



San Bernardino County Homeless Partnership
Homeless Provider Network
Registration Form

Instructions: Please submit this form via e-mail to: homelessrpf@hss.sbcounty.gov, or by mail to the Office of Homeless Services – 560 E. Hospitality Lane, Suite 200, San Bernardino, CA 92408-0044

			Date:
Member Name: <input type="checkbox"/> (Mr.) <input type="checkbox"/> (Ms.)			
Mailing Address:			
City:	State:	Zip:	Phone: () -
E-mail Address:			

Organization Name (if applicable):			
Executive Director: <input type="checkbox"/> (Mr.) <input type="checkbox"/> (Ms.)			
Business Address:			
City:	State:	Zip:	Phone: () -
E-mail Address:			Fax: () -

Member Representative (Name one Voting and two Alternates)	
Voting Name:	Email
Alternate Name:	Email:
Alternate Name:	Email:

Regional Meeting (Please identify <u>ONLY ONE</u> primary region where you are interested in serving)		
<input type="checkbox"/> Central Valley	<input type="checkbox"/> Desert Region	<input type="checkbox"/> East Valley
<input type="checkbox"/> Mountain Region	West Valley	(A member may participate in more than one Region but may Only vote in their primary)

Do you provide homeless services to San Bernardino County residents? If no, please provide an explanation of services and service area.	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Are you a current voting member of the San Bernardino County Interagency Council on Homelessness (ICH)?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Will you benefit from financial gain if you are appointed as a HPN Representative? If yes, please provide an explanation.	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>

Signature: _____ Date: _____

For Office Use Only: (Do Not Write Below the Line)

Approved: <input type="checkbox"/>	Denied: <input type="checkbox"/>	Log#:	Reviewer Initials:
Comments:			