

ACHC PER REPORT

Agency: _____ DBA: _____

Web site: _____ Phone: _____ fax: _____

Address: _____

Tax ID: _____ Exp. Date Accreditation: _____ Locations: _____

Contacts:

Name	Title	Phone	e-mail
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Services: DME Pharmacy SN HHA MSW OT PT ST
 staffing to Hospice Private Duty Sleep Testing

Contract any services: _____ Numbers of Employees: _____ Hours: _____

Date Established: _____

BLOCK out dates: _____

MC Provider #: _____ NPI #: _____ Unduplicated Admission last 12 months: _____

SCAN and e-mail to: **rcamacho@pnsystem.com**

- * Copy of Articles of Incorporation and/or other documentation of legal authority
- * PAC Meeting Minutes (last 4 minutes)
- * Marketing Materials Including Electronic Media (Brochure)
- * Employee Handbook

Please send your Preliminary Evidence Report (PER) and \$1,500.00 deposit to:

*Accreditation Commission for Health Care
4700 Falls of Neuse Road
Suite 280
Raleigh, NC 27609*