

## Summary of Ancillary Providers

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

Requested County: \_\_\_\_\_

For each county in the applicant's requested service area, provide the types, names and locations of contracted ancillary providers. If the applicant does not provide services provided by a listed ancillary provider, enter NA after the name of the type of ancillary provider. Add or delete rows as applicable.

| Type of Ancillary Provider and Name of Provider | City | Identify If Other Requested Counties Are Served By This Provider* |
|---|------|---|
| Ambulance:                                      |      |   |
|   |      |   |
|   |      |   |
| Audiology:                                      |      |   |
|   |      |   |
|   |      |   |
| Durable Medical Equipment:                      |      |   |
|   |      |   |
|   |      |   |
| Orthotics/Prosthetics:                          |      |   |
|   |      |   |
|   |      |   |
| Hospice:  |      |   |
|   |      |   |
|   |      |   |
| Home Health:                                    |      |   |
|   |      |   |
|   |      |   |
| Physical Therapy:                               |      |   |
|   |      |   |
|   |      |   |
| Occupational Therapy:                           |      |   |
|   |      |   |
|   |      |   |
| Speech Therapy:                                 |      |   |
|   |      |   |
|   |      |   |
| Mental Health:                                  |      |   |
|   |      |   |
|   |      |   |

| Type of Ancillary Provider and Name of Provider | City | Identify If Other Requested Counties Are Served By This Provider* |
|---|------|---|
| Substance Abuse:                                |      |   |
|   |      |   |
|   |      |   |
| Radiology:                                      |      |   |
|   |      |   |
|   |      |   |
| Laboratory:                                     |      |   |
|   |      |   |
|   |      |   |
| Family Planning:                                |      |   |
|   |      |   |
|   |      |   |
| Vision:   |      |   |
|   |      |   |
|   |      |   |
| Pharmacy:                                       |      |   |
|   |      |   |
|   |      |   |
| Other – Identify:                               |      |   |
|   |      |   |
|   |      |   |

\* If an ancillary provider is located in one county and provides services in adjacent counties, include this provider on the Summary of Ancillary Provider forms for each requested county it provides services.

Officer Certification: I certify that the information reported is complete and correct.

\_\_\_\_\_  
Signature of Authorized Representative                      Date Signed

\_\_\_\_\_  
Officer Name and Title    (type or print)

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

\_\_\_\_\_  
Contact Person    (type or print)

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

PA 252 of 2000 requires submission of this form. Failure to complete and submit this form could result in denial of the application for a certificate of authority.



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