



The Adam Haslam Foundation

SERVICE PROVIDER APPLICATION

Name of Individual or Agency: _____

Contact Name (if different from above): _____ Title or Position _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Fax: (____) _____

E-Mail: _____ Web Address: www. _____

Individual **Sole Proprietor** **Partnership** **Corporation** **Other:** _____

Federal Tax ID Number: _____

Are you willing to donate your services or a portion of your services as a charitable contribution? **Yes** **No**

What type of service(s) do you or your organization provide:

(Check all that apply)

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Dental | <input type="checkbox"/> Psychiatric | Substance Abuse | Legal |
| | | | <input type="checkbox"/> Detox | <input type="checkbox"/> Civil |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Food | <input type="checkbox"/> Transportation | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Criminal |
| | | | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Family/Child Custody |
| Counseling | DUI Services | | <input type="checkbox"/> Residential | <input type="checkbox"/> Bankruptcy |
| <input type="checkbox"/> Individual | <input type="checkbox"/> Licensed Evaluation | | <input type="checkbox"/> Individual | <input type="checkbox"/> Personal Injury |
| <input type="checkbox"/> Group | <input type="checkbox"/> Licensed Treatment | | <input type="checkbox"/> Group(s) | <input type="checkbox"/> Corporate |
| <input type="checkbox"/> Couples/Marital | <input type="checkbox"/> Driving School | | | |
| <input type="checkbox"/> Family | | | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Pastoral | | | _____ | |

List licensure(s), accreditation(s) and other professional recognition(s) for you and/or your organization (including license numbers, dates of affiliation, etc.) Attach copies or additional sheets if necessary:

PROFESSIONAL REFERENCES

Agency: _____ Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

Agency: _____ Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

Agency: _____ Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

BUSINESS REFERENCES

Bank: _____ Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

Checking: _____ Saving: _____

Other: _____ Other: _____

Trade Reference: _____ Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

Trade Reference: _____ Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

Trade Reference: _____ Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

POPULATION(S) SERVED

(Check all that apply)

- Male Only Female Only Pregnant Women Women with Children
- Co-Ed H.I.V. Positive Gay/Lesbian Senior Citizens
- Adolescents Physically Handicapped Visually Impaired Hearing Impaired
- Dual Diagnosed Veteran's Administration African-American Hispanic
- Other: _____ Other: _____
- Other: _____ Other: _____

FINANCIAL INFORMATION

Fees Charged:

\$ _____ per Hour Day Week Month Other: _____

Do you offer or accept:

(Check all that apply)

- Cash Check Visa/MC AMEX Diners Other: _____
- Sliding Scale Scholarship Insurance Medicaid Medicare SSI SSDI

MISSION STATEMENT AGREEMENT/RELEASE OF INFORMATION

As an authorized representative of the provider or agency listed within this application, I am requesting that I/we be accepted as an approved provider of services for H.O.W.Co. – The Adam Haslam Foundation. I am authorizing H.O.W.Co. – The Adam Haslam Foundation to investigate any statements contained within this application. I further authorize the release of information from any agency in order for H.O.W.Co. – The Adam Haslam Foundation to determine my eligibility to become an approved provider. I agree to hold harmless any agency which provides information to H.O.W.Co. – The Adam Haslam Foundation which causes H.O.W.Co. – The Adam Haslam Foundation to decline my application for an approved provider status. I have read the Mission Statement of H.O.W.Co. – The Adam Haslam Foundation and I/we will honor this statement in regards to my/our relationship as a service provider to H.O.W.Co. – The Adam Haslam Foundation.

Applicant/Representative Signature	Title/Position	Date
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Official Use Only – Do not write below this line.

Interviewed By: _____ Date: _____

- Professional References Checked Trade References Checked Physical Plant Inspection (if applicable)

Notes: _____

Applicant presented to the Board by: _____ Date: _____

Motion to: Accept Decline this applicant's request to be an approved provider of H.O.W.Co. – The Adam Haslam Foundation.

RECORD VOTE HERE:

To be incorporated in the minutes of the meeting of the Board of Directors of H.O.W.Co. – The Adam Haslam Foundation.