Brain Injury Treatment, Rehabilitation or Residential Facility Information Form

Facility name/type (Acute care, post-acute care, rehabilitation, residential, other):

_____

Provider ID number: _____

Facility Address: _____

_____

_____

Facility phone number: _____

Facility email: _____

Name of contact person/position:

_____

Means of contact/alternate contact:

_____

Closest major highway:

_____

Number of beds: _____

Number of residents: _____

Age range: _____

Special equipment needs/requirements: _____

_____

Facility evacuation/preparedness plan on file _____

TEXAS Health and Human Services Commission

Office of Acquired Brain Injury

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