**Agency Name: Sue Pinto**  
 **Name and Title of Representation: Sue Pinto,   
  
Main Office Address:  
  
Has agency submitted a Reopening template to OPWDD?**

\_\_x Yes  
\_\_\_No  
  
**Has agency sent any materials to individuals/families?**\_\_x Yes  
No  
  
**For each of the agencies Sites and/or Programs, please answer the following**  
**Program Type:**  
  
\_\_\_ Assistive Technology   
\_\_\_ Community Habilitation    
\_\_\_ Day Habilitation   
\_\_\_ Environmental Modification   
\_\_\_ Fiscal Intermediary   
\_\_\_ Individual Directed Goods and Services   
\_\_\_ Intensive Behavioral Services    
\_\_\_ Live-In Care Giver   
\_\_\_ Pathway to Employment   
\_\_\_ Prevocational Services   
\_\_\_ Residential Habilitation    
\_\_\_ Respite   
\_\_\_ Support Broker   
\_\_\_ Supported Employment   
\_\_\_ Vehicle Modification   
\_\_\_ Other

**Other program:**  
**Subcategory, if applicable:**   
(please type full name, no abbreviations or acronyms)  
  
**\_\_\_ No changes to program check here**   
  
  
  
  
**Is program delivered at alternate site?**\_\_\_ Yes  
\_\_\_ No  
  
**If yes, provide appropriate address:**  
  
**Contact for Site/Program:**(first, last, title)  
  
**Contact Phone Number:  
  
Contact Email:  
  
Date of Site/Program reopening:  
  
Program schedule upon reopening:**\_\_\_ 8-4/5  
\_\_\_ 12 hours  
\_\_\_ 24 hours  
\_\_\_ Other  
  
**If other, please explain:  
  
Changes to plan for transportation to/from Program:**  
  
  
**Program/ Site will serve individuals from:**

\_\_\_ Community  
\_\_\_ Residential  
\_\_\_ Community and Residential  
  
**Are you accepting new referrals?**

\_\_\_ Yes  
\_\_\_ No  
  
**Any other information pertinent to individuals/families/Care Managers?**