Hope Connection Service Provider Registration

Organization Name: ____________________

Contact Person: ____________________ Phone #: ____________________

E-mail Address: ____________________

Address: ____________________ Zip Code: ____________________

To ensure we have an accurate lunch count, how many individuals from your agency will attend? ____________

Service Category of Organization (please select one):

- ☐ Business (For Profit)
- ☐ Church/Faith-Based Organization
- ☐ Foundation/Philanthropic
- ☐ Government - Federal
- ☐ Government - State
- ☐ Government - Local
- ☐ Civic Organization
- ☐ Educational Institution

Category of Service Organization Will Provide at Hope Connection:

- ☐ Medical Services
  Specify: ____________________
- ☐ Mental Health Service
- ☐ Substance Abuse Treatment
- ☐ Legal Support
- ☐ Housing
  Specify: ____________________
- ☐ Employment
- ☐ Children's Services
- ☐ Basic Needs
  Specify: ____________________
- ☐ Legal Documentation
  Specify: ____________________

What forms of identification will you require from clients (e.g. picture ID, social security card, birth certificate, etc.)?

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Each provider will have one table and two chairs. If you need additional amenities, such as close proximity to an electrical outlet, etc., please let me know:

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Please return this completed form to

Community Partnership
Attn: Michelle Garand
330 N. Jefferson Ave.
Springfield, MO 65806

or fax to 888-2322, Attn: Michelle Garand

or register online at www.commpartnership.org/hope.php