

# Provider Profile Table

**Agency Name:**

	Name	Address	Email	Telephone Number
<b>Executive Director/CEO :</b>				
<b>Chief Financial Officer:</b>				
<b>Chief Operations Officer:</b>				
<b>HIPAA Privacy Officer:</b>				
<b>Compliance Officer:</b>				
<b>Disaster Response Lead:</b>				
<b>Data Security Officer:</b>				

## Main Site Name and Branch Site Name

Main Site Name						
Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact:

Phone #:

Email Address:

Back-Up:

Phone #:

Email Address:

Back-Up:

Phone #:

Email Address:

Branch Site Name						
#1 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact: Phone #: Email Address:  
 Back-Up: Phone #: Email Address:  
 Back-Up: Phone #: Email Address:

Branch Site Name						
#2 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact: Phone #: Email Address:  
 Back-Up: Phone #: Email Address:  
 Back-Up: Phone #: Email Address:

Branch Site Name						
#3 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact: Phone #: Email Address:  
 Back-Up: Phone #: Email Address:  
 Back-Up: Phone #: Email Address:

Branch Site Name						
#4 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact: Phone #: Email Address:  
 Back-Up: Phone #: Email Address:  
 Back-Up: Phone #: Email Address:

Branch Site Name						
#5 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact:

Phone #:

Email Address:

Back-Up:

Phone #:

Email Address:

Back-Up:

Phone #:

Email Address:

# License/Certification

Enclose a current copy of the Contractor's DBHR Certification for each site, and DOH License, if applicable.

**Agency Name:**

Please list the Division of Behavioral Health and Recovery (DBHR) Certification # for each site:

Main Facility: \_\_\_\_\_  
DBHR Certification #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
Certified for: \_\_\_\_\_ NPI # \_\_\_\_\_

Branch: \_\_\_\_\_  
DBHR Certification #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
Certified for: \_\_\_\_\_ NPI # \_\_\_\_\_

Branch: \_\_\_\_\_  
DBHR Certification #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
Certified for: \_\_\_\_\_ NPI # \_\_\_\_\_

Department of Health (DOH) License (if applicable):  
License # \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

Drug Enforcement Administration (DEA)/Federal Drug Administration (FDA) (if applicable)  
Methadone License #: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

