Provider Profile

Name: _____ Address: _____

Phone# (Home/Office): _____ Phone # (Cell):_____

E-Mail:_____ Provider #_____

Website: _____ Cert. Expiration Date: _____

Preferences/Availability/Specialty:

I am interested in receiving RFP's: Yes or No

Children – Yes or No age range _____
Availability_____
Specialty_____

Adults –Yes or No
Availabilty_____
Specialty_____

I/O Waiver Provider Yes or No
Level 1 Waiver Provider Yes or No
Self-Empowered Life Funding (Self) Waiver Yes or No
Transportation Provider Yes or No

Please check the following services/supports that you are certified for and/or can provide with rate.

____Homemaker/Personal Care
____HPC Transportation
____Day Habilitation
____Non-Medical Transportation
____ Independent Provider
____ Home Environmental Modifications
____ Respite
____ Vocational
____ Speech Therapy
____ Psychological Therapy
____ Physical Therapy
____ Occupational Therapy

I grant permission to the Union County Board of DD to enter this information onto the website www.ucbdd.org

_____

_____ _____
Signature Date

Please return to Provider Support by email at providersupport@ucbdd.org/ mail at:UCBDD,
16900 Square Drive, Suite 110, Marysville, Ohio 43040 Attn: Provider Support