SKILLED AGENCIES ** do not not print or scan the form please*

** Please save the document in your computer, using Adobe Reader type the info, and then email to us.*

www.pnsystem.com 305.818.5940 email: info@pnsystem.com CEMP submission **NOT INCLUDED**

☐ Emergency Plan only $ 185.00

☐ Federal addendums $ 75.00 *(Medicare Providers only)*

☐ Add electronic submission $ 100.00

User:

Password:

Please Fill OUT The following Information for your Emergency PLAN:

please use proper capitalization,* ***means Use Capital Letter at beginning of Names, Street, City, then lower case.*

Basic Information about the Agency

Agency: License #:

Address:

Phone Number: *(This number will be answered at all times)*

Fax Number:

County (ies) Licensed in: Email:

(All counties in your service area)

**please use proper capitalization*

Person in Charge during Emergency (Key Staff)

Administrator Name/Title:

Home Address:

Work Phone Number: **please use proper capitalization*

Personal email:

(alternate number can be a family member phone number)

Home-Cell Phone Number: alternate: ***Local Police Information*** *(Address/ph/fax/email):*

**please use proper capitalization*

Alternate Resp. Name: Tittle:

Home Phone Number:

Work Phone Number:

Personal email: Lease Landlord, or Association, Name / **phone**:

Cell Phone Number:

Agency Owner(s) **please use proper capitalization*

Agency Owner 2 (if applicable)

Name/Title: Tittle: Tittle:

Home Address:

Home Address:

Work Phone Number:

Home Phone Number:

Personal email:

Cell Phone Number: alternate: alternate:

(alternate number can be a family member phone number)

Agency population, service provided: ☐ Skilled Services (Nursing & Therapy) ☐ Non Skilled Services (Aide, Personal Care, etc.) ☐ Elderly persons ☐ Minors

☐ Any ages patients ☐ Other: Other:

4. DON: **please use proper capitalization,* ***means Use Capital Letter at beginning of Names, Street, City, then lower case***

Name/Title:

Home Address:

Work Phone Number: Email:

Cell Phone Number:

(Alternate DON Name)

Nursing Supervisor: Email:

Education Coordinator: Email:

Medical Records: Email:

(Resp. for filling)

Backup Agency Name: Phone Number:

Address:

Submitted by (NAME):

**do not sign*

Date:

** Please save the document in your computer, using Adobe Reader type the info, and then email to us.*