Community Living Connections Resource Directory
Organization Information Form

COMMUNITY LIVING CONNECTIONS — Seattle & King County

* Staff Name Completing Form: ______________________________

*Staff Phone #: _____________ *Staff Email Address: _______________________________________

ORGANIZATION/AGENCY INFORMATION

Please clearly fill out all items. If not applicable, please mark N/A

*New Agency/Organization's Legal Name: ____

*New Agency/Organization's Listing Name (i.e. Abbreviation, Doing Business As [DBA]):

____Legal Status:_______________________

Site Location

*Address Type: Select All That Apply: __ Confidential, __Internet Only, __ Site, __ Mailing Address, __ Main, __ Temporary, _ Alternate Main, __ Alternate Home adding addresses appropriate.

*Address: Street ____

City, State, Zip ____

County ____

Address Same as Main Agency: Yes______ No ______

*Phone Type: Select One: __ Afterhours, __ Alternate Fax, __ Alternate Main, __ Alternate Phone, __ Beeper/Pager, __ Chinese Line, __ Emergency, __ Fax, __ Hotline, __ Information Line, __ Main, __ Office, __ Office 2, __ Russian Line, __ Spanish Line, __ TDD, __ Toll-Free Line, __ TTY adding phone numbers as appropriate.

*Phone Number: ____

*E-Mail: ____

*Check if Applies: _____No Physical Address ______Confidential Location

*Is your Facility ADA (Americans with Disabilities Act) compliant? (Select N/A if you do not provide services in-house or are not required to be accessible.)

Please Select One: __ Unknown, __ No, __ Yes Fully, __ Yes Partially, __ N/A)

Equipped with Elevators: Please Select One: __ No, __ Yes, __ N/A)

Please check if Applicable: _____Accessible to Public Transportation

_____Provides Transportation to/from Service?

Days Open: Regular Office Hours:

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Service Information (Use separate sheets/pgs. 2 and 3 for each service provided.)

*Name of Service: ____

*AKA: ____

*Detailed Description of Service (A succinct but relevant description of services provided):

*Where Service is Provided: __ Consumers Home, __ On Site, __ Telephone, __ Website
*Website: ____
*E-Mail: ____

*Administrative Contact (who to contact to update listing):

Name: Last________________________ First_____________________ MI____
Title: ____
Phone: ____
E-Mail: ____

*Service Area (Indicate all counties where this service is provided):

Target Population
*Age Range Served: From:______ To_________(Please include minimum age if applicable and leave maximum age blank if there is no upper age limit)
*Other Eligibility Criteria: ____

*Languages Spoken: Indicate All that Apply:

Availability

*Program Hours of Operation

____Check if 24/7

Day	Open	Close
Monday	__________	___________
Tuesday	__________	___________
Wednesday	__________	___________
Thursday	__________	___________
Friday	__________	___________
Saturday	__________	___________
Sunday	__________	___________

How to Access Services:

*Can Service providers refer directly? _____Yes ______No

*Intake Contact:

Name: Last_________________________ First______________________ MI____

Title: ____

Phone: ____

E-Mail: ____

***Cost**

____Check here to indicate that no one will be denied service for inability to pay

___ Fee Range From_____ To_______

Per: __ Day, __ Hour, __ Meal, __ Month, __ Night, __ Trip, __ Unit, __ Week

____Fixed Fee (for "Fixed Fee" or "Suggested Donation", only fill out the "From" box and select units)

____Sliding Scale

____Suggested Donation Minimum Income: Select One: __ Monthly, __ Yearly)

____No Fee Maximum Income: Select One: __ Monthly, __ Yearly)

_____Call for Information

_____Scholarship Available

_____(percentage) of Gross Income

*Funding Sources Accepted: ____Call for Information, _____Medicaid, ____Medicare, _____Private Insurance, _____Private Pay, _____Veterans Administration

*Does Not Accept: _____Medicare, _____Medicaid, ____ Other (describe)_______________