

DATE: \_\_\_\_\_

SERVICE TYPE: \_\_\_\_\_

### SERVICE PROVIDER RESOURCE INFORMATION

PLEASE COMPLETE THIS FORM AS THOROUGHLY AS THIS WILL ASSIST US IN MAKING REFERRALS

PROVIDER'S NAME: \_\_\_\_\_

ALSO KNOWN AS (dba): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OTHER LOCATION: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ HOURS: \_\_\_\_\_

DIRECTOR AND/OR  
CONTACT PERSON: \_\_\_\_\_

TAX ID OR SOCIAL SECURITY NUMBER: \_\_\_\_\_ STAFF RATIO: \_\_\_\_\_

ELIGIBILITY REQUIREMENTS (Include age and type of population and any special exclusion policy):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SERVICE DESCRIPTION: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

CAPACITY: \_\_\_\_\_ AREA SERVED: \_\_\_\_\_

FUNDING ACCEPTED: MEDI-CAL: • MEDICARE: • PRIVATE INSURANCE: •

OTHER FUNDING: \_\_\_\_\_

LANGUAGES SPOKEN OTHER THAN ENGLISH: \_\_\_\_\_

TYPE OF LICENSE HELD: \_\_\_\_\_ LICENSE #: \_\_\_\_\_

MEDI-CAL PROVIDER NUMBER (IF APPLICABLE): \_\_\_\_\_

DO STUDENTS, UNDER YOUR SUPERVISION, PROVIDE THIS SERVICE: \_\_\_\_\_