**VENDOR CONTACT SPECIFICATION**

|  |  |
| --- | --- |
| **NAME OF AGENCY:** | **DATE:** |
| **FEDERAL ID/SSN:** | **WEBSITE:** |
| **ADDRESS** | **PHONE** | **FAX** |
| **PERSONAL SERVICE AGENCY**  | **HOME HEALTH CARE AGENCY** | **OTHER-please list** |
| YES | NO | YES | NO |
| **DOES YOUR AGENCY PROVIDE MEDICAID PA SERVICES?** | **EDS#** |

**CHECK THE COUNTIES YOU CAN SERVE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DAVIESS | GREENE | KNOX | MARTIN | DUBOIS | PIKE |

**LOCAL ADMINISTRATIVE CONTACT**

|  |  |
| --- | --- |
| Name: | Title: |
| Phone: | Email: |

**CORPORTATE CONTACT**

|  |  |
| --- | --- |
| Name: | Title: |
| Phone: | Email: |

**REFERRAL CONTACT**

|  |  |
| --- | --- |
| Name: | Title: |
| Phone: | Email: |

**STAFFING CONTACT**

|  |  |
| --- | --- |
| Name: | Title: |
| Phone: | Email: |

**FISCAL CONTACT**

|  |  |
| --- | --- |
| Name: | Title: |
| Phone: | Email: |

**VENDOR AUTHORIZATION FORM SHOULD BE SENT TO**

|  |  |
| --- | --- |
| Name: | Email |

**PERSON COMPLETING THIS FORM**

|  |  |
| --- | --- |
| Name: | Title |

June 2021