CHECK INFORMATION FORM

Temporary Health Care Services Agencies
and Health Care Technology Platforms

SEND TO: ESP Corning Tower, Room 1695 Albany NY 12237

Temporary health care services agencies must submit a non-refundable payment of $1,000 in the form of a check.

Parent companies should specify each subsidiary agency for which they are registering when submitting the annual fee for more than one agency.

Illegible forms will be returned to the agency for correction, resulting in delay. AGENCY NAME:		DATE:
CHECK IF PARENT COMPANY: ☐ YES ☐ NO	**IF YES,** THIS IS A PARENT COMPANY, PLEASE IDENTIFY EACH AGENCY THAT IS BEING REGISTERED:	
STREET ADDRESS:		
CITY:	STATE:	ZIP:
EMAIL:	PHONE:	AMOUNT OF PAYMENT (increments of $1,000 only):
PREPARED BY:		PHONE:

PLEASE INCLUDE A CHECK WITH THIS FORM AND MAIL TO THE DEPARTMENT OF HEALTH ADDRESS LISTED ABOVE.

Checks must be made out to: New York State Department of Health
Memo Line of Check: Temporary Health Care Services Agencies

Questions can be directed to: TempAgencyRegistration@health.ny.gov

Revised: 3/15/20234