -
C. OWNER NAME	EFFECTIVE	% OWNED	OWNER SSN - -

SECTION 3 (TO BE COMPLETED BY *BOTH* INDIVIDUAL AND AGENCY PROVIDERS)

20. HAVE YOU OR ANY OF YOUR EMPLOYEES BEEN CONVICTED OF A CRIME PROHIBITING YOU FROM RECEIVING PAYMENTS FROM FEDERAL OR STATE FUNDS? ☐ NO ☐ YES - If YES, attach explanation on a separate sheet.

- I agree that personal care services will be provided for a Michigan Medicaid beneficiary, as authorized by the Michigan Department of Human Services (DHS) according to the DHS Adult Services Comprehensive Assessment.
- In order to receive payment, I agree to keep and submit to DCH, DHS or their designee, any and all records necessary to disclose the extent of services provided to the client.
- Under Section 3504 of the Internal Revenue Code, I agree to accept the Michigan Department of Community Health (DCH) as the acting agent of the beneficiary for the deduction of withholding taxes and union dues. I further agree to accept payments issued by DCH as payment in full and not to seek or accept additional payments from the beneficiary or any other source. I agree to return any payments received for Home Help services not provided.
- Upon request, I agree to provide DCH, DHS or their designee, any information regarding services or purchases for which payment was made.
- I agree to cooperate with DCH, DHS, or their designee, regarding any audits, investigations or inquiries related to Home Help services provided.

Michigan Department of Community Health
Medical Assistance Home Help Provider Agreement

21.	PROVIDER SSN (Required for Individuals) – –
	TAX ID NO. (Required for Agencies)

SECTION 3 (TO BE COMPLETED BY *BOTH* INDIVIDUAL AND AGENCY PROVIDERS) - *continued.*

- I agree to comply with the privacy, security and confidentiality provisions of all applicable laws governing the use and disclosure of protected health information (PHI), including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR parts 106 and 164, Subparts A, C, and E).

- I agree to comply with the provisions of 42 CFR 431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the Medical Assistance Program is allowed.

By signing the Provider Agreement, I acknowledge that I have read the Provider Agreement, and the included instructions. I agree to fully comply with all program requirements.

23. ☐ Individual Home Help Provider	**OR** ☐ Authorized Home Help Agency Representative	
SIGNATURE		DATE

By virtue of the signature date on this form, it is understood that this document supersedes all previous versions (paper and electronic) of this form.

AUTHORITY: P.A. 280 of 1939, as amended.
COMPLETION: Required.
PENALTY: Application may not be approved.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.