

**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: \_\_\_\_\_

\_\_\_\_\_