## COA/PSA-1 Contract Renewal Notice for

## PASSPORT Choices Home Care Attendant Service (CHCAS) Provider

Legal Full Name:

Address:

Contact Phone:

Email Address:

By signing and submitting this form it is understood that the individual referenced above agrees to maintain the requirements of the PASSPORT Waiver program, and that I wish to continue as a contracted and certified provider with the Council on Aging (COA) and the Ohio Department of Aging (ODA).

Printed Name _____

Title _____

Signature _____ Date _____