VETERANS CARE™
COORDINATION

*This is the number that we'll be contacting you from shortly.*

o **855-380-4400**
f 855-380-4401
e *sales@vcchc.com*

# Provider Enrollment Form

*Please fill in ALL INFORMATION completely to better serve you and your clients*

Date ___/___/___

Please Print Clearly

## COMPANY

Legal Business Name _____ Tax ID# ☐☐-☐☐☐☐☐☐☐

DBA (if applicable) _____ Phone _____

Street Address _____ Fax _____

City _____ State _____ Zip _____ email _____

☐ **Corporate Owned** ☐ **Individual Owned** ☐ **Franchisee / Franchisor**
**ID#** _____ ☐ **Franchisee / Franchisor (Multiple Owned)**
*please include list w/ locations & ID#s*

## PAYMENT

**Checks and Remittance Address** ☐ **Check here if same address as above**

Street Address _____ Phone _____

City _____ State _____ Zip _____ Fax _____

## CONTACT

Owner Name _____ Phone _____

Owner email _____

Marketing Contact Name _____ email _____

Billing/Office Manager Name _____ email _____

Scheduler Name _____ email _____

## RATES

| | | | |
|---|---|---|---|
| Private Pay | | Couple | /hr |
| **up to 2 hours** | /hr | Personal Care | /hr |
| **3 hours** | /hr | Companion Care | /hr |
| **4 or more hours** | /hr | Medicaid | /hr |

## HOURS

| | | | |
|---|---|---|---|
| Mon | | Fri | |
| Tue | | Sat | |
| Wed | | Sun | |
| Thur | | | |

## ADDITIONAL INFO

Does your company provide transporation services? ☐ Yes* ☐ No

**If "Yes" please specify:* ☐ Caregiver's Vehicle ☐ Client's Vehicle ☐ Company Vehicle

Serviceable Counties or Zip Codes _____

Billing Cycle *(please choose one)*: ☐ Weekly ☐ 2 Weeks ☐ Monthly ☐ 2 Months

Are your caregivers hired as contractors? ☐ Yes ☐ No

Does your company provide skilled medical services? ☐ Yes* ☐ No

**If "Yes" please explain:* _____

Does your company accept major credit cards? ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express