

**Provider Enrollment Information Form
Home and Community Based Services
SERVICE COORDINATION**

Provider Name: _____ **MPI #:** _____

OLTL must be provided with the job description for each service checked on this form.

I wish to become a Service Coordinator for the following waivers (check all that apply):

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Aging | <input type="checkbox"/> Independence |
| <input type="checkbox"/> Attendant Care / Act 150 Program | <input type="checkbox"/> OBRA |
| <input type="checkbox"/> COMMCARE | |

Please indicate the counties that you are willing and able to provide services in:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Requested effective date: _____

Signature of Authorized Representative

Title

Print Name

Date

Definitions of the service and qualifications needed to provide that service can be found in each individual waiver.
http://www.aging.state.pa.us/portal/server.pt/community/information_for_families_and_individuals/19326/support_services_waiver_information/733116