Provider Contact Form

Please type information or print

Provider

Provider Name:

Address
Line 1:
Line 2:
City:
State: Zip:

County:

Phone no.: Ext.:

Fax no:

E-mail Address:

Executive Director

Name:

Title: Position:

Degree:

Phone no.: Ext.:

E-mail Address:

Chairperson of the Board

Name:

Title: Position:

Degree:

Address
Line 1:
Line 2:
City:
State: Zip:

Phone no.: Ext.:

Contact Information

Name:

Title

Phone no.: Ext.:

E-mail Address:

Disaster Preparedness

Participates: Yes ☑ No ☐

If Yes, for Contact:

Name:

Title: Position:

Phone no.: Ext.:

E-mail Address:

Payment Information

Name:

Title:

Address (Please enter exactly as entered/supplied to the Office of the State Comptroller)

Line 1:
Line 2:
City:
State: Zip:

Phone no:

Circle appropriate entry(ies)

OMRDD **OMH** OASAS SED

Article 28 Article 31

Auspice
County State Voluntary Proprietary

State funded : Yes ☑ No ☐

Additional Information

Federal ID #:

Date Opened:

Charity Registration #:

MMIS #:

Please return this form to: New York State Office of Mental Health, Community Budget and Financial Management, 44 Holland Avenue, Albany, New York 12229.