

**Private Hospital Supplemental Fund Program  
FY 2012-13  
Round 8B  
Contact Information**

<b>Hospital Legal Name</b>	
<b>Contact Person*</b> For negotiations	
<b>Title</b>	
<b>Mailing Address</b>	
<b>Telephone #</b>	
<b>Fax #</b>	
<b>E-mail Address**</b>	
<b>Person Authorized to Sign Contract</b>	
<b>Mailing Address</b> (or indicate if same as above)	
<b>Emergency Room Status</b> (circle one)	<b>standby / basic / comprehensive / closed / other (explain)</b>

\*Contact person must have the authority to contractually bind the hospital to the negotiated terms.

\*\* An e-mail address is required; the supplemental amendment will be transmitted electronically after DHCS' approval.

	Yes	No
<b>Copy of License attached?</b>		
<b>Do you anticipate a change to your hospital's legal name or has the hospital's legal name been changed?*</b>		
<b>Do you anticipate a change in your hospital's ownership and/or operator, or has the hospital's ownership and/or operator changed?*</b>		

\*If yes, please provide all relevant information to your SPCP negotiator.

Please return this form with the Proposal by **January 29, 2013** to:

Department of Health Care Services  
Office of Selective Provider Contracting Program  
1501 Capitol Avenue, MS 4000  
Sacramento, CA 95814  
(916) 440-7570 fax  
**SPCPcontact@dhcs.ca.gov**