

SECTION I: Group/Office Information

Primary Office Information

_____ Type of Practice: Solo Group Other: _____
Agency or Office Name

_____ *Address (Physical Office)* _____ *City* _____ *County* _____ *State*

_____ *Zip/Postal Code* _____ *Country*

_____ *Landmark or Identifying Description (i.e. Borough, Quarter, Mid-Town, etc.)*

_____ and _____
Cross Streets

Handicap and wheelchair accessible? Yes No

Location accessible by affordable public transportation? Yes No

Preferred, but not required:

Ability to access the Internet on a full-time basis to review and respond to referral intakes, complete necessary forms, document all case activity, and submit invoices? Yes No

Ability to access the Internet via Internet Explorer 6.0 or higher? Yes No

Office E-Mail Address: _____ Office Web Site: _____

Office Contact /EAP Coordinator: _____

Telephone, Main, **(confidential)** : _____

Telephone, 24 hour/7 day **(confidential)**: _____

referral authorization voice mailbox or answering service number: _____

Describe what arrangements you provide for 24/7 emergency coverage:

Fax Number **(confidential and secure)**: _____

TTY/TTD, telecommunication typewriter, phone number: _____

Payee Tax Number: (Must match W-9 name)

When submitting invoices, what tax ID number/business name do you use? (Choose one: Employer ID# and name **OR** Social Security number and name)

1. Employer Identification Number: _____ Employer Identification Name: _____

2. Social Security Number: _____ Social Security Name: _____

Payee Tax Information: (Must match W-9 address)

Address (Billing Office): _____ Suite: _____

City: _____ County: _____

State/Province: _____ Zip/Postal Code: _____ Country: _____

Office Hours:

What hours can clients be seen for in-person appointments (main location):

Mon _____ Tues _____ Wed _____

Thurs _____ Fri _____ Sat _____

Sun _____

SATELLITE/OTHER OFFICE LOCATIONS

(If different than main office location)

Satellite Office 1	Satellite Office 2
Street: _____	Street: _____
City: _____ County: _____	City: _____ County: _____
State/Province: _____ Zip/Postal Code: _____	State/Province: _____ Zip/Postal Code: _____
Phone: _____	Phone: _____
Handicap and wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicap and wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No
Location accessible by affordable public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location accessible by affordable public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No
EAP Contact: _____	EAP Contact: _____

(Attach supplemental pages for additional office locations.)

What hours can clients be seen for in-person appointments at Satellite Office 1

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

What hours can clients be seen for in-person appointments at Satellite Office 2

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

Accessibility (Attach explanations for “no” responses to the following questions.)

- Ability to return client phone calls within 1 business day? Yes No
- Ability to offer a routine appointment within 3 business days? Yes No
- Ability to offer an urgent appointment within 1 business day? Yes No
- Do you comply with federal, state and/or provincial, and local legal requirements governing public accessibility, health, and safety? Yes No
- Do you maintain a service environment in all primary and affiliate offices that is:
 - safe Yes No
 - clean Yes No
 - free of fire hazards Yes No
 - smoke free Yes No
 - child friendly Yes No
 - professional Yes No

Which classification best describes your agency as defined by the Small Business Administration? (Please select all that apply; for example, you may be small women owned and located in a HUBZONE)

- Large Business Small Disadvantaged Business Non-Profit
 Small Business Women-Owned Small Business Veteran-Owned Small Business
 HUBZone Small Business Service-Disabled Veteran-Owned Small Business

The following information is used for the VETS-100 annual report. Because The Sand Creek Group, Ltd. contracts with federal government agencies, our group is required to submit an annual report that includes the following information about our sub-contractors.

Please report the total maximum and minimum number of permanent employees in the past year:

Maximum Number _____ Minimum Number _____

Please report number of permanent full-time or part-time employees and new hires who are targeted veterans:

Job Categories	Special Disabled Veterans	Vietnam Era Veterans	Newly Separated Veterans	Other Protected Veterans
Officials and Managers				
Professionals				
Technicians				
Sales Workers				
Office and Clerical				
Craft Workers (Skilled)				
Operative (Semi-Skilled)				
Laborers (Unskilled)				
Service Workers				
Total				