



GSRP Provider Interest Survey

The purpose of this questionnaire is to gather all the necessary information to begin your GSRP Implementation

Please gather the following information:

Owner's Name: _____

Work Number: _____

Mobil Number: _____

Email Address: _____

Company's Legal Name: _____

Doing business as: _____

Company Address: _____

Website: _____

Date business started: _____

Tax Reporting: Calendar Year or Fiscal Year
If Fiscal Year, when does your year-end? _____

License Number: _____



1. Please list all locations and indicate federal employee identification numbers (FEIN) for each.

Entity Types: LLC filing as Sole Proprietorship, Partnership, S-Corporation, Corporation.

Location Name _____ FEIN # _____ Entity Type _____

Location Name _____ FEIN # _____ Entity Type _____

Location Name _____ FEIN # _____ Entity Type _____

Location Name _____ FEIN # _____ Entity Type _____

Location Name _____ FEIN # _____ Entity Type _____

2. For Each of the Locations listed above, please provide the total licensed capacity.

Location Name _____ Licensed Capacity # _____

Location Name _____ Licensed Capacity # _____

Location Name _____ Licensed Capacity # _____

Location Name _____ Licensed Capacity # _____

Location Name _____ Licensed Capacity # _____

3. Which grant programs are you currently working with (outside of GSRP)?

Grant Name _____ Taxable Non-Taxable

Grant Name _____ Taxable Non-Taxable

Grant Name _____ Taxable Non-Taxable

Grant Name _____ Taxable Non-Taxable

