



**NON-LICENSED RESIDENTIAL AND/OR SUPPORTED
LIVING QUESTIONNAIRE ***

- 1. **Applicant Name:** _____
- 2. **Contact Person:** _____
- 3. **Phone No.:** _____
- 4. **E-Mail Address:** _____
- 5. **Mailing Address:** _____
- 6. **Location Address:** _____

7. Please complete the following:

Location #	Location/Program Name	Location Address
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

8. Please complete the following information on each location:

Location #	# of Clients	Funding Agency for Clients	Contracted Services Provided at Each Location
1.			
2.			
3.			
4.			
5.			
6.			
7.			

* To be completed in connection with the Human Services Program Questionnaire
A-10 (10/05)

Location #	# of Clients	Funding Agency for Clients	Contracted Services Provided at Each Location
8.			
9.			
10.			

9. Please complete the following information on each location:

Location #	House or Apartments	# of Bedrooms or Apartments	Leased in Client's Name Yes or No	Swimming Pool or Hot Tub (list which)	Total # of Staff	Staff to Client Ratio
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

10. Please complete the following support service information for each location:

Location #	Transportation Provided Yes/No	Type of Vehicle	# of Staff That May Drive	Medication Monitoring or Supervision Provided Y/N	List Any Medical Staff Positions at This Location
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

11. Please complete a short narrative on each location. Describe the program using the terminology that you and your funding agency use. Such as Adult Developmental Home, ASH Model, Individually Designed Living Arrangement, etc.

Location 1.	
Location 2.	
Location 3.	
Location 4.	
Location 5.	
Location 6.	
Location 7.	
Location 8.	
Location 9.	
Location 10.	

Signature of Applicant

Date

Title