Reset Form

Print Form

Appendix A
Agency Transmittal Form

Provider

Provider Agency Name: _____

Address:

City: _____

State: NY Zip: _____

County: _____

Phone: _____

Fax: _____

E-Mail Address: _____

Executive Director

Name: _____

Title: _____

Phone: _____

E-mail Address: _____

Chairperson of the Board

Name: _____

Title: _____

Address:

City: _____

State: NY Zip: _____

Phone: _____

Contact Information For All Correspondence

Name: _____

Title: _____

Address:

City: _____

State: NY Zip: _____

Phone: _____

E-Mail Address: _____

Payment Information For All Payments to Agency

Name: _____

Title: _____

Address:

(Please enter exactly as entered/supplied to the Office of the State Comptroller, if applicable)

City: _____

State: NY Zip: _____

Electronic Payment ID#: _____

Additional Information *Required*

Federal ID #: _____

Date Opened: _____

Charity Registration #: _____

MMIS #: _____

Select appropriate entry(ies)

☐ OPWDD ☐ **OMH** ☐ OASAS ☐ SED

☐ Article 28 ☐ Article 31

Auspice

☐ County ☐ State ☐ Voluntary ☐ Proprietary

State funded: ☐ Yes ☐ No