

# DSHS REGION 2/3 HEALTHCARE FACILITIES - SNS CONTACT

**F  
R  
O  
M**

Point of Contact \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_

**T  
O**

Matthew Honza Region 2/3 SNS Coordinator \_\_\_\_\_

Texas Department of State Health Services \_\_\_\_\_

1301 South Bowen Road Suite 200 \_\_\_\_\_

Arlington, TX 76013 \_\_\_\_\_

(817) 264-4663 \_\_\_\_\_

Patients Covered: \_\_\_\_\_

Employees Covered: \_\_\_\_\_

Others Covered\*: \_\_\_\_\_

Family Members\*\*: \_\_\_\_\_

**Total Covered:** \_\_\_\_\_

\*Describe Others:

<b>SNS Delivery Location</b>	
Street Address _____	Delivery Details:
Suite/Room No. _____	
City _____	
State/Zip _____	

<b>Contact Information (for Delivery)</b>	<b>Primary Contact</b>
First Name _____	Work Phone: _____
Last Name _____	Home Phone: _____
Work E-mail _____	Cell Phone: _____
Personal E-mail _____	Fax Phone: _____

<b>Contact Information (for Delivery)</b>	<b>Alternate Contact</b>
First Name _____	Work Phone: _____
Last Name _____	Home Phone: _____
Work E-mail _____	Cell Phone: _____
Personal E-mail _____	Fax Phone: _____

<b>Contact Information (for Delivery)</b>	<b>Second Alternate Contact</b>
First Name _____	Work Phone: _____
Last Name _____	Home Phone: _____
Work E-mail _____	Cell Phone: _____
Personal E-mail _____	Fax Phone: _____

The above information is submitted for the coordination of SNS assets delivery for the facility mentioned above by an authorized agent of the company.	PRINT NAME _____ COMPANY NAME _____ TITLE _____ DATE _____
--	---

\*\* If you do not know the exact number of family members, you can assume an average of three dependents for each patient, employee or other person(s) that you wish to cover at this facility.