Community Living Connections Resource Directory
Organization Information Form

* 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:

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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)_____

Please complete and send form back to Sarah.Desai@Seattle.Gov