CBDS Community of Practice Application

(untitled)

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1. Name of organization

[   ]

2. Name of person completing this application

Name [   ]

Address [   ]

Email [   ]

Phone number [   ]

Job title [   ]

3. Does your organization currently contract with DDS to provide CBDS services? If the answer to this question is no please note that only current CBDS providers are eligible for this CoP. We do not recommend that you proceed with this application.

○ Yes

○ No

4. Does your agency currently contract with DDS to provide employment services?

  ○ Yes

  ○ No

5. How many individuals does your agency serve either part time or full time in CBDS?

[   ]

6. How many CBDS program sites do you operate?

[   ]

7. Which regions do your CBDS programs currently serve?

  ☐ Central/West

  ☐ Northeast

  ☐ Southeast

  ☐ Metro

8. Please provide a brief description of your agencies CBDS services. Please share strengths as well as challenges.

[   ]

9. Rank the following items based on the level of importance to you in your CBDS program development efforts.
1=least important
11=most important *

	1	2	3	4	5	6	7	8	9	10	11
Transportation	○	○	○	○	○	○	○	○	○	○	○
Development of community resources	○	○	○	○	○	○	○	○	○	○	○
Developing individualized services	○	○	○	○	○	○	○	○	○	○	○
Integrating discovery/career planning into CBDS	○	○	○	○	○	○	○	○	○	○	○
Supporting transitions from CBDS to employment	○	○	○	○	○	○	○	○	○	○	○
Managing schedules	○	○	○	○	○	○	○	○	○	○	○
Developing a siteless CBDS program	○	○	○	○	○	○	○	○	○	○	○
Capacity of staff to provide services in the community	○	○	○	○	○	○	○	○	○	○	○
Financial support for community activities	○	○	○	○	○	○	○	○	○	○	○
Insuring that CBDS experiences are goal directed	○	○	○	○	○	○	○	○	○	○	○
Other	○	○	○	○	○	○	○	○	○	○	○

10. If you selected other please describe below.

11. Participant 1

Name

Job title

Email address

12. Participant 2

Name

Job title

Email address

13. Participant 3

Name

Job title

Email address

14. Participant 4

Name

Job title

Email address