Please return this form for evaluation to be an Authorized Service Provider

COMMUNITY ASSISTANCE PARKING PROGRAM
LOS ANGELES DEPARTMENT OF TRANSPORTATION
221 N. Figueroa Street 13th Floor
Los Angeles, CA 90012
Office (213) 978-4435 – ladot.capp@lacity.org
Fax (800) 430-8039

SERVICE PROVIDER FORM

Service Provider Organization Name: _____

Managing Contact Person Name and Title: _____

Contact Phone: _____ Fax: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

The person listed above will be your managing contact for administration and verification of completion of the Community Assistance Parking Program community hours. Will they be at the Clinic? ☐ Yes ☐ No
If "No," please provide the name and contact information for your on site representative.

On Site Representative: _____ Title: _____

Contact Phone: _____ Email: _____

Please choose the category that best describes your organization's services

☐Benefits Assistance ☐Employment ☐Faith ☐Food ☐Housing ☐ID ☐Legal ☐Medical
☐Mental Health ☐Substance Abuse ☐Other (Pets, Outreach, Travel assistance, etc.)

Brief description of services provided (i.e. "Provide housing vouchers" or "Connect clients to job training"):

_____

_____

Description of community obligation work available at your facility: check all that apply

☐General Labor ☐ Office Work ☐ Job Readiness Training ☐Anger Mgt ☐ AA/NA Meetings
☐Life Skills Classes ☐Mental Health Counseling ☐Parenting ☐Other _____
☐Accept Both Female and Male ☐Female Only ☐Male Only

Special requirements for CAPP participants: (residents only; closed toed shoes, etc.).

_____

_____

Other Pertinent Information

_____

Thank you for your participation!