ATTACHMENT D

CRUCIAL DATA EXTRACT
PARTIAL HOSPITALIZATION SERVICES

Section I – Facility Information

1. Name and Address of Facility

____

____

2. Name of Responsible Agent including the address and telephone number

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3. The facility's Medicare provider number, if the facility is already participating in the Medicare program _____________________.

4. The Medicare provider number of the entity, if the facility is operated as part and under control of another entity that is participating in the Medicare program ________________.

5. Type of ownership and control: (Please circle)

For Profit:	Nonprofit:	Government:
Corporation	Church related	State
Other	Nonprofit corporation	Local
	Other non-profit	Federal

6. Services provided with number of full time equivalents.

	Directly	Arrangement	Number FTE
M.D. (psychiatrist)	_______	____________	____________
M.D. (other)	_______	____________	____________
Psychologist	_______	____________	____________
Nurse	_______	____________	____________
Social Worker (B.S.W.)	_______	____________	____________
Social Worker (M.S.W.)	_______	____________	____________
Therapist (recreational)	_______	____________	____________
Therapist (occupational)	_______	____________	____________
Therapist (group)	_______	____________	____________
Other (specify)	_______	____________	____________