Facility Profile

Legal Name: _____
(Legal Name should match what is on the W9)

d/b/a: _____

Facility Type

- ☐ Hospital
- ☐ Intensive Family Intervention
- ☐ Autism Facility
- ☐ Outpatient Clinic
- ☐ Residential Treatment Center
- ☐ Community Mental Health Center (CMHC)
- ☐ Behavioral Health Agency/Child Placing Agency
- ☐ FQHC
- ☐ Rural Health Clinic
- ☐ Chemical Dependency/ Substance Abuse Treatment Facility

Facility Information

Practice Location (*Please use page 3 if you have more than one location.)*

Address: _____

City: _____ **State**: _____ **Zip**: _____ **County**: _____

Phone: _____ **Fax**: _____ **Website**: _____

Billing Office Contact Information: _____
Name Phone Email address

Medicaid #: _____ **Medicare #:** _____

NPI #: _____ **Taxonomy Type:** _____

Tax ID#: _____

Are services provided in languages other than English? ☐Yes ☐No

If "Yes," what other languages? _____

Hours of Operation: ☐ 24-hours, or

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
___to___	___to___	___to___	___to___	___to___	___to___	___to___

Do you offer emergency services? ☐Yes ☐No

If "Yes," please describe: _____

Do you provide services to both males and females? ☐Yes ☐No

If "No," please explain: _____

Are you able to provide services to any of the following special needs population? (Check those that apply)

☐Deaf/ Hearing Impaired ☐Blind/ Vision Impaired ☐Developmental Disability

☐Physical Disability ☐Other (*please specify)*: _____

Facility Profile

Age Groups Treated:

☐0-6 yrs ☐6-12 yrs ☐13-17 yrs ☐18-64 yrs ☐65 + yrs ☐All ages ☐Other

Are the following areas handicapped accessible? (check those that apply)

☐Building ☐Bathroom(s) ☐Therapy Room(s) ☐Parking

Are Physician Assistant's and/or Nurse Practitioners used? Yes ☐ No ☐

Behavioral Health Services Provided (please check all that apply)			
	Inpatient Mental Health		Inpatient - Eating Disorders
	Inpatient Substance Abuse		ECT – Inpatient
	Day Treatment – Mental Health		ECT - Outpatient
	Day Treatment – Substance Abuse		IOP – Substance Abuse
	IOP – Mental Health		PHP – Substance Abuse
	PHP – Mental Health		Residential Treatment – Chemical Dependency
	Observation		Community Based Services
	Residential Treatment – Mental Health (PRTF)		Targeted Case Management
	Outpatient Treatment Services – Mental Health		Crisis Stabilization
	Outpatient Treatment Services – Substance Abuse		
	Other (please specify)		

Accreditation and/or Licensure

Is the facility accredited? Yes ☐ No ☐ Is the facility licensed? Yes ☐ No ☐

Agency Name	Acronym	Applied Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAAHC		
American Osteopathic Hospital Association	AOHA		
Commission on Accreditation for Rehab Facilities	CARF		
Community Health Accreditation Program	CHAP		
Council on Accreditation	COA		
Healthcare Quality Association on Accreditation	HQAA		
Joint Commission on Accreditation of Healthcare Organizations	JCAHO		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc	URAC		
State Facility Operating License	N/A		
Other (please list)			

Signature of authorized designee

Title

Name (Print)

Date

Facility Profile

ADDITIONAL SERVICE SITES:

Site 1 Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Phone (for patient use): _____ **Fax:** _____

Tax ID# (if different than Page 1): _____

Hours of Operation: ☐ 24-hours, or

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
___to___	___to___	___to___	___to___	___to___	___to___	___to___

Type of services offered: _____

_____

_____

_____

Site 2 Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Phone (for patient use): _____ **Fax:** _____

Tax ID# (if different than Page 1): _____

Hours of Operation: ☐ 24-hours, or

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
___to___	___to___	___to___	___to___	___to___	___to___	___to___

Type of services offered: _____

_____

_____

_____

Please copy and complete this form should you have more than two additional service locations.