**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?**