

NEW PROGRAM FORM/UPDATE

PROGRAM: _____

Other Name: _____

Contact Person: _____

Address: _____

City: _____ ZIP Code: _____

Please give mailing address, if different:

Phone: () _____

Office Hours: _____

TTY: () _____

Fax: () _____

Program Hours: _____

email: _____

web address: _____

ELIGIBILITY: Please indicate any eligibility criteria (age, geographic, type of disability, ambulatory/non-ambulatory, etc.): _____

PAYMENT: Please indicate any fees and third party payment (i.e. vendorization by Regional Center, Rehabilitation, Medi-Cal, insurance, etc.): _____

DESCRIPTION: Please give a program description. Use additional information if necessary.

APPLICATION: Please indicate the application procedure, i.e. by telephone, by mail, in person, etc.:

ACCESSIBILITY: Are all facilities wheelchair accessible? Please indicate any restrictions:

Client/Staff Ratio (if applicable): _____

PUBLIC TRANSPORTATION: Please indicate closest public transportation:

Closest bus line: _____

Closest BART station: _____

FOREIGN LANGUAGES/SIGN LANGUAGES: Please indicate if services are offered in any foreign languages/sign. Which language(s)? _____

SPECIAL TARGET POPULATION(S): Are your programs specific to one particular target population? Please indicate: _____
