

Please provide the following information. The information you provide for data submission purposes will be kept confidential.

**Program Information Form:**

Program Identification Number

Associated Agency Identification Number

Program Name

Address1

Address2

City

State

Zip

Program Contact Name

Program Contact Email

Program Contact Phone

Program Setting Type (e.g. Provider-Owned, Individual Residence, etc.)

Population(s) Served (e.g. TBI/Physically Disabled, etc.)

Total Number of Enrollees

Program Funding Sources (e.g. Medicaid/Non-Medicaid, Managed Long-Term Services and Supports)

Public reporting burden for this collection of information is estimated to average 5 minutes per response, the estimated time required to complete the form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-xxxx) AHRQ, 5600 Fishers Lane, Rockville, MD 20857.