HCC Bi-ennial Renewal Data Sheet

Health Care Clinic Information: Answer where applicable and write legibly.

County: _____
Name of Clinic: _____ License #_____
DBA: if applicable: _____
Full Address: _____
EIN: _____ NPI: _____
Medicaid Number, if applicable: _____ / Medicaid waiver: _____
Telephone: _____Fax: _____
Email: _____ Website: _____
Hours of Operation: _____ to _____ Days of Week: _____ to _____

Medical Director: _____ Lic# _____
Medical Director's social security number: _____ DOB: _____
Full Address: _____
Telephone Number: _____ Email: _____

Management Company: _____ Yes _____ No?

Administrator: _____ Cell: _____
Full Address: _____
Email Address: _____
Administrator social security number: _____ DOB: _____

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

STAFF

#1: Full Name: _____ Telephone: _____
Full Address: _____ License: #_____

#2: Full Name: _____ Telephone: _____
Full Address: _____ License: #_____

#3: Full Name: _____ Telephone: _____
Full Address: _____ License: #_____

#4: Full Name: _____ Telephone: _____
Full Address: _____ License: #_____