

**CRP Service Design Proposal for Existing Approved CRPs**

DR 402A (New 03/23)

**Community Resources Development  
Community Rehabilitation Program  
Service Design Proposal for Existing Approved CRPs**

**Please complete one form per fee for service DOR Service you are requesting approval to provide.**

Date Form Completed:

**SERVICE INFORMATION**

Service Name:

Business Locations / Satellite Office Name(s) if applicable, where the above service will be provided (please list all):

DOR CRD Specialist(s) for the locations / satellite sites named above (if applicable):

**DOR DISTRICT(S) TO BE SERVED WITH SERVICE NAMED ABOVE (CHECK ALL THAT APPLY)**

Blind Field Services

Specify location(s):

Greater East Bay

Greater Los Angeles

Inland Empire

Los Angeles South Bay

Northern Sierra

Orange/San Gabriel

Redwood Empire

San Diego

San Francisco

San Jose

San Joaquin Valley

Santa Barbara

Van Nuys/Foothills

**SERVICE DESIGN PROPOSAL**

Please use the following format to describe the service to be provided. You may utilize this document for the service description or create your own if all the necessary and needed information is included. Please ensure to submit a fully completed application and service design proposal to not delay the addition of service(s).

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**Population to be Served Information**

Disability population to be served:

Optimum number of clients to be served per fiscal year (projected /actual):

Define unit of service (hour, day, client, other):

Average number of units of service per client:

Staff to client ratio - e.g., 1 to 1:

**Service Methodology:**

How will service be provided?

Where will service be provided (community, facility based, classroom, etc.)?

What curriculum or special techniques will be used?

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Who will provide the direct service?

What are the staff qualifications?

Who will monitor staff performance?

What training is required and how will it be provided to direct service staff?

**Service Outcomes:**

Describe expected outcomes and how they will be measured:

Describe how client satisfaction will be measured:

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**Referral and Marketing:**

Describe your referral process:

Describe plan for monthly reporting:

Describe how you will market this service:

**CERTIFICATION**

By entering my name and title below, I certify that the information provided is true and accurate to the best of my knowledge and I have authority from my organization's governing body to develop and submit this information. I acknowledge all required documents to begin the initial steps of the required DOR certification process are attached.

CRP Contact Name and Title:

CRP Contact Phone and Email Address:

Date Signed: