Premier
Financial Management Services

OREGON VETERAN DIRECTED CARE PROVIDER RATE AGREEMENT FORM

Instructions: *Fill out each section as appropriate. Once complete, please sign and date the form and submit using the following options below.*

PROVIDER'S INFORMATION

Name: _____ Last 4 Digits of SSN: _____

ID Number: _____ Veteran's Name: _____

Employer Name: _____

RATE AGREEMENT INFORMATION

Check **ONLY** ONE

New Service	Existing Rate Change	Service Type	Wage	Per	Effective Date
		Personal Assistance Services & Supports		Hour	

By signing below, we understand that only the pay rates above will be paid.

Provider Signature: _____ Date: ___/___/_____

Veteran/Employer Signature: _____ Date: ___/___/_____

Rate Agreement Form Submission:

Mail:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

Email:
ORVSDP@premier-fms.com

Fax:
1-855-571-7670