



We give help, you give hope

**Care Home & Service Provider Registration**  
Incomplete registrations will not be considered

\_\_\_\_\_ Date

\_\_\_\_\_ Name of Care Home/Service Provider (Please print or type)

\_\_\_\_\_ Street **(Address of Facility)** City State Zip

\_\_\_\_\_ Phone E-mail

\_\_\_\_\_ Care Home Owner's Name

\_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Does Applicant: Live in a Residential Care Facility \_\_\_\_\_ SLS \_\_\_\_\_ ILS \_\_\_\_\_ other \_\_\_\_\_

**Please list individual clients below.**

Name of Clients, SLS or ILS Clients	Date of Birth M/D/YY	Male/Female (M/F)	Caucasian	Ethnicity (Optional) Check all that apply					Wheel Chair yes/no	Regional Center Client yes/no	Degree of Mental Retardation		
				African American	Hispanic	Asian	Other	Mild			Moderate	Severe	

Please attach a copy of a Regional Center assessment for applicant, along with Case Manager's name. If not a Regional Center client, please send a *Doctor's Diagnosis* with registration form.

Revised in January 2011