Type of Program

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TYPE OF PROGRAM

Name:
Address:

Phone Number:
Fax Number:
Internet/E-Mail:

Other Names/Contact Numbers:

Type of Program:	***Setting Type:***	***Staff to program participant ratio:***
☐ Independent Living Services ☐ Supportive Living Services ☐ Day Care ☐ Social Recreation Program ☐ Camp ☐ After school Program ☐ Activity Center ☐ Adult Development Center ☐ Behavior Management Program ☐ Habilitation (Job Training) ☐ Adult Day Health Care Program ☐ Adult Residential Facility–OO ☐ Adult Residential Facility–SO ☐ Children Residential Facility–OO ☐ Children Residential Facility–SO ☐ Assisted Living ☐ Respite ☐ Other: _____ *(OO – Owner Operated SO – Staff Operated)*	☐ Site/Center Based ☐ Community Based ☐ Residential Setting ☐ Other: _____ ***Funding Source:*** ☐ Medi-Cal (primary source) ☐ Regional Center (primary source) ☐ Dept. of Rehabilitation Funding ☐ Regional Center (secondary funding) ☐ Grant: _____ ☐ Private ☐ Other: SSI	☐ 1:8 ☐ 1:7 ☐ 1:6 ☐ 1:4 ☐ 1:3 ☐ Other: _____ ***Residential Service Level:*** ☐ L1 ☐ L2 ☐ L3 ☐ L4_____ ☐ Specialized _____ ***Licensed Capacity:*** Regional Center Vendored Capacity: Male/Female – Current # of participants: Age Group Served:

Vendor Numbers (if existing program)

Program Vendor Number:	Program License Number:

Other Existing Programs: