**Directions:**

The Agency Information schedule of the Adult Day Health (ADH) cost report has been expanded for FY16 and includes auto-populated data from our records that you must verify on this form. Please refer to the online version of the cost report and check the data in the first section of the Agency Information schedule, “Organization,” to complete this form. If the information is correct check the box next to the line item. If the information needs to be updated, use the line next to the item to add the updated information. *Note:* If an organization does not have a Parent Company and a blank line appears in the Agency Information schedule online, make sure to check the box on this form to confirm that the organization does not have a Parent Company.

If you have any questions about this form, please call the CHIA help desk at 617-701-8297. **This form is due on February 28, 2017.** Please email a ***signed*** form to CHIA-DL-Data-Submitter-HelpDesk@MassMail.State.MA.US

 CHIA-DL-Data-Submitter-HelpDesk@MassMail.State.MA.US

***If information from the online cost report is correct, check box. If edits are necessary, then fill in the line item.***

**Check Box If Correct:**

**Fill in the line(s) below to update:**

Operating Name:

Doing Business As (DBA)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Company (if any)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |

MassHealth Provider ID#

with Location

\*This consists of 9 numbers for the provider ID# and 1 letter for the location (i.e 123456789A)

Mailing Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUIRED INFORMATION**

**Preparer’s Name**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Agency Name and** **Title** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_