

# Living Choice Program Provider Information Sheet

*Note: Complete one sheet per branch office and per office type (i.e. CM or HC)*

<b>Provider Name:</b>	
<b>Is this a branch location?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Type of office (check only one per sheet) :</b> <input type="checkbox"/> Case Management/Transition Coordination <input type="checkbox"/> Home Care	
<b>If Home Care, mark any therapies that will be provided?</b> <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> RT	
<b>Identify what counties will be served out of the office/branch:</b>	
<b>Mailing Address:</b>	
Contact Name:	
Address:	
Phone #:	
Fax #:	
Toll Free#:	
Cell #:	
Email:	
<b>Physical Address: (if different from mailing)</b>	
Contact Name:	
Address:	
<b>Authorized Signature:</b>	
Contact Name:	
Address:	
Phone #:	
Fax #:	
Toll Free#:	
Cell #:	
Email:	
<b>FOR OFFICE USE ONLY</b>	Validate Provider Number and Location codes