



ACCSSES Membership Directory Information Form

In an effort to get to know all of our ACCSES partners, please complete the questions below for the Website and Directory. At ACCSES, we respect your privacy and can assure you that your information is well protected on our secured website and will only be available for other members to view. Please send the saved copy to cecile.accses@verizon.net.

Thanks in advance for your time and assistance. Please do not hesitate to contact us with your questions/concerns.

Contact Name for Directory _____

Organization _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

Email _____

Website _____

Total Budget \$ _____

Total # of Employees (FTE's) _____

Total # of Individuals Served _____

Describe your Geographic Service Area _____

Please indicate yes or no next to the services offered by your organization.

Who do you serve?

- | | | |
|------------------------------|-----------------------------|--------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Children (0-5 years old) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Children (5-21/22) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Adult (16-64) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Adult (21-65) |

Yes No Seniors (65 and over)

Do you provide Day Habilitation Services? Yes No

Do you provide Employment and Training Services?

Yes No Supported Employment
 Yes No AbilityOne Employment (*If yes, please list product lines*)

Yes No Waiver Pre-vocational Employment

Yes No Organizational Employment

Yes No Other (*If yes, please list*)

Do you provide Residential/Community Living Services?

Yes No Intermediate Care Facility (ICF) Children
 Yes No Intermediate Care Facility (ICF) Adult
 Yes No Individual Residential Alternative (IRA) Children
 Yes No Individual Residential Alternative (IRA) Adult
 Yes No Community/Apartment Residence
 Yes No At Home Residential Hab
 Yes No Agency-Sponsored Family Care
 Yes No Consumer Directed Personal Care
 Yes No Individualized Support Services
 Yes No Traumatic Brain Injury (TBI) Waiver
 Yes No Other (*If yes, please list*)

Do you provide Family Support Services?

Yes No Respite
 Yes No Sibling Programs
 Yes No After School Care
 Yes No Support Groups
 Yes No Referral
 Yes No Advocacy

Do you provide Service Coordination Services?

- | | | |
|------------------------------|-----------------------------|-------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medicaid Service Coordination |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Early Intervention (EI) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Home Service |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Traumatic Brain Injury (TBI) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Care at Home |

Do you provide the following Leisure and Recreation Services?

- | | | |
|------------------------------|-----------------------------|---------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Summer Program – Adult |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Summer Program – Children |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Year-Round Recreation |

Do you provide the following Clinic Services?

- | | | |
|------------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dental Clinic |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Assistive Technology |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Durable Medical Equipment |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Primary Care |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medical/Rehabilitation/Habilitation |

Do you provide Transportation Services? Yes No

Do you provide Traumatic Brain Injury Waiver Services? Yes No

Do you provide the following Children’s Services?

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Early Childhood Detection/Development Center |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Early Intervention |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Preschool |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | School Age (5-21 year old) Programs |

Do you provide the following Behavioral/Mental Health Services?

- | | | |
|------------------------------|-----------------------------|------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Outpatient Therapy |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Supervised / Supported Residential |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Crisis Services |

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Physician Medication / Monitoring Services |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vocational Services |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Inpatient Hospitalization Services |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Partial Hospitalization / Day Treatment / Day Services |

Do you provide Substance Abuse Services? Yes No

Do you provide Interpreter Services? Yes No