Registration Information (Contact)

8. Contact Information:*

Business Name (if applicable)	
Last Name	
First Name	
Address 1	
Address 2	
City	
State	
Zip	
Telephone Number (000-000-0000)	
Email (Enter "none" if none)	
Website (Enter "none" if none)	

9. Include this information in a publicly published directory of Service Providers.*

○ Yes ○ No

10. Provide a program statement of not more than 250 words (1800 characters) describing this provider. Providers may wish to discuss the numbers of sites and capacity available in different locations. If the provider has any special skills or abilities such as working with people with challenging behavior, health conditions or memory loss, the provider is advised to consider mentioning these. If there are geographical limitations within the specified county, or if contracts exists with counties other than where services are provided, please mention them here. *

The County or Counties in which the service would be provided

Select the population group or groups to be served. Check all that apply

- ☐ Children with Developmental Disbilities
- ☐ Children with a Physical Disability
- ☐ Children with a Severe Emotional Disturance

I give permission for United Cerebral Palsy to register me on the online State Medicaid Waiver Provider Registry.