Enrollment Form for:
Community Health Worker (CHW)
Doula
Maternal Infant Health Program (MIHP)
Michigan Diabetes Prevention Program (MiDPP) Provider

Instructions

1. Please complete all the fields below.
2. Sign and date the form.
3. Email this form and the information below to providernetwork@hap.org. Put "CHW/Doula/MIHP/MiDPP" in the subject line.
    - Completed HAP Disclosure of Ownership and Control Interest Statement form
    - Current W-9
    - IRS EIN Letter
    - Professional Liability Insurance (not required for Doula)
    - Care Coordination Agreement (CCA) - MIHP providers only

Application for:	☐ CHW	☐ Doula	☐ MIHP	☐ MiDPP
Name (first, middle, last):				
☐ Male ☐ Female	Race/Ethnicity (optional):			
Individual Type 1 NPI #:			CHAMPS number:	

Office address information

Street:

City, ST, Zip:

Phone: Fax: Email:

Website:

Billing information

Pay to name:

Tax Identification Number: Billing NPI:

Street:

City, ST, Zip:

Phone: Fax: Email:

Consent and Authorization

Through signature below, I certify that the information provided herein is true, accurate and complete. Additions to or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in denial of participation.

Provider name (please print)

Provider signature Date