# MSSP Service Vendor Application

(Definition of service to be provided, including approved MSSP Waiver Service unit types)

(Additional specifications)

1. Vendor Name: _____
   Address: _____
   Telephone: _____
   FAX: _____
   Email: _____

2. Vendor SSN# or FID#: _____

3. Authorized Signature: _____
   Telephone: _____
   Name/Title: _____

4. Vendor Contact Person: _____
   Title: _____
   Telephone: _____

5. Type of Provider (check one):
   - ☐ Incorporated, non-profit, tax-exempt
   - ☐ Government Agency
   - ☐ Unincorporated Group
   - ☐ Individual
   - ☐ Profit Agency

6. List the rate(s) per unit at which your organization offers to provide services to MSSP participants. For each rate, provide a breakdown of the cost factors that comprise that rate. Also, if the proposed rate is higher than that charged to other agencies please provide a thorough explanation of the reason(s) for the difference.

   _____

7. List the days and hours of your organization's service availability.

   _____

8. Are there any restrictions or limitations on the availability of your services such as eligibility criteria, service area, minimum number of units or maximum number of units?

9. If applicable, what type of business or professional licenses are held by your organization?

   Type:_____ License Number:_____

10. List the number and position titles of all staff (paid and volunteer) to be involved in providing services to MSSP participants. List professional certificates, licenses, degrees, etc., where appropriate (i.e., R.N., Nurse Practitioner, Medical Doctor, MSW, etc.).

11. List the number and position titles of all staff (paid and volunteer) to be involved in the administrative and fiscal tasks related to the provision of services to MSSP participants. List professional degrees and certificates, etc., where appropriate (i.e., MBA, CPA, MPH).

12. Describe the organization's general fiscal methods and procedures, (i.e., "double entry bookkeeping by CPA two hours per day," or "computerized accounting system with four full-time fiscal staff," etc.).

13. List the carrier name, carrier number, policy number and coverage limits for each type of insurance your organization maintains.

    Please attach a copy of the current certificate of proof of coverage:

| Type | Carrier Name | Carrier Number | Policy Number | Coverage |
|---|---|---|---|---|
| Comprehensive/ General Liability | | | | |
| Professional Liability/ Malpractice | | | | |
| Auto | | | | |
| Workers' Compensation | | | | |
| Products Liability | | | | |
| Other | | | | |

14. Summarize your organization's experience in the provision of services to our participant population.

15. List two or more organizations/individuals, which have used your service and can comment on your organization's experience and quality of service provision.

16. I certify that the above is true to the best of my knowledge.

Authorized Name:_____

Title: _____

Signature: _____ Date: _____