I. Provider Information

Part A: General Information

Date Completed: ____________________

Provider Name: ____________________ Number: __________ Region: __________

Taxpayer Identification Number: ____________________

Address:

City: ____________________ State: __________ Zip: __________ Attention: ____________________

Phone Include Area Code: ______________ Extension: ________ Fax Include Area Code: ______________

Modem Include Area Code: ______________ TDD Include Area Code: ______________

Operator of Business: ______________ Owner of Business: ______________

County Code: __________ Township/Community Area: ______________ Planning Area: ______________

Executive Director: ____________________

Contact Name: ____________________ Title: ____________________

Phone Include Area Code: ______________ Extension: ______________

Parent/Related Company: ____________________

Part B: Legislative Districts

IL Senate: ______________ IL House: ______________ U.S. Congressional: ______________

Part C: Relationships With Other Entities

Public Funding Boards:

Please list name(s) and type(s) of board(s) (708,553,377) from which you received funding.

PAS/ISC Agency: ____________________

PAS MH Agency: ____________________

Part D: Warrant Mailing Information

Please complete if warrants (payments) are to be mailed to an address other than your provider location.

Name: ____________________ Account Number: ______________

Address:

City: ______________ State: ______________ Zip Code: ______________

Phone Include Area Code: ______________ Extension: ______________

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 20ILCS 1705/15. Non-disclosure of this information may prevent this form from being processed. This form has been approved by the Forms Management Center.

II. Satellite Information

Provider Name: ______________________ Number: ____________ Date: ____________

Satellite Name: ______________________ Number: ____________

Part A: Physical Location

Contact Name: ______________________ Title: ____________

Address:

Attention: ____________

City: ____________ State: ________ Zip: ________

Phone Include Area Code: ____________ Extension: ______

Fax Include Area Code: ____________ Modem Include Area Code: ____________

Region: ____________ County Code: ________ Township/Community Area: ____________

Planning Area: ____________

PAS/ISC Agency: ____________ PAS MH Agency: ____________

Part B: Legislative Districts

IL Senate: ____________ IL House: ____________ U.S. Congressional: ____________

Part C: Mailing Address Please complete if different from physical location

Name: ______________________ Attention: ____________

Address:

Phone Include Area Code: ____________ Extension: ______

Fax Include Area Code: ____________

City: ____________ State: ________ Zip: ________

Satellite Name: ______________________ Number: ____________

Part A: Physical Location

Contact Name: ______________________ Title: ____________

Address:

Attention: ____________

City: ____________ State: ________ Zip: ________

Phone Include Area Code: ____________ Extension: ______

Fax Include Area Code: ____________ Modem Include Area Code: ____________

Region: ____________ County Code: ________ Township/Community Area: ____________

Planning Area: ____________

PAS/ISC Agency: ____________ PAS MH Agency: ____________

Part B: Legislative Districts

IL Senate: ____________ IL House: ____________ U.S. Congressional: ____________

Part C: Mailing Address Please complete if different from physical location

Name: ______________________ Attention: ____________

Address:

Phone Include Area Code: ____________ Extension: ______

Fax Include Area Code: ____________

City: ____________ State: ________ Zip: ________

III. Program Information

Provider Name: ______________________ Number: ______________ Date: ______________

Program Information

Satellite Name: ______________________ Number: ______________

Program Code: ______________ Suffix Codes: ______________ Accreditation: ______________

Contact Name: ______________________ Title: ______________________

Address: ______________________ Attention: ______________________

City: ______________ State: __________ Zip: __________

Phone Include Area Code: ______________ Extension: ________ Fax Include Area Code: ______________

Total Staff (FTE): __________ Weekly Hours of Operation: __________ Standard Length of Day: __________

Direct Care Staff (FTE): __________

Distribution of Clients by Illinois House District (Total must equal 100%)

District: ______ ______ ______ ______ ______ ______ ______ ______ ______ ______

Percent: ______ ______ ______ ______ ______ ______ ______ ______ ______ ______

Program Information

Satellite Name: ______________________ Number: ______________

Program Code: ______________ Suffix Codes: ______________ Accreditation: ______________

Contact Name: ______________________ Title: ______________________

Address: ______________________ Attention: ______________________

City: ______________ State: __________ Zip: __________

Phone Include Area Code: ______________ Extension: ________ Fax Include Area Code: ______________

Total Staff (FTE): __________ Weekly Hours of Operation: __________ Standard Length of Day: __________

Direct Care Staff (FTE): __________

Distribution of Clients by Illinois House District (Total must equal 100%)

District: ______ ______ ______ ______ ______ ______ ______ ______ ______ ______

Percent: ______ ______ ______ ______ ______ ______ ______ ______ ______ ______

Program Information

Satellite Name: ______________________ Number: ______________

Program Code: ______________ Suffix Codes: ______________ Accreditation: ______________

Contact Name: ______________________ Title: ______________________

Address: ______________________ Attention: ______________________

City: ______________ State: __________ Zip: __________

Phone Include Area Code: ______________ Extension: ________ Fax Include Area Code: ______________

Total Staff (FTE): __________ Weekly Hours of Operation: __________ Standard Length of Day: __________

Direct Care Staff (FTE): __________

Distribution of Clients by Illinois House District (Total must equal 100%)

District: ______ ______ ______ ______ ______ ______ ______ ______ ______ ______

Percent: ______ ______ ______ ______ ______ ______ ______ ______ ______ ______

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 20ILCS 1705/15. Non-disclosure of this information may prevent this form from being processed. This form has been approved by the Forms Management Center.

IV. Residence Information

Provider Name: ______________________ Number: ____________ Date: ____________

Satellite Name: ______________________ Number: ____________ Program Code

Part A. Residence Information

Residence Name: ______________________ Residence Number: ____________

Contact Name: ______________________ Title: ____________

Address: ______________________ Mail to Residence? ____________

City: ____________ State: ________ Zip: ________ Attention: ____________

Phone Include Area Code: ____________ Extension: ________ Fax Include Area Code: ____________

Region: ____________ County Code: ________ Township/Community Area: ____________

Planning Area: ____________

Part B: Legislative Districts

IL Senate: ____________ IL House: ____________ U.S. Congressional: ____________

Part C: Capacity Information

Licensed/Approved/Certified Capacity: ____________ Non-IDHS Usage: ____________

By Whom? ______________________ Effective Date: ____________

Satelite Name: ______________________ Number: ____________ Program Code

Part A: Residence Information

Residence Name: ______________________ Residence Number: ____________

Contact Name: ______________________ Title: ____________

Address: ______________________ Mail to Residence? ____________

City: ____________ State: ________ Zip: ________ Attention: ____________

Phone Include Area Code: ____________ Extension: ________ Fax Include Area Code: ____________

Region: ____________ County Code: ________ Township/Community Area: ____________

Planning Area: ____________

Part B: Legislative Districts

IL Senate: ____________ IL House: ____________ U.S. Congressional: ____________

Part C: Capacity Information

Licensed/Approved/Certified Capacity: ____________ Non-IDHS Usage: ____________

By Whom? ______________________ Effective Date: ____________

Use additional forms as needed to provide all necessary information.

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 20ILCS 1705/15. Non-disclosure of this information may prevent this form from being processed. This form has been approved by the Forms Management Center.