

# Council on Aging of Southwestern Ohio

Provider Information Form (PIF)

Date Completed:

By Whom:

THIS FORM IS INTENDED TO UPDATE INFORMATION MAINTAINED AND UTILIZED BY COA STAFF FOR YOUR AGENCY. Please keep in mind, especially with regard to Referrals for Service, this information may be critical to your agency's ability to receive and accept referrals, and to be awarded services. Report all changes to the Provider Services Department immediately.

Legal Name:		Tax ID:	
Doing Business As (DBA):			
Main Office Street Address:		Primary Business Phone:	
Main Office City, State, Zip:		Fax:	
Main Office County: <input type="checkbox"/> Butler <input type="checkbox"/> Clermont <input type="checkbox"/> Clinton <input type="checkbox"/> Hamilton <input type="checkbox"/> Warren <input type="checkbox"/> Other (Explain): _____		Governing Board: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Organization structure: <input type="checkbox"/> Incorporated <input type="checkbox"/> Limited Liability Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other (non-profit, etc.): _____		How are you available through Directory Assistance: <input type="checkbox"/> Yellow Pages <input type="checkbox"/> White Pages <input type="checkbox"/> 411 <input type="checkbox"/> Other (Explain): _____	
Agency Website:		Bonded: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hours of Operation:			

<b>ADMINISTRATOR</b>		Phone:	
Name & Title:		Fax:	
Address:		E-mail:	
County: <input type="checkbox"/> Butler <input type="checkbox"/> Clermont <input type="checkbox"/> Clinton <input type="checkbox"/> Hamilton <input type="checkbox"/> Warren <input type="checkbox"/> Other (Explain): _____			

<b>HOSPITAL ADMISSION ALERTS</b>		Phone:	
Name & Title:		E-mail:	

<b>REFERRALS</b>		Phone:	
Name & Title:		Fax:	
Address:		E-mail:	

<b>BILLING</b>		Phone:	
Name & Title:		Fax:	
Address:		E-mail:	
County: <input type="checkbox"/> Butler <input type="checkbox"/> Clermont <input type="checkbox"/> Clinton <input type="checkbox"/> Hamilton <input type="checkbox"/> Warren <input type="checkbox"/> Other (Explain): _____			

<b>CONTRACT SIGNER (Individual Authorized to Sign Contract)</b>		Phone:	
Name & Title:		Fax:	
Address:		E-mail:	

Contract information will be sent to the signatory listed above and additional contract below if completed:

Name:		Phone:	
Title:		Fax:	
Address:		E-mail:	

<b>PROBLEM RESOLUTIONS</b>		Phone:	
Name & Title:		Fax:	
Address:		E-mail:	

**CLINICAL CORRESPONDENCE**

Phone:

Name &amp; Title:

Fax:

Address:

E-mail:

**EMERGENCIES**

Cell Phone:

Name &amp; Title:

Alternate Phone:

Additional Sites:

**If your agency operates additional sites, please provide with the following information for each site:**

1. Site Name
2. Address (including Street Address, City, State, Zip code and County)
3. Phone
4. Fax
5. Days & hours of operation
6. Administrator's Contact name & email address
7. Referral Contact's name & e-mail address

**Thank you.**

Rev. 03/16/2016