Supplement #1
Community Services & Services for the Developmentally Disabled

APPLICANT NAME:____

OUTPATIENT FACILITIES

1. **PROVIDE # OF ANNUAL CLIENT CONTACTS/or number of clients in the program FOR EACH DESCRIPTION CHECKED:**

Service	# of annual visits	# of clients in program
☐ In Home Services	________________	______________________
☐ Services for Developmentally Disabled		
☐ Sheltered Work Shop	________________	______________________
☐ Day Programs	________________	______________________
☐ Supportive Living Services	________________	______________________
☐ Wilderness/Adventure Programs		
☐ Referral Agencies/EAP	________________	______________________
☐ Day School	________________	______________________
☐ Meals on Wheels:	____ #of meals served annually	
☐ Agency for the aged/seniors	________________	______________________
☐ Adult Day Care	________________	______________________
☐ Adult Day Health Care	________________	______________________
☐ Big Brother/Big Sister Program	________________	______________________
☐ Boys/Girls Clubs	________________	______________________
☐ Head Start	________________	______________________
☐ Early Intervention	________________	______________________

☐ Other (Please describe)____
____

2. Number of clients in the following age ranges:

   Under 18 years old_______________18 year to 65 years old_______________ Over 65 years old ________________

3. If the applicant provides a wilderness/adventure therapy program, please describe activities in full detail.

   ____

   ____

4. If the applicant has a Big Brother/Big Sister Program, please describe or attach employee and mentor screening procedures: ____

   ____

5. Indicate the type of work performed at onsite workshops:____
   ____

6. Indicate the type of vocational work performed by off-site contracts:

   Off-site Janitorial:___________________ Payroll: $___________________
   Off-site Landscaping:_________________ Payroll:$____________________
   Restaurant/Cafeteria:_________________ Receipts:$____________________
   Stores/Goodwill:_____________________ Sales:$______________________

RESIDENTIAL FACILITIES:

1. How many residential locations run by the applicant: ____________________

1. Any location with 25 beds or more beds? ☐ Yes ☐No

If yes, please identify each location (provide additional sheet if necessary):

Name/Address of Location	**#Beds**
________________________	________
________________________	________
________________________	________
________________________	________
________________________	________

3. PROVIDE # OF BEDS FOR EACH DESCRIPTION CHECKED

☐ Shelter for:

☐ Homeless __________

☐ Battered/Transitional __________

☐ Ex-Criminal/Halfway Homes __________

☐ Developmentally Disabled

☐ Community Residential __________

☐ Group Homes ___________

2. Number of clients in following age ranges:

Under 18 years old__________18 year to 65 years old ___________Over 65 years old___________