COMMUNITY LINK, INC.
formerly CCCW, ContinuUs, & WWC

SERVICE LOCATIONS

A service location is defined as each facility-based location where members will be able to go to for services; or for in-home services, each location that will receive referrals for service. The Service Locations Form coincides with the Provider Application Form if more than one service location is needed.

***Service Location Name:** _____

***Street Address:** _____

City: _____ State: _____ Zip Code: _____

County of Location: _____

General Phone Number: _____ General Fax Number: _____

Medicaid Certification, if applicable State: Number:

Medicare Certification, if applicable Number:

***If a residential service, indicate staffing pattern of service location:**

***If a *residential service*, please mark all of the following that apply:**

- ☐ Location has overnight awake staff
- ☐ Location has semi-awake overnight staff
- ☐ Location is fully accessible on exterior (no steps or ramped)
- ☐ Location is fully accessible on interior (no steps)
- ☐ Location has specialized programming for challenging behaviors
- ☐ Location has specialized programming for moderate to severe Alzheimer's/dementia
- ☐ Location serves persons with developmental disabilities
- ☐ Location serves persons with physical disabilities
- ☐ Location serves aging/frail adults
- ☐ Location has specialized programming to serve individuals with criminal/sex offender issues
- ☐ Location has other specialized programming, please describe:

Other information specific to location:

*If service is based at a provider operated facility or office, is location Wheelchair Accessible? ☐ Yes ☐ No

*If licensed or regulated by the State of authority, has service location been issued any citations or statements of deficiency within the last 3 years? ☐ Yes ☐ No

If yes, please provide a description and current status:

Service Location Contacts- (if different from agency contacts listed in the Provider Application)

***Program/Facility Manager Name:** _____
(main point of contact for program or department questions, information)

Phone: _____ **Fax:** _____ **Email Address:** _____

Notifications to receive from CLI: ☐ Applicable CLI Notices ☐ Member Rate Agreement ☐ Insurance Renewal Notices ☐ Credentialing Notices

***Service Referral Recipient Name:** _____ **Same as Program Manager:** ☐

Phone: _____ **Fax:** _____ **Email Address:** _____

Notifications to receive from CLI: ☐ Applicable CLI Notices ☐ Member Rate Agreement ☐ Insurance Renewal Notices ☐ Credentialing Notice

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SERVICE LOCATIONS

Name: _____ **Same as Program Manager:** ☐

Phone: _____ **Fax:** _____ **Email Address:** _____

Notifications to receive from CLI: ☐ Applicable CLI Notices ☐ Member Rate Agreement ☐ Insurance Renewal Notices ☐ Credentialing Notice

***Hours of Operation or Availability, if NOT a residential service:**

Operations Available 24/7 ☐

Monday	to	☐Closed	Friday	to	☐Closed
Tuesday	to	☐Closed	Saturday	to	☐Closed
Wednesday	to	☐Closed	Sunday	to	☐Closed
Thursday	to	☐Closed			

Holiday Schedules for providers with annual Holiday Schedules when business is closed, please submit a current Holiday calendar with this application.