

OMB Approval No. 0938-0685

<b>7. Chain Home Office Information</b>			
This section is to be completed with information about the "Home Office" for those providers that are members of, or are joining, a chain organization.			
<b>A. Check here <input type="checkbox"/> if this section does not apply and skip to Section 8.</b>			
<b>B. Type of Action this Provider is Reporting</b>			
Check one:			
<input type="checkbox"/> Provider in chain for first time (Initial Enrollment or Change of Ownership)			
<input type="checkbox"/> Provider dropped out of current chain		Effective date: _____	
<input type="checkbox"/> Provider in a different chain since last report		Effective date: _____	
<input type="checkbox"/> Provider in same chain under new chain name		Effective date: _____	
<b>C. Chain Home Office Administrator Information <input type="checkbox"/> Change Effective Date: _____</b>			
Name of Home Office Administrator or CEO		First	Middle
		Last	Jr., Sr., etc.
Title of Home Office Administrator		Social Security Number	
		Date of Birth (MM/DD/YYYY)	
<b>D. Chain Home Office Information <input type="checkbox"/> Change Effective Date: _____</b>			
1. Name of Home Office as Reported to the IRS			
2. Home Office Business Street Address Line 1 (Street Name and Number)			
Home Office Business Street Address Line 2 (Suite, Room, etc.)			
City		State	ZIP Code + 4
Telephone Number ( ) ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)
3. Home Office Tax Identification Number		Home Office Cost Report Year-End Date (MM/DD)	
4. Home Office Intermediary		Home Office Chain Number	
<b>E. Type of Business Structure of the Chain Home Office <input type="checkbox"/> Change Effective Date: _____</b>			
Check one:			
Voluntary:		Government:	
<input type="checkbox"/> Non-Profit – Religious Organization		<input type="checkbox"/> Federal	
<input type="checkbox"/> Non-Profit – Other (Specify): _____		<input type="checkbox"/> State	
Proprietary:		<input type="checkbox"/> City	
<input type="checkbox"/> Individual		<input type="checkbox"/> County	
<input type="checkbox"/> Corporation		<input type="checkbox"/> City-County	
<input type="checkbox"/> Partnership		<input type="checkbox"/> Hospital District	
<input type="checkbox"/> Other (Specify): _____		<input type="checkbox"/> Other (Specify below): _____	
<b>F. Provider's Affiliation to the Chain Home Office <input type="checkbox"/> Change Effective Date: _____</b>			
Check one:			
<input type="checkbox"/> Joint Venture/Partnership		<input type="checkbox"/> Managed/Related	
<input type="checkbox"/> Operated/Related		<input type="checkbox"/> Leased	
		<input type="checkbox"/> Wholly Owned	
		<input type="checkbox"/> Other (Specify): _____	