



AGENCY INFORMATION FORM

Please return this form to:

2-1-1 Tampa Bay Cares, Resource Dept, P.O. Box 5164, Largo, FL 33779 or Fax to (727) 518-3353.

It is very important that the information we have about your agency is accurate.

The relevance of referrals to your organization depends on that accuracy.

Please print clearly. Please do not leave any blanks. Write N/A if question does not apply. Attach PROGRAM/SERVICES Forms.

Agency/Business Name: _____

Federal ID #: _____

Contact Person for Listing (communicates with 2-1-1 Resource Specialist for agency information updates):

Name: _____ **Title:** _____

Phone: _____ **Fax:** _____ **E-mail Address:** _____

Does agency agree NOT to discriminate in providing services based on race, ethnicity, sexual orientation, religion, or disability?

YES NO

Director of Agency: _____ **Title:** _____

Agency Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mailing Address (if different than above): _____

City: _____ **State:** _____ **Zip Code:** _____

Agency Phone(s): _____ **Agency TTY/TDD:** _____

Agency FAX: _____ **Email Address:** _____

Website: _____

Agency Business Hours: _____ **Days:** _____

Agency Type: Government Not-for-Profit for Profit Informal/Not-Incorporated Other _____

License & Accreditation: JACHO COA JWBASSET Other _____

Does your Agency offer a Support Group? Yes No

If so, please fill out a separate Support Group Information Form for each support group in addition to the Agency Information Form and the Individual Program Form.

If your agency provides medical services within one or more of its programs, please fill out a Medical Services Information Form in addition to the Agency Information Form and the Individual Program Form. Thank you.

INDIVIDUAL PROGRAM / SERVICE INFORMATION

(program pg 1 of 3)

> Use one form per Program. Make copies, if necessary.

Program/Service Name: _____

Person In Charge of Program: Name: _____ **Title:** _____

Contact Person for Program (communicates with 2-1-1 Resource Specialist for program information updates)

Name: _____ **Title:** _____

Phone Number: _____ **Fax:** _____

E-mail Address: _____

Address of the Program: _____

City: _____ **State:** _____ **Zip Code:** _____

Address is confidential.

Program Phone(s): _____

Program TTY/TDD: _____ **FAX:** _____

Website: _____ **Email Address:** _____

INTAKE/CLIENT Hours: _____ **Days:** _____

OFFICE Hours: _____ **Days:** _____

Description of Services (or attach): Please list below those services you offer to anyone meeting your eligibility requirements.

NOTE: Callers are referred to your agency based on this description: _____

Eligibility: Populations Served (check all groups served by program)

Gender: Male Female Both

Ages: 0-3 3-18 18-54 55 and above 65 and above All Other _____

Marital Status: Single Divorced Married Separated Single Widowed All

Employment Status: Full-time Part-time Student Unemployed Disabled

Citizenship: US citizen Permanent resident (green card) Documented individual Undocumented individual

Residency: County residents Homeless individuals Visitors

Disabilities: Mental Health Physical Disability

Income Criteria: 100% of Federal Poverty Level 150% of Federal Poverty Level No set criteria
 Other _____

Insurance Status: Insured (Medicaid, Medicare, veteran, or HMO/PPO) Uninsured Both

Proselytization: Do clients need to adopt a particular value system or set of religious beliefs to be served?
 Yes No

Criminal background check: Is a criminal background check required? Yes No

INDIVIDUAL PROGRAM / SERVICE INFORMATION

(program pg 3 of 3)

Transportation: Please specify your program's accessibility to transportation.

- Program provides transportation
 Program will arrange for transportation
 Client responsible

Public Transportation: Within 7 blocks of bus system (Route # _____)

Seasonal: Does this program provide seasonally specific services (e.g. summer, back-to-school, Thanksgiving, Holiday)?

- Summer youth program
 Back-to-school

 Thanksgiving Holiday
 Other _____

Are seasonal services restricted to current clients only? Yes No

Other Program Locations: Does your agency have other program locations that provide the EXACT SAME services as this program? If so, list them below. Attach separate sheet if additional space is needed.

Location Name: _____

Address: _____ City: _____

Zip Code: _____ Phone: _____ Hours/Days: _____

Location Name: _____

Address: _____ City: _____

Zip Code: _____ Phone: _____ Hours/Days: _____

Signature of Program Manager (required)

Phone #

Today's Date

Program/Service Name: _____ **Location:** _____

VOLUNTEER OPPORTUNITIES / DONATION REQUESTS
For Non-Profit Agencies ONLY

ATTENTION: Use one form per Program. Make copies, if necessary.

Volunteer Opportunities: In which of the following areas can volunteers make a contribution in your organization?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Accounting/Bookkeeping | <input type="checkbox"/> Counseling | <input type="checkbox"/> Health/Medical | <input type="checkbox"/> Researchers |
| <input type="checkbox"/> Administrative/Office | <input type="checkbox"/> Crafts/Hobbies | <input type="checkbox"/> Host/Hostess | <input type="checkbox"/> Skilled Trades |
| <input type="checkbox"/> Animal care/rights | <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Immigration/Refugee | <input type="checkbox"/> Special Events |
| <input type="checkbox"/> Board development | <input type="checkbox"/> Data Entry | <input type="checkbox"/> Intake Counselors | <input type="checkbox"/> Store Clerk |
| <input type="checkbox"/> Business development | <input type="checkbox"/> Donation pick-up | <input type="checkbox"/> Literacy/GED | <input type="checkbox"/> Supervision |
| <input type="checkbox"/> Caretakers | <input type="checkbox"/> Donations sorter | <input type="checkbox"/> Maintenance/yard work | <input type="checkbox"/> Telephone counselor |
| <input type="checkbox"/> Career Counseling | <input type="checkbox"/> Education/Training | <input type="checkbox"/> Mentors | <input type="checkbox"/> Translation |
| <input type="checkbox"/> Child/Youth development | <input type="checkbox"/> Entertainers | <input type="checkbox"/> Public Relations | <input type="checkbox"/> Transportation/Delivery |
| <input type="checkbox"/> Childcare/Daycare | <input type="checkbox"/> Environmental | <input type="checkbox"/> Public Speaking | <input type="checkbox"/> Tutors |
| <input type="checkbox"/> Community policing | <input type="checkbox"/> Fine & Performing Arts | <input type="checkbox"/> Reception/Greeter | <input type="checkbox"/> Volunteer Coordinators |
| <input type="checkbox"/> Companion/Visiting | <input type="checkbox"/> Food Prep/Serving | <input type="checkbox"/> Recreation/Sports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Computer/Technology | <input type="checkbox"/> Fundraising/Grants | <input type="checkbox"/> Recycling | _____ |

Do you accept groups as volunteers (e.g. corporate, civic, church)? Yes No

Do you accept youth groups? Yes No

Do you accept families with children as volunteers? Yes No

Do you accept youth (age 10-17) as volunteers? Yes No Minimum age _____

Do you do a criminal background check on volunteers? Yes No

Do you accept court-ordered youth? Yes No Minimum age _____

Do you accept court-ordered adults over 18 yrs old? Yes No

Seasonal: Does this program offer any of the seasonal volunteer opportunities (examples listed below)?

- Summer Back-to-school Summer Holiday Other _____

Donations: Does your agency accept ongoing, non-monetary donations in support of program/services? Yes No

If yes, please check all that apply

Cell phones Clothing (please specify): men women children infants

Food Household items Furniture Small appliances (microwaves, toasters, etc.)

Large appliances (TVs, refrigerators, etc.) Office equipment/computers Other _____

Is pickup available? Yes No

Seasonal: Does this program offer seasonal donations (e.g. back-to-school, Thanksgiving, Holiday)?

- Back-to-school Summer Holiday Other _____

Volunteer Contact: _____

Donation Contact: _____

Signature: _____

Signature: _____

Phone: _____

Phone: _____



Get Connected. Get Answers.

Today's Date: _____

Today's Date: _____

MEDICAL SERVICES/CLINIC PROGRAM INFORMATION

- 1. Do you limit services to people without health insurance? Yes No
- 2. Do you have a pharmacy available to clients? Yes No
 If so, is medication free or on a sliding scale for clients? Free Sliding Scale (for those who qualify) No
- 3. Do clients need documentation of US citizenship? Yes No
- 4. Do you have a drug assistance program, which assists patients in completing applications to drug companies?
 Yes No
- 5. Do you provide lab work and X-Rays? Yes No If so, where are these procedures performed?
 Clinic Hospital (which one) _____ other _____
- 6. Do your clinic doctors provide referrals to specialists? Yes No
 If so, what type of specialists may be available? cardiologist dietician endocrinologist
 physical therapist podiatrist ophthalmologist urologist
 other(s) _____
- 7. Where do these specialists see your patients? at your clinic at the specialist' office
 at the hospital other _____
- 8. If clients are receiving services at the clinic for free or for reduced fees, are the services of the specialists free or reduced also? Yes No Depends (explain) _____
- 9. Do you provide diabetes screenings for patients? Yes No
- 10. Do your doctors write prescriptions for insulin? Yes No
- 11. Do you provide free diabetic testing supplies? Yes No
- 12. Do you have a diabetes educator, nutritionist, or dietician available to help patients with meal planning and diabetes management? Yes (which one?) _____ No
- 13. Do you offer cholesterol screenings for patients? Yes No
- 14. Do you offer any services for smoking cessation? Yes No
 If so, what kind? classes support groups medication other _____
- 15. Do you provide physicals for employment/school? Yes No
- 16. Do you provide immunizations? Yes No

SUPPORT GROUP INFORMATION

Parent Agency _____ Agency Web Site _____

 Program _____

 Name of support group _____

Contact Information:

Please provide full names, phone numbers, and email addresses for **two** contacts if possible.

Contact #1:

Name _____

 Phone number _____

 Email Address _____

Contact #2:

Name _____

 Phone Number _____

 E-mail Address _____

Meeting Information:

Name of support group _____

 This support group has been in existence since _____

 Meeting Day(s) _____

 Meeting Time(s) _____

 Address _____

 City _____ State _____ Zip Code _____

 Location/Building _____ Room _____

 Is this a 12-Step program? Yes No

 Is meeting information provided on your website? Yes No

 Local Website Address _____

 Do you charge fees for participation? Yes No

 If so, what are the fees? _____

 What is the first step in joining this support group?

Services: Please provide a brief description for this support group's services.
