<table>
<thead>
<tr>
<th>AGENCY NAME</th>
<th>AGENCY CONTACT PERSON</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
</table>

| DATE AVAILABLE | PROGRAM TYPE (CHECK ONE) |  |
|----------------|--------------------------|  |
|                | Supported Living | Group Home | Other: |

Address where supports are available or the geographical area where services can be provided:

**BRIEFLY DESCRIBE THE RESIDENCE AVAILABLE**

**RESIDENCE IS WHEELCHAIR ACCESSIBLE**

- Yes
- No
- Interior
- Exterior

<table>
<thead>
<tr>
<th>MAXIMUM OCCUPANCY OF RESIDENCE</th>
<th>PRESENT OCCUPANCY OF RESIDENCE</th>
</tr>
</thead>
</table>

**Current Tenants**

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>GENDER M / F</th>
<th>NAME</th>
<th>AGE</th>
<th>GENDER M / F</th>
</tr>
</thead>
</table>

**DESIRED REFERRALS**

- Male
- Female
- Either Gender

- Smoker
- Non-Smoker
- Either

Characteristics agency specializes in providing (e.g., specific age group, mental health supports, etc.):

Describe the level of assistance provided to current individuals, including any professional or specialized services that are also available:

Other characteristics of desired referrals:

A current staffing schedule is also attached:  

- Yes
- No

Additional comments, if any:

**DSHS 15-360 (REV. 05/2015)**