* 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

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*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:

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)_____