Provider Information Sheet

Center Care ◯	Family Home Care ◯	In-Home Care ◯	FFN Exempt Care ◯
Provider's Name:			
Physical Address:			
Mailing Address:			
City:		County:	
State:		Zip Code:	
Phone Number:		Message Phone:	
Email Address:		Social Security Number:	

Licensed Facility

License Facility Only	
License Regulated Date:	Yes: ☐ No: ☐
License Number:	Expiration Date:
Type: State: ☐ Business: ☐ State Registration: ☐ Tribal: ☐	
Accreditation Type: ___ Multiple ☐ National ☐ Religious ☐ State ☐ No ☐	
Physical Exam Date:	TB Test Date:
Facility Review:	Contact:

Exempt

Exempt Facility Only	Vendor Name:
Trustline: Submission	Trustline Clearance:
Physical Exam Date:	TB Test Date & result: negative ☐ positive ☐
CPR Expiration Date:	First Aid Expiration Date:
Free from all communicable Diseases:	
Relationship to child(ren) in care: Grandparent ☐ Aunt ☐ Uncle ☐ Sibling living outside the residence ☐	
Last Date of Facility Review:	

Transportation Optional

Name on Driver's License	DL #	Expiration Date
Insurance Company	Policy Number	
Vehicle License Plate Number		