

**HUMAN SERVICE PROVIDER  
INVENTORY**

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**SECTION A**

Provider Name: \_\_\_\_\_

Contact Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Mid. Init. \_\_\_\_\_

Mailing Address (Line 1): \_\_\_\_\_

Mailing Address (Line 2): \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Provide a description of your agency.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check all the services you provide:

- |  |   |
|--|---|
| <input type="checkbox"/> Developmental Services                | <input type="checkbox"/> Mental Health Services         |
| <input type="checkbox"/> Developmental Service Case Management | <input type="checkbox"/> Mental Health Case Management  |
| <input type="checkbox"/> Developmental Services Preschool      | <input type="checkbox"/> Nursing Facility               |
| <input type="checkbox"/> Group Home                            | <input type="checkbox"/> Senior Center                  |
| <input type="checkbox"/> Headstart                             | <input type="checkbox"/> Senior Nutrition               |
| <input type="checkbox"/> Headstart Other                       | <input type="checkbox"/> Sheltered Workshop             |
| <input type="checkbox"/> Headstart Homepage                    | <input type="checkbox"/> Other (Please Describe): _____ |
| <input type="checkbox"/> Job Training                          | _____   |

Please fill out the table on the following page and include each county served by your agency.

