

Manual can be found at the link above.

NCCareLINK Program/Service Information Form

Provider: _____

DBA or Also Known As: _____

Program/Site Name: _____

Web Site Address (of program/service): _____

Physical Address:

Street: _____

City: _____

State: _____ **Zip:** _____

Program Manager: _____

Mailing Address (if different):

Street: _____

City: _____

State: _____ **Zip:** _____

Title: _____

Phone Numbers:

Primary: (_____) _____

Secondary: (_____) _____

Fax Number: (_____) _____

After-hours contact number: (_____) _____

Descriptions (Work, Home, Cell):

Business Operating Hours: _____

(Circle all that apply) S M T W TH F SA 24 hours/7 days per week.

Area Served (Circle all that apply)

Beaufort Bertie Craven Gates Hertford Jones Northampton Pamlico Pitt

Program Description: _____

Fees (For each service): Please list the Medicaid or IPRS (State) reimbursement rate(s) \$ _____

Per (15 minute unit, hour, day, week) **Please circle one.** Use another sheet if necessary.

Eligibility: Please indicate eligibility requirements that need to be met in order to become enrolled in the program. _____

Payment Options:

- Medicare
- Medicaid
- Sliding Scale
- Other _____

Attached Taxonomy: _____

Keywords: _____

Form completed by: _____ **Phone:** _____

To ensure accurate NCCareLINK information, we will be in contact every six months. Please list a contact person.

Contact Name: _____ Title: _____

Contact Phone: _____ Contact Email Address: _____