@rrendell's™
Training & Consulting

HHA Bi-ennial Renewal Data Sheet

Home Health Agency Information: Answer where applicable and write legibly.

County: _____
Name of Agency: _____ License #_____
DBA: if applicable: _____
Full Address: _____
Telephone: _____Fax: _____
Email: _____ Website: _____
EIN: _____ NPI: _____
Medicaid Number, if applicable: _____ / Medicaid waiver: _____

Medicare: _____

Management Company: _____ Yes _____ No?
Administrator: _____ Cell: _____
Full Address: _____
Email Address: _____ Telephone_____
Administrator social security number: _____ DOB: _____
___ Nurse ____M.D. license # _____ or _____at least 1 year experience ___
Full Time ___Part Time

Alternate Administrator: _____ Cell: _____
Full Address: _____
Email Address: _____
Alt. Administrator social security number: _____ DOB: _____
___ Full Time ___Part Time

Director of Nursing_____ RN License #_____
Full Address: _____
Email Address: _____Telephone: _____
___ Full Time ___Part Time

Alternate DON: _____ DOB: _____
Full Address: _____RN License # _____
Email Address: _____Telephone: _____
___ Full Time ___Part Time ___Contractor

Chief Financial Officer: _____ DOB: _____
Full Address: _____
Email: _____ Telephone: _____

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: _____