

**STATE OF MAINE
DEPARTMENT OF HEALTH & HUMAN SERVICES**

PROVIDER SUMMARY PAGE

Community Agency/Program Name: _____

TTY: _____

Executive Director: _____

Telephone #: _____ Fax #: _____

Address: _____

E-mail address: _____

Agreement Contact Person: _____

Telephone #: _____ Fax #: _____

Address: _____

E-mail address: _____

Fiscal Contact Person: _____

Telephone #: _____ Fax #: _____

Address: _____

E-mail address: _____

Clinical Director: _____

Telephone #: _____ Fax #: _____

Address: _____

E-mail address: _____

IT Services Contact: _____

Telephone #: _____ Fax #: _____

Address: _____

E-mail address: _____

Other Contact Information:

List all locations where client services are provided and include the contact person, telephone number, and hours of service.

Service	Service Site	Contact Person	Telephone #	Hours of Service	License Type and Capacity