

Facility Profile



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

d/b/a: _____

Facility Type

- | | |
|--|--|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Community Mental Health Center (CMHC) |
| <input type="checkbox"/> Intensive Family Intervention | <input type="checkbox"/> Behavioral Health Agency/Child Placing Agency |
| <input type="checkbox"/> Autism Facility | <input type="checkbox"/> FQHC |
| <input type="checkbox"/> Outpatient Clinic | <input type="checkbox"/> Rural Health Clinic |
| <input type="checkbox"/> Residential Treatment Center | <input type="checkbox"/> 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)*

- | | | |
|---|---|---|
| <input type="checkbox"/> Deaf/ Hearing Impaired | <input type="checkbox"/> Blind/ Vision Impaired | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Other <i>(please specify):</i> _____ | |

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)			
<input type="checkbox"/>	Inpatient Mental Health	<input type="checkbox"/>	Inpatient - Eating Disorders
<input type="checkbox"/>	Inpatient Substance Abuse	<input type="checkbox"/>	ECT – Inpatient
<input type="checkbox"/>	Day Treatment – Mental Health	<input type="checkbox"/>	ECT - Outpatient
<input type="checkbox"/>	Day Treatment – Substance Abuse	<input type="checkbox"/>	IOP – Substance Abuse
<input type="checkbox"/>	IOP – Mental Health	<input type="checkbox"/>	PHP – Substance Abuse
<input type="checkbox"/>	PHP – Mental Health	<input type="checkbox"/>	Residential Treatment – Chemical Dependency
<input type="checkbox"/>	Observation	<input type="checkbox"/>	Community Based Services
<input type="checkbox"/>	Residential Treatment – Mental Health (PRTF)	<input type="checkbox"/>	Targeted Case Management
<input type="checkbox"/>	Outpatient Treatment Services – Mental Health	<input type="checkbox"/>	Crisis Stabilization
<input type="checkbox"/>	Outpatient Treatment Services – Substance Abuse	<input type="checkbox"/>	
<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>	

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	AAHC		
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.