# New Service Provider Form

## 1) Agency Name (legal name):
- Enter Name

## 2) AKA (acronym, popular or former name):
- Enter AKA

## 3) Program Name (only if program exists):
- Enter Program Name

## 4) Street Address:
- Enter Street Address
- City, State, Zip:
  - Enter City
  - Enter State
  - Enter Zip Code
- Mailing Address:
  - Enter Mailing Address
  - City, State, Zip:
    - Enter City
    - Enter State
    - Enter Zip Code

## 5) Telephone Number(s)
- Main:
  - Enter Number
- Toll-free #:
  - Enter Number
- Fax:
  - Enter Number
- Toll-free #:
  - Enter Number
- TTY:
  - Enter Number

## 6) Agency Director & Title:
- Enter Name

## 7) Secondary Contact Person & Title:
- Enter Name

## 8) URL/Web Site:
- Enter Web Site

## 9) Primary/Public E-Mail Address:
- Enter E-Mail Address
- E-Mail Address for updating purposes:
  - Enter E-Mail Address

## 10) Days & Hours:
- Enter Days & Hours

## 11) Other Language(s):
- ☐ Spanish
- ☐ Sign Language
- ☐ Other

## 12) Geographic Area Served:
- ☐ McHenry County
- ☐ Lake County
- ☐ Kane County
- ☐ Other IL counties
- ☐ State of Illinois
- ☐ Nationwide Service

## 13) Is your agency public transportation accessible (by local bus service)?
- ☐ Yes
- ☐ No

## 14) Facility Accessibility:
- ☐ Full wheelchair access
- ☐ No access
- ☐ Limited access
- ☐ N/A

## 15) Agency Type/Legal Status (choose one):
- ☐ Non-profit / 501(c)(3)
- ☐ For-Profit/Proprietary
- ☐ Public/City
- ☐ Public/County
- ☐ Public/State
- ☐ Public/Federal
- ☐ Church Affiliated
- ☐ Support Group
- ☐ Unincorporated
- ☐ Coalition/Other
- ☐ Special District
16) Facility Type:
☐ Agency   ☐ Church   ☐ School
☐ Hospital   ☐ Clinic   ☐ Government Office
☐ Group Home   ☐ Private Practitioner   ☐ Other

17) Agency Funding:
☐ United Way   ☐ Donations   ☐ Corporation
☐ Foundation   ☐ Fees   ☐ Private fundraising
☐ City funding   ☐ County funding   ☐ State funding
☐ Federal funding   ☐ FEMA   ☐ HUD

18) Maximum Income Guidelines (% of Federal Poverty Level):
Enter Maximum Income Percent

19) Documents required:
☐ Birth Certificate   ☐ Proof of Income   ☐ Proof of Residency
☐ Social Security Card   ☐ Immunization Record   ☐ Other

20) Eligibility Requirements:
Please provide narrative here.

21) Provide a brief description of your agency/program. (Also include brochures or other printed materials that might be helpful.)
Please provide program narrative here.

22) Fees:
☐ No fees   ☐ Sliding Scale   ☐ Vary
☐ Fixed Fees   ☐ Donations requested   ☐ Other

23) Method of Payment Accepted:
☐ Medicaid   ☐ Medicare
☐ Private Insurance   ☐ Private pay

24) Referral/Application Procedures (i.e., by phone, walk-in, appointment):
Provide narrative of procedures here.

25) Meeting Times, Location (i.e., support groups and other groups that meet on a regular basis):
Provide information on groups and meetings here.
Meeting Contact Person(s) + Phone Number:
Provide information for meeting contacts here.

26) Are there other sites associated with your agency where services are offered?  ☐ Yes  ☐ No
If yes, please include applicable contact information (site address, phone, hours, director) as well as the services provided at that site:
Please provide all other information here.

27) Please print the name of the person who filled out this form and date.
Please provide information on person completing form here.