



ALF Bi-ennial Renewal Data Sheet

Facility Information: Answer where applicable and write legibly.

County: _____
 Name of Facility: _____ License # _____
 DBA: if applicable: _____
 Full Address: _____
 EIN: _____ NPI: _____
 Medicaid Number, if applicable: _____ / Medicaid waiver: _____
 Telephone: _____ Fax: _____
 Email: _____ Website: _____
 Capacity: _____ - ___OSS ___ Private Specialty License: ___LNS ___ECC ___LMH
 Nurse On Site: ___ Full Time ___ Part Time ___ Third Party ___ None

Management Company: ___ Yes ___ No?

Administrator: _____ Cell: _____
 Full Address: _____
 Email Address: _____
 Administrator social security number: _____ DOB: _____
 Education: ___ Highschool Diploma ___ GED
 Are you administering to any other facilities: ___ Yes ___ No

Chief Financial Officer: _____
 Chief Financial Officer social security number: _____

Who owns the property? ___ Business ___ You ___ Other: _____
 Name: _____ Phone _____
 Full Address: _____

OWNERSHP

Owner #1: Full Name: _____ %: _____
 Owner #2: Full Name: _____ %: _____
 Owner #3: Full Name: _____ %: _____
 Owner #4: Full Name: _____ %: _____

BOARD MEMBERS

BM #1: Full Name: _____ Telephone: _____
 BM #2: Full Name: _____ Telephone: _____
 BM #3: Full Name: _____ Telephone: _____
 BM #4: Full Name: _____ Telephone: _____



1. Are you willing to hold a bed for a resident if, for example, they went to the hospital, rehab temporarily?
____ Yes ____ No

2. Are you affiliated with any religion / religious group? ____ Yes ____ No, if yes, please list here;

3. What forms of payment(s) do you accept? ____ Private Pay ____ Medicaid ____ SSI Other:

4. Will you provide day service to adults who will not residing on the premises? _____

5. Languages spoken at the facility by administrator and staff?
