Advocate Name:

Organization Information Collection Form

Organization Name: ____

Type of Organization:

Mental Health Education Residential Therapies Adult Day Facility

Vocational: Sheltered Workshop, Rehab, Vocational Supported Employment Other ___________

Disability Population Served: ______________________ Age Served:______________________

Geographical Area Served: ____

Funding Sources: Medicaid Government Private Pay Donors Other _______________

Do you have a waiting list: Yes No

How do you get most referrals: ____

What are admission requirements: ____

____

Programs Offered: ____

Notes: