PROVIDER RECRUITMENT CAMPAIGN FORM

Name: **Date**

Provider Name:

Address:

City/State/Zip:

Phone:

Email:

Type of Services Provided (If known):

- ☐ PERSONAL CARE
- ☐ HOMEMAKER
- ☐ TRANSPORTATION
- ☐ PEST
- ☐ CHORE
- ☐ ERS
- ☐ SOCIAL WORK COUNSELING
- ☐ MINOR HOME MODIFICATION
- ☐ HOME MEDICAL EQUIPMENT
- ☐ HOME DELIVERED MEALS
- ☐ ADULT DAY SERVICES
- ☐ ASSISTED LIVING/COMMUNITY TRANSITION SERVICE
- ☐ INDEPENDENT LIVING ASSITANCE

Email the information to Provider Management Division:
providerrelations@aaa9.org