STATE OF WASHINGTON
DEPARTMENT OF HEALTH

**CLIENT SERVICES**
**EARLY INTERVENTION & PRE-EXPOSURE PROPHYLAXIS PROGRAM**

**APPENDIX A (REQUIRED)**

| **SELECT ENTITY TYPE** | |
|---|---|
| ☐ TRB –Tribal Entity | ☐ GVS – Government State (EXCEPT Higher Ed) |
| ☐ CBO – Community Based Organization/Non-Profits | ☐ GVL – Government Local (EXCEPT Con-Con/LHJ) |
| ☐ PRV – Private/For-Profit | ☐ CLH – Local Health Jurisdiction |
| ☐ HSP – Hospital | ☐ HED – Higher Education |
| ☐ EMS – EMS/Trauma Center | ☐ GVF – Government Federal |
| ☐ SCH – Schools, School Districts & Education Institutions (excluding Higher Ed) | |

| **MAIN CLINIC/PRACTICE INFORMATION** | | | | | |
|---|---|---|---|---|---|
| Provider Name: | | Federal Tax ID#: | | | |
| Facility Name: | | Appointment Phone: | | | |
| Facility Address: | | | | | |
| City: | | State: | | Zip: | |
| **Services offered at this location:** ☐ Medical ☐ Laboratory ☐ Mental Health ☐ Radiologist ☐ Vision ☐ Dentist ☐ Oral Surgeon ☐ Denturist ☐ Endodontist | | | | | |

| **BILLING AND MAILING INFORMATION** | | | | | |
|---|---|---|---|---|---|
| Mailing address: | | | | | |
| City: | | State: | | Zip: | |
| Billing Address *(as it appears on your tax documents):* | | | | | |
| City: | | State: | | Zip: | |

| **CONTACT INFORMATION (DOH USE ONLY; *Information is not shared with clients*)** | | | |
|---|---|---|---|
| Contracts Manager Name: | | Phone Number: | |
| Email Address: | | Fax Number: | |

| Billing Manager Name: | ☐ *(same as above)* | Phone Number: | |
|---|---|---|---|
| Email Address: | | Fax Number: | |

| Office Manager Name: | ☐ *(same as above)* | Phone Number: | |
|---|---|---|---|
| Email Address: | | Fax Number: | |

| QUESTIONS |
|---|
| 1. How would you like to receive your remittances?<br><br>☐ Mail ☐ Online ☐ Both |
| 2. Do you have multiple clinic locations? *(please note, that all locations listed MUST bill under the same TIN you are contracting under)*<br><br>☐ Yes *(if 'Yes', please complete Appendix B)* ☐ No |
| 3. May we post your clinic location on our interactive map? *(please note that personal contact information will not be posted)*<br><br>☐ Yes ☐ No |
| 4. May we share your clinic location with case managers? ☐ Yes ☐ No |
| 5. Do you have bilingual providers and/or staff? ☐ Yes ☐ No<br><br>If 'Yes', what languages are spoken at your location(s)?<br><br>________________________________________<br><br>________________________________________ |
| 6. Does your location offer gender affirming care? ☐ Yes ☐ No |
| 7. Is your location LGBTA+ friendly? ☐ Yes ☐ No |
| 8. Would you like to receive further information on stigma reduction? ☐ Yes ☐ No |


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