PROVIDER INFORMATION & CONTACTS - *Complete for each provider affiliate community*

Provider Name: _____

Address: _____

City/State/Zip: _____

County: _____

Telephone: _____

Website: _____

Primary Contact Name: _____

Primary Contact Title: _____

Primary Contact Telephone: _____

Primary Contact Email: _____

Number of employees:

Full Time: _____ Part Time: _____ PRN: _____

Names, titles, and emails of other key personnel (e.g., ED, NHA, Director of Nursing, PCHA, Staff Dev).

Please also indicate if personnel listed should receive the quarterly Five-Star Report and/or A4 Report.

NAME	TITLE	EMAIL

SERVICE TYPE(S) – *check all that apply at this organization*

❑ Skilled Nursing Name _____

Total # of SNF Licensed Beds _____ # of SNF Beds in Secure Dementia Unit _____

❑ Medicare certified ❑ Medicaid certified NPI#_____ MC#_____

❑ Personal Care Name _____

Total # of PCF Licensed Beds _____ # of PCF Beds in Secure Dementia Unit _____

❑ Assisted Living Name _____

Total # of AL Licensed Beds _____ # of AL Beds in Secure Dementia Unit _____

❑ CCRC/Life Plan Community Name _____

CCRC Certified: ❑ Yes ❑ No Rental Option: ❑ Yes ❑ No

Total # of IL Units _____ # of IL Beds Certified for Personal Care _____

Contract Type: ❑ Type A (Life-care) ❑ Type B (Modified) ❑ Type C (Fee-for-service)

❑ Home and Community Based Services (HCBS) Name _____

Services offered:

- ❑ Adult Day Service
  - ❑ Enhanced Adult Day
  - ❑ Adult Night Services
- ❑ Care/Case Management
- ❑ Hospice
- ❑ Home Care Agency
  - ❑ Medicaid Certified
- ❑ LIFE Program
- ❑ Outpatient Rehabilitation
- ❑ Certified Home Health
  - ❑ Medicare Certified

❑ Affordable/Subsidized Housing

Total # of Affordable/Subsidized Units_____

❑ Market-Rate Housing

Total # of Market Rate Units_____

❑ Other Services Available at this Community, Specify type(s) of services (*check all that apply*):

	Available	Company-Owned
Ventilator Care	❑	❑
Child Care Center	❑	❑
Intergenerational Programming	❑	❑
Home Delivered Meals	❑	❑
Dialysis Center	❑	❑
Veterans Administrator Contract	❑	❑
Senior Center Sponsorship	❑	❑

Other : _____

THANK YOU!

Please remember to complete one form for each provider affiliate community, and either upload the forms to your membership application, or email to ***membership@leadingagepa.org*** *after your submission.*