

# APPLICATION CENTER CONTRACTUAL AGREEMENT

## MVA FORM AC-2 (Page 1 of 3)

Completion of this form and HIPAA Business Associate Addendum is a condition of certification and participation as an Application Center in the Medicaid Program.

Answer all questions as of the date the form is completed. Ensure that all appropriate signatures are obtained in the designated areas and that the current date is used.

These instructions are designed to simplify the completion of this form. No instructions are given for sections considered to be self-explanatory.

Return the completed and signed original form to DHH. (A copy will be forwarded to you upon certification.) Mail to:

**DHH/MVA**  
**Application Center Coordinator**  
**P.O. Box 91283**  
**Baton Rouge, LA 70821-9283**

### SECTION ONE: IDENTIFYING INFORMATION

**Assigned Application Center Identification Number** - If your facility is a new AC, leave this space blank. The AC-ID number will be assigned by staff of the Department of Health and Hospitals. If your facility is an existing AC and this contractual agreement is being submitted because of a change, such as a new administrator, please indicate your existing AC-ID number which was issued on the initial contract.

**Application Center Name** - Enter the legal name of your facility, organization, or agency.

**Street Address** - Enter the actual physical (geographical) location of your facility.

**City, State, and Zip Code** - Enter the city, state, and zip code for your facility's street address.

**Post Office Box/Mailing Address** - Enter the facility's mailing address if different from the street address. If the post office box/ mailing address is the same as the physical address, please enter "same" in the space provided.

**Parish** - Enter the name of the parish in which your facility is located.

**City, State, and Zip Code** - Enter the city, state, and zip code for your facility's Post Office Box/ mailing address.

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**Contact Person** – Enter the name of a representative of your facility or organization who is responsible for Application Center operations and who will serve as liaison between DHH and your facility.

**E-Mail** – Enter the E-mail address of the contact person.

**Federal Tax ID Number** – Enter the federal tax ID number for the facility.

**Telephone Number** – Enter the area code and telephone number where your contact person may be reached.

**Fax Number** – Enter the area code and fax number where your contact person may be reached or notified.

**SECTION TWO: TYPE OF FACILITY**

Indicate the type of facility, organization, or agency. Check the most appropriate block that describes the type of services provided by your facility.

**SECTION THREE: CONTROL OF FACILITY**

Check the appropriate block that best describes the administration of your facility.

**SECTION FOUR: TYPES OF CLIENTS TO BE SERVED FOR MEDICAID APPLICATIONS**

Indicate the type(s) of clients or enrollees your facility will serve. Place a check in each box that applies.

**SECTION FIVE: NOTICE**

The notice section is self-explanatory. Please read carefully.

**SECTION SIX: PRINTED OR TYPED NAME AND SIGNATURE**

**Printed or Typed Name and Signature of Administrator/CEO** – Review Sections I-V then, print or type name, sign and indicate date in the appropriate spaces.

**SECTION SEVEN: DHH STATE OFFICE / DESIGNEE USE ONLY**

This section is for official use by the DHH State Office only.

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**SECTION EIGHT: FACILITY CONFIDENTIALITY STATEMENT**

**Administrator/CEO** - Review Confidentiality statement, then print name, sign and indicate date in the appropriate spaces.

**SECTION NINE: AGREEMENTS AND RESPONSIBILITIES**

**Administrator/CEO** - Review Agreements/Responsibilities Section then sign name and indicate date in the appropriate spaces.