

CCANS Member Information Form

DATE: _____

Organization Name: _____

Mailing Address: _____

_____ Postal Code _____

Phone: (902) _____ Fax: (902) _____

Primary Contact Name: _____

Position Title: _____

E-mail: _____

Website: _____

Phone (in addition to above): (902) _____

Type of Organization: _____ non-profit _____ for-profit

Total Number of Staff Members: _____ Approximate number of FTEs: _____

Union Status: _____ non-union _____ unionized with: _____

Funded by: _____ DCS _____ Health _____ other: _____

Services provided – please check all that apply and list the number of facilities and total number of people served in each category.

	# Facilities	# People
<input type="checkbox"/> Nursing Home	_____	_____
<input type="checkbox"/> Adult Residential Centre	_____	_____
<input type="checkbox"/> Regional Rehabilitation Centre	_____	_____
<input type="checkbox"/> Residential Care Facility (Health)	_____	_____
<input type="checkbox"/> Residential Care Facility (Community Services)	_____	_____
<input type="checkbox"/> Licensed Group Home	_____	_____
<input type="checkbox"/> Small Option Home (persons with disabilities)	_____	_____
<input type="checkbox"/> Small Option Home (seniors)	_____	_____
<input type="checkbox"/> Supported Apartments	_____	_____
<input type="checkbox"/> Other: _____	_____	_____
Totals:	_____	_____