
Name _____
Organization _____
Title _____
Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
Email_____

Population Served (Circle all that apply):
Those with Disabilities Age Vulnerable Economically Disadvantaged
Geographic/Cultural Isolation Limited Language Proficiency
Other (please list) _____

Outreach Capabilities _____
_____

Topic Suggestions for Future Workshops_____
_____
_____

**Are you interested in becoming a KOIN member? Yes No (Circle One)**
**Are you a current KOIN member? Yes No (Circle One)**
**If yes, has there been a recent change in your contact information? Yes No**
**Please provide updated contact information here: _____**
_____
_____

Please return completed form to:

Barbara Fox
CHFS Office of Communications
275 East Main Street 5C-A
Frankfort, KY 40621