



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES
IN-HOME SERVICES PROVIDER PROFILE

PLEASE TYPE OR PRINT CLEARLY

Vendor Number (if assigned):

SECTION I: VENDOR INFORMATION

1. LEGAL VENDOR NAME AS FILED WITH THE SECRETARY OF STATE, INCLUDING DBA NAME (SOLE PROPRIETORS, INCLUDE NAME AND DBA NAME)

2. PHYSICAL ADDRESS

4. TELEPHONE NUMBER

CITY

STATE

ZIP CODE

5. FAX NUMBER

3. MAILING ADDRESS, IF DIFFERENT

6. ALTERNATE PHONE NUMBER (cannot be the same as the main)

CITY

STATE

ZIP CODE

7. E-MAIL ADDRESS

8. FEDERAL EMPLOYER IDENTIFICATION NUMBER (EIN)

9. MISSOURI EMPLOYER IDENTIFICATION NUMBER

10. NATIONAL PROVIDER IDENTIFICATION NUMBER

11. DAYS AND HOURS OF OPERATION

12. IF A SATELLITE OFFICE IS LISTED IN SECTION IV, INDICATE COUNTIES SERVED BY MAIN OFFICE

SECTION II: PERSONNEL INFORMATION

13. EXECUTIVE DIRECTOR

16. DESIGNATED MANAGER

14. TELEPHONE NUMBER

17. TELEPHONE NUMBER

15. E-MAIL ADDRESS

18. E-MAIL ADDRESS

19. REGISTERED NURSE

20. MO RN LICENSE NUMBER

21. TELEPHONE NUMBER

22. E-MAIL ADDRESS

SECTION III: ELECTRONIC TRACKING SYSTEM

Currently Using an Automated Electronic Telephone Tracking System in lieu of paper timesheets. Required effective 7/1/15.

Yes No If Yes, Name of Company Providing Service:

SECTION IV: SATELLITE OFFICE INFORMATION

CONTACT PERSON

TELEPHONE NUMBER

ADDRESS

FAX NUMBER

CITY

EMERGENCY TELEPHONE NUMBER (NIGHTS, WEEKENDS, ETC.)

STATE

ZIP CODE

E-MAIL ADDRESS

DAYS AND HOURS OF OPERATION

COUNTIES SERVED BY THIS OFFICE

CONTACT PERSON

TELEPHONE NUMBER

ADDRESS

FAX NUMBER

CITY

EMERGENCY TELEPHONE NUMBER (NIGHTS, WEEKENDS, ETC.)

STATE

ZIP CODE

E-MAIL ADDRESS

DAYS AND HOURS OF OPERATION

COUNTIES SERVED BY THIS OFFICE

VENDOR PROFILE FORM INSTRUCTIONS	
SECTION I: VENDOR INFORMATION	
Vendor Number	If this form is completed as part of a proposal application, leave the field blank. Otherwise, enter the Vendor Number assigned to the business. The Vendor Number is located on the first page of the Participation Agreement for Home and Community Based Care.
1. Legal Vendor Name	Enter the name as filed with the Internal Revenue Service (IRS) and Missouri Secretary of State, including DBA name, if applicable. Sole Proprietors include DBA name. This name must match the legal name as filed with the Missouri Secretary of State, Internal Revenue Service (IRS) and Missouri Department of Revenue (DOR).
2. Physical Address	Enter the physical location of the main office.
3. Mailing Address	Enter the mailing address for the main office, if different from the physical address.
4. Telephone Number	Enter the primary business telephone number.
5. Fax Number	Enter the fax number for the main office.
6. Alternate Telephone Number	Enter the alternate number for the provider when provider cannot be reached by the main (cannot be same as main)
7. E-mail Address	Enter the e-mail address for the main office
8. Federal Tax ID	Enter the Federal Employer Identification Number (FEIN) assigned to the business by the IRS.
8. Missouri Tax ID	Enter the State Employer Identification Number (SEIN) assigned to the business by DOR
7. National Provider Identifier	Enter the National Provider Identification Number (NPI). The NPI must be in the business name and the entity type should be 02-Organizational
11. Days and Hours of Operation	Enter the business days and hours of operation when the main office is open and business employees are on site.
12. Service Area	If Satellite office(s) are listed in Section IV; list out the counties served by main office
SECTION II: PERSONNEL INFORMATION	
13. Executive Director	Enter the name of the owner of the highest-ranking person in charge of the business operations.
14. Director's Telephone Number	Enter the telephone number for the Executive Director.
15. Director's E-mail Address	Enter the e-mail address for the Executive Director
16. Designated Manager	Enter the name of the Designated Manager
17. Designated Manager's Telephone Number	Enter the telephone number for the Designated Manager
18. Designated Manager's E-mail Address	Enter the e-mail address for the Designated Manager
19. Registered Nurse (RN)	Enter the name of the Registered Nurse (RN)
20. RN's MO License Number	
21. RN's Telephone Number	
22. RN's E-Mail address	
SECTION III: ELECTRONIC TRACKING SYSTEM	
Electronic Tracking System	Effective 7/1/15 the Electronic Tracking System become mandatory. Mark the correct box to indicate you are or are not currently using an Electronic Tracking System. If you are, please indicate the name of the company you are using.
SECTION IV: SATELLITE OFFICE INFORMATION	
Satellite office is defined as an office that is regularly staffed. Offices used solely to drop off timesheets, pick up schedules, etc. do not need to be reported. If there are more than two satellite offices, attach additional sheets as necessary.	
Contact Person	Enter the name of the Contact Person for the satellite office
Address	Enter the physical street location of the satellite office. It cannot be the same address as the main office
City, State, Zip Code	Enter the city, state and zip code information for the satellite office
Telephone Number	Enter the telephone number for the satellite office. It cannot be the same address as the main office
Fax Number	Enter the fax number for the satellite office.
Emergency Telephone Number	Enter the emergency telephone number, pager, etc. for nights, weekends, holidays, etc. for the satellite office.
E-mail Address	Enter the E-mail address for the satellite office
Days and Hours of Operation	Enter the business days and hours of operation when the satellite office is open and employees are onsite
Counties Served By Satellite Office	Indicate the counties serviced by the satellite office. Do NOT include the counties to be serviced by the main office or another satellite office. This office will be contacted regarding the participants residing in the county(ies).