



## *Elder Independence of Maine*

Dear Applicant:

We appreciate your interest in our organization. A clear understanding of your background and history will aid us in determining if your agency would be appropriate in serving the needs of our frail elderly and disabled adult consumers. Failure to fully and accurately disclose information requested may be grounds for non-approval of your request for a Provider Agreement or for termination of an existing Agreement.

EIM reserves the right to request additional information at any time during the application process. If EIM, in its sole discretion, determines that an Applicant has successfully completed this initial stage of the application process and if EIM, in its sole discretion, desires to pursue the possibility of entering into a contractual relationship with the applicant, EIM will request additional information and will require the Applicant to meet certain requirements.

The Applicant certifies that the facts set forth in this application for participation in the EIM Provider Network, and in all documents submitted in connection with this application, are true and complete. The Applicant understands that any false statement on this application or any of the required documentation associated with the Provider Agreement may result in EIM's refusal to enter into a Provider Agreement or termination of an existing or future Provider Agreement. False statements may also result in recoupment of funds paid to a Provider for services rendered. The Applicant further understands and agrees that this application is not intended to imply a contract with EIM, nor does it obligate EIM to enter into a contract with the Applicant.

Please complete the requested information. EIM Provider Relations is available to answer questions related to the contract paperwork or process at 1-888-234-3920.

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Signed by: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_



## *Elder Independence of Maine*

### **Initial Application for EIM Provider Network**

1. Please provide the following information about the Applicant. Additional pages may be attached if required. Indicate which question applies on supplemental materials.

(a) Legal name of Applicant: \_\_\_\_\_

(b) Type of business (e.g., sole proprietorship, partnership, corporation, limited liability company):  
\_\_\_\_\_

(c) All d/b/a's and assumed names: \_\_\_\_\_

(d) Mailing Address: \_\_\_\_\_

(e) Physical Location: \_\_\_\_\_

(f) Telephone: \_\_\_\_\_

(g) Taxpayer Identification Number: \_\_\_\_\_

(h) Employer Identification Number: \_\_\_\_\_

2. Please provide the following information concerning all of the Applicant's owners, partners, shareholders, members, directors, officers, managers, and administrators (completion required even if sole proprietor):

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

Length of time with Applicant (inclusive dates): \_\_\_\_\_

Resume' and employment history for past ten years (including name, address, and telephone number of employer(s), position(s) held, name of supervisor(s), length of time in each position, and reason for leaving).

3. Please identify all owners, partners, shareholders, members, directors, officers, managers or administrators who intend to provide direct, hands-on care to EIM consumers, state the nature of the services they intend to provide, and state the qualifications of each individual who will provide such services. EIM reserves the right to request independent competency demonstration.

a) Name: \_\_\_\_\_ Title: \_\_\_\_\_

Services: \_\_\_\_\_

Qualifications: \_\_\_\_\_

b) Name: \_\_\_\_\_ Title: \_\_\_\_\_

Services: \_\_\_\_\_

Qualifications: \_\_\_\_\_

c) Name: \_\_\_\_\_ Title: \_\_\_\_\_

Services: \_\_\_\_\_

Qualifications: \_\_\_\_\_

4. Designated contact person regarding EIM Provider Agreement:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Business Address: \_\_\_\_\_

\_\_\_\_\_

Business Telephone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

5. Has the Applicant or any of its owners, partners, shareholders, members, directors, officers, managers, or administrators, ever done business with EIM in any capacity before?

\_\_\_\_ Yes \_\_\_\_ No

If yes, please explain in detail who and in what capacity.

\_\_\_\_\_

\_\_\_\_\_

6. What services does the Applicant desire to contract for? (list all)

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7. List the Applicant's qualifications to carry out these services, and describe applicable, relevant experience in delivering direct care.

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8. Has the Applicant or any of its owners, partners, shareholders, members, directors, officers, managers, or administrators, ever been sanctioned or disqualified from Medicare, Medicaid, or MaineCare participation?

Yes  No

If yes, please explain in detail:

9. Do any of the Applicant's owners, partners, shareholders, members, directors, officers, managers, or administrators have any criminal convictions?

Yes  No

If yes, please explain in detail:

10. Within the past ten years, has the Applicant, or any of its owners, partners, shareholders, members, directors, officers, managers, or administrators, been sued for fraud, conversion, breach of contract, breach of fiduciary duty, misappropriation of funds, misrepresentation, or any similar claim?

Yes  No

If yes, please explain in detail:

11. Please provide a complete business plan, including, but not limited to, the following elements:
- (a) Operating budget for the first year demonstrating financial viability
  - (b) Contingency plan for interruptions/delays in receivables
  - (c) For sole proprietorships, a signed release to allow a credit check
  - (d) For corporations or limited liability companies, a copy of Articles of Organization or Incorporation
  - (e) Indication of willingness to provide certification of professional and general liability insurance of \$1 million

I affirm that all information provided in this application and its attachments is complete and true to the best of my knowledge.

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Signed by: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_