



## Provider Agreement

Provider Number		State ID		Amendment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Payee Name			Telephone Number ( )		
Payee Street Address		City		State	Zip Code
Client Name		Client Social Security Number		Telephone Number ( )	
Client Street Address		City		State	Zip Code
Service Provider Name		Provider Social Security Number		Telephone Number ( )	
Service Provider Street Address		City		State	Zip Code

The client is a member of my family (a parent, stepparent, child, stepchild, brother, stepbrother, sister, stepsister, lineal ancestor, or lineal descendent, or such person by marriage or adoption).  Yes  No

Description of Specific Duties	Number of 15-Minute Units per Month	Rate Per Unit	Total
Personal care		\$	\$
Homemaker		\$	\$
Medication supervision		\$	\$
Food preparation		\$	\$
Transportation		\$	\$
Other:		\$	\$
<b>Total</b>			\$

I certify that I will provide the services as stated above before submitting the billing for payment. I will not request additional payment from the client. **Payments I receive may be taxable as income for federal and state purposes.**

Provider Signature	Date
--------------------	------

I certify that this agreement is at my request and approval.

Client (or authorized representative) Signature	Date
---	------

Start Date	End Date	Unit Cost	Per 15 minutes
Billable Per Month DHS		Client Participation (CP)	

Based on current available information, this client meets the eligibility for reimbursement for in-home health services. Services may be provided until the provider receives notice to discontinue due to ineligibility, expiration of agreement, or other cause.

Worker Signature	Date
Area Administrator or Designee	Date