# 2-1-1 Community Resource Database And Volunteer Solutions Inclusion Application

Return completed application to: Sasha Reinoso, Manager of Information Resources
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## AGENCY/ ORGANIZATION INFORMATION – PAGE ONE

**AGENCY LEGAL NAME:** ______________________________

**AGENCY COMMON NAME (ABBREVIATION, AKA, DBA):** ______________________________

**PARENT ORGANIZATION (IF ANY):** ______________________________

**AFFILIATIONS:** ______________________________

**AGENCY VISION/ MISSION STATEMENT OR MOTTO:** ______________________________

______________________________

______________________________

______________________________

**MAILING ADDRESS:** ______________________________

______________________________

**PHONE NUMBER:** ____________________ **FAX NUMBER:** ____________________

**WEBSITE:** ____________________ **EMAIL:** ____________________

**AGENCY DIRECTOR (INCLUDE TITLE):** ______________________________

**DIRECTOR PHONE NUMBER:** ____________________ **EMAIL:** ____________________

**AGENCY CONTACT (INCLUDE TITLE):** ______________________________

**CONTACT PHONE NUMBER:** ____________________ **EMAIL:** ____________________

**(Contact person is individual who may be reached by 2-1-1 for additional information and updates)**

**AGENCY/ FACILITY TYPE:** ______________________________

**AGENCY TAX STATUS (CHECK ONE):**

**FOR PROFIT**______ **NON-PROFIT**______ **GOVERNMENT**______ **OTHER, PLEASE EXPLAIN:** ____________________

**MONTH AND YEAR ESTABLISHED/ INCORPORATED:** ______________________________

**DOES AGENCY OFFER VOLUNTEER OPPORTUNITIES? YES / NO** **IF NO, CONTINUE TO NEXT PAGE.**

**VOLUNTEER COORDINATOR:** ______________________________

**PHONE NUMBER:** ____________________ **EMAIL:** ____________________

**DOES AGENCY ALLOW COURT-ORDERED VOLUNTEERS? YES / NO**

**IF YES, WHAT CHARGES/ CONVICTIONS ARE NOT ACCEPTED? (E.G. NO VIOLENT CRIMES)**

______________________________

**ARE GROUPS OF VOLUNTEERS ACCEPTED? YES / NO**

**WHAT IS THE MAXIMUM NUMBER OF VOLUNTEERS IN A GROUP YOUR AGENCY CAN ACCOMMODATE?** ____________

**WHAT IS THE MINIMUM AGE FOR VOLUNTEERS AT YOUR AGENCY?** ____________

**DOES AGENCY ACCEPT VOLUNTEERS IN THE EVENING AND ON WEEKENDS? (CHECK ONE)**

**NO**___________ **YES, EVENINGS**___________ **YES, WEEKENDS**___________ **YES, BOTH**___________

# AGENCY LOCATIONS/ SITES AND SERVICES – PAGE TWO

**LOCATION A – This is your primary or main location information.**
**It will be labeled as "main office" unless you specify otherwise.**

LOCATION A – PRIMARY OR MAIN OFFICE: ___________________________________________________________

ADDRESS: ________________________________________________________________________________

CITY: ______________________ STATE: ___________ ZIP: ________________ COUNTY: ____________________

MAILING ADDRESS (IF DIFFERENT): _____________________________________________________________

PHONE NUMBER: ________________________________ FAX NUMBER: ____________________________________

OTHER NUMBERS: _______________________________________________________________________

ADMINISTRATIVE HOURS (DAYS & HOURS): _______________________________________________________

ACCESSIBILITY AT THIS LOCATION (CHECK ALL THAT APPLY):

WHEELCHAIR ACCESSIBLE _______ FLASHING LIGHTS FOR HEARING IMPAIRED _______ PUBLIC PARKING _______

LANGUAGES SPOKEN: ____________________________________________________________________

SITE MANAGER (INCLUDE TITLE): ________________________________________________________________

MANAGER PHONE NUMBER:_____________________ EMAIL: ______________________________________________

SITE CONTACT (INCLUDE TITLE): ________________________________________________________________

CONTACT PHONE NUMBER:_____________________ EMAIL: ______________________________________________

(Contact person is individual who may be reached by 2-1-1 for additional information and updates)

COUNTIES SERVED BY <u>THIS</u> LOCATION (CHECK ALL THAT APPLY):

ORANGE ____ OSCEOLA ____ SEMINOLE ____ MARION ____ ALACHUA ____ BRADFORD ____ DIXIE ____

GILCHRIST ____ LAFAYETTE ____ LEVY ____ UNION ____ OTHER(S): ________________________________________

NAME OF SERVICE/ PROGRAM A: _________________________________________________________________

BRIEF DESCRIPTION OF SERVICE/ PROGRAM: ______________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

LICENSES: ______________________________________________________________________________

PLEASE IDENTIFY TARGET GROUP(S) FOR THIS SERVICE (E.G. ELDERS, PEOPLE WITH DEMENTIA, TEENS, ETC):

______________________________________________________________________________________

WHO IS ELIGIBLE? (CHECK ALL THAT APPLY):

AGES ACCEPTED {MIN AGE: _______ MAX AGE: _______} ALL AGES ACCEPTED ____ SERVES CAREGIVERS 18+ ____

ACCEPTS ADULTS WITH SPMI 18+ _____ FEMALES ONLY _____ MALES ONLY _____ ONLY SERVES FAMILIES _____

ADDITIONAL ELIGIBILY REQUREMENTS: ___________________________________________________________

HOW DOES SOMEONE ACCESS THIS SERVICE? PHONE _____ WEBSITE _____ OTHER: __________________________

DOCUMENTATION REQUIRED: ___________________________________________________________________

HOW DOES SOMEONE PAY FOR THIS SERVICE/ PROGRAM? (CHECK ALL THAT APPLY)

FREE SERVICE ________ SLIDING SCALE {$______ to $______} PRIVATE PAY/ FEE FOR SERVICE {$______ to $______}

MEDICAID ACCEPTED _______ MEDICARE ACCEPTED _______ INSURANCES ACCEPTED _________________________

# ADDITIONAL SITES AND/OR SERVICES– PAGE THREE

**Location B is used for an additional physical location of your agency.**
**If you have more than two locations, please make appropriate copies before continuing.**

LOCATION B– PRIMARY OR MAIN OFFICE: ____________________________________________________________

ADDRESS: ______________________________________________________________________________

CITY: ______________________ STATE: ___________ ZIP: ________________ COUNTY: ____________________

MAILING ADDRESS (IF DIFFERENT): ___________________________________________________________

PHONE NUMBER: ________________________________ FAX NUMBER: ____________________________________

OTHER NUMBERS: _________________________________________________________________________

ADMINISTRATIVE HOURS (DAYS & HOURS): ______________________________________________________

ACCESSIBILITY AT THIS LOCATION (CHECK ALL THAT APPLY):

WHEELCHAIR ACCESSIBLE _______ FLASHING LIGHTS FOR HEARING IMPAIRED _______ PUBLIC PARKING _______

LANGUAGES SPOKEN: _____________________________________________________________________

SITE MANAGER (INCLUDE TITLE): ____________________________________________________________

MANAGER PHONE NUMBER:_____________________ EMAIL: ______________________________________________

SITE CONTACT (INCLUDE TITLE): _____________________________________________________________

CONTACT PHONE NUMBER:______________________ EMAIL: _____________________________________________

COUNTIES SERVED BY THIS LOCATION (CHECK ALL THAT APPLY):

ORANGE ____ OSCEOLA ____ SEMINOLE ____ MARION ____ ALACHUA ____ BRADFORD ____ DIXIE ____

GILCHRIST ____ LAFAYETTE ____ LEVY ____ UNION ____ OTHER(S): ________________________________________

**Service/ Program B is used for an additional service or program provided by your agency.**
**If you have more than two services/ programs, please make appropriate copies before continuing.**

NAME OF SERVICE/ PROGRAM B: ______________________________________________________________

BRIEF DESCRIPTION OF SERVICE/ PROGRAM: ____________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

LICENSES: _____________________________________________________________________________

PLEASE IDENTIFY TARGET GROUP(S) FOR THIS SERVICE (E.G. ELDERS, PEOPLE WITH DEMENTIA, TEENS, ETC):

_______________________________________________________________________________________

WHO IS ELIGIBLE? (CHECK ALL THAT APPLY):

AGES ACCEPTED {MIN AGE: _______ MAX AGE: _______} ALL AGES ACCEPTED ____ SERVES CAREGIVERS 18+ ____

ACCEPTS ADULTS WITH SPMI 18+ _____ FEMALES ONLY _____ MALES ONLY _____ ONLY SERVES FAMILIES _____

ADDITIONAL ELIGIBILY REQUREMENTS: ___________________________________________________________

HOW DOES SOMEONE ACCESS THIS SERVICE? PHONE _____ WEBSITE _____ OTHER: __________________________

DOCUMENTATION REQUIRED: _________________________________________________________________

HOW DOES SOMEONE PAY FOR THIS SERVICE/ PROGRAM? (CHECK ALL THAT APPLY)
FREE SERVICE ________ SLIDING SCALE {$______ to $______} PRIVATE PAY/ FEE FOR SERVICE {$______ to $______}
MEDICAID ACCEPTED _______ MEDICARE ACCEPTED _______ INSURANCES ACCEPTED _________________________