

**Southwest Developmental Services, Inc.
Provider Data Sheet**

(complete electronically; submit electronically; manual submissions will be rejected)

Agency Name:

Completion Date:

Address Information

Primary Location *(Where your business is physically located)*

Street:

City:

State:

Zip:

Mailing Address *(Where you want to receive correspondence)*

Street:

City:

State:

Zip:

Billing Address *(Where you want billings to be sent)*

Street:

City:

State:

Zip:

Business Phone:

Business Fax:

Business E-Mail:

After hours emergency name:

(Indicate the name of a staff member and the number where they can be reached after hours should an emergency situation occur and someone at your organization must be notified.)

After hours emergency number:

Profit Status: *(check one)*

NOT FOR PROFIT

FOR PROFIT

Federal Tax Number:

Type of Business:

NPI Number:

KMAP Number:

Submit the individual with your organization who is authorized to enter into contractual agreements:

Contract Signer:

Contract Signer Title:

Phone:

E-Mail:

KEY STAFF MEMBERS *(Please list names of staff members in the following positions or indicate N/A if this does not apply to your organizational structure)*

Agency Director:

Agency Director's Title:

Phone:

E-Mail:

DD Services/Program Director:

DD Services/Program Director's Title:

Phone:

E-Mail:

Financial Director:

Phone:

E-Mail:

Contact Person for ANE Reports:

Phone:

E-Mail:

Complete this section if you provide Targeted Case Management

Supervisor Name:

Supervisor Title:

Phone:

E-Mail:

Complete this section for persons to be included in SDSI emails:

Name:

Title

Phone:

Email:

Name:

Title

Phone:

Email:

Name:

Title

Phone:

Email:

Name:

Title

Phone:

Email:

GENERAL INFORMATION

- | | | |
|---|-----|----|
| 1. Has SDSI ever denied or terminated a contract with your agency?
If yes, please provide type and date along with details: | Yes | No |
| 2. Has the agency ever been denied a provider agreement by Medicaid?
If yes, please provide type and date along with details: | Yes | No |
| 3. Has the agency ever been banned from providing Medicaid services?
If yes, please provide type and date along with details: | Yes | No |
| 4. How many full time equivalent (FTE) direct care staff are employed to provide services to people funded under the CDDO/CSP contract? | | |

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