Print Form

OWNED, LEASED OR OPERATED BUILDING / SERVICE
(Please complete a PAGE 3 for EACH service location / units)

Name of Bldg _____

Address _____

City _____ **State** _____ **Zip Code** _____ **County** _____

Phone Number _____ **Fax Number** _____

Ownership of Building _____

Type of Construction: _____ **Square Footage** _____ **Number of Stories** _____

Sprinkled? ☐ Yes ☐ No **If 24-hour adult residential, are ALL consumers capable of self-preservation?** ☐ Yes ☐ No

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DISABILITY SERVED *(Check ALL that APPLY)*
☐ Intellectually Disabled (ID)
☐ Mentally Ill (MI)
☐ Substance Abuse (SA)

AGE RANGE OF CONSUMERS SERVED *(Check ALL that APPLY)*
☐ Children 2-17
☐ Adults 18 +
☐ Adults 60+

TYPE OF SERVICES PROVIDED *(Check ONLY the service(s) provided via this building)*	
☐ Administrative Office	☐ I/DD Waiver Services
☐ Employment Services	☐ Outpatient Services
☐ Day Treatment - Intellectually Disabled	☐ Sheltered Workshop
☐ Day Treatment - Mentally Ill	

Total # of Consumers who Receive Services from this Building [Open Cases/Files ONLY]: _____

Please check all that apply & enter number of beds

☐ **Residential - ID** ☐ **Residential - MI** ☐ **Residential - SA**

TYPE OF RESIDENTIAL SERVICE			
Crisis Residential Unit		Detox Services	
Group Residential		Public Inebriate Shelter	
Respite		Other (please specify):	
Individual Apartments (Facility-Owned)			
Intermediate Care Facility / Individuals who are Intellectually Disabled (ICF/IID)			