



Agency Name:	
Email:	Phone:
Address:	
Program Participation: <input type="checkbox"/> STAR <input type="checkbox"/> CHIP <input type="checkbox"/> CHIP Perinatal <input type="checkbox"/> Preferred Administrators <input type="checkbox"/> Health Care Options <input type="checkbox"/> Medicare DSNP <input type="checkbox"/> STAR PLUS	
Accepting New Patients: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Established Only	Accepting: <input type="checkbox"/> Pediatric Ages _____ <input type="checkbox"/> Adult Ages _____

Services Provided
<input type="checkbox"/> Personal Assistance Services
<input type="checkbox"/> Skilled Nursing
<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> 24/7 RN Support
<input type="checkbox"/> Stroke / Cardiac Rehab
<input type="checkbox"/> Wound Care
<input type="checkbox"/> Wound Vac
<input type="checkbox"/> Medical Social Workers
<input type="checkbox"/> Fall Prevention
<input type="checkbox"/> Catheter Care
<input type="checkbox"/> Ostomy Care
<input type="checkbox"/> IV Therapy
<input type="checkbox"/> DM Management
<input type="checkbox"/> HTN Management
<input type="checkbox"/> COVID Management
<input type="checkbox"/> Metabolic Syndrome Management
<input type="checkbox"/> Home Health Aide
<input type="checkbox"/> Disease Processes
<input type="checkbox"/> Enteral Feeding
<input type="checkbox"/> Other:

Additional Services / Comments: