



Letter of Interest

Legal Business Name:

DBA:

Services and Specialty:

Business Contact Name and Phone

Location Address(es):

Location Phone:

Location Fax:

Languages spoken by Staff and Providers:

Office Hours:

<u>M</u>	<u>T</u>	<u>W</u>	<u>Th</u>	<u>F</u>	<u>Sat</u>	<u>Sun</u>

After Hours Coverage: Yes No

Providers at offices (First, Last name, NPI) attach copies of CV (MMYYYY format)

1.

Ages served : Newborn to Preschool (0 to 5 years) Preschool (3 to 5 years) Children (6-12 years)

Adolescents (13-18 years) Serves Intellectual & Developmental Disabilities (IDD) population

Other

Telehealth Services: Yes No **Telehealth Modality**

Service Areas: SD or Riverside or both?

Tax ID:

Attach W9

Site NPI(s):

Business License Number:

Attach copies

Accreditation/Certifications w/Effective and Expiration dates:

Attach copies

Malpractice Insurance: Yes No **Attach copies**

Medi-Cal Enrolled (Required for SD county) Yes No Pending **(If pending, attach pending status confirmation):**

Medi-Cal Enrollment Date:

Website Review (List name of webpage, locations, services, contact info etc?):

Please provide any additional information you would like us to know when reviewing your Letter of Interest:

Physical Therapy, Occupational Therapy and Speech Therapy Providers only

Please identify if your office provides PT/OT/ST

How many PT/OT/ST providers do you have at each location?

Please indicate any restrictions with availability