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| Please clearly fill out all items and sign on the last page. If not applicable, please mark N/A.  After completion, please send by email to: Davette.wellmaker@myeldersource.org  Or by fax to: (904) 391-6684  For questions, call: Davette Wellmaker (904) 391-6684 | | |
| **YOUR CONTACT INFORMATION (Person completing this form.)** | | |
| Name: | Title: | |
| Telephone: | Email: | |
| **AGENCY INFORMATION** | | |
| Agency Legal Name: | | |
| Also known as: | | |
| Physical Address: Confidential? ☐ | Mailing Address (if different): Confidential? ☐ | |
| Line 1: | Line1: | |
| Line 2: | Line 2: | |
| City, State, Zip: | City, State, Zip: | |
| **PHONE & OTHER CONTACT INFORMATION** | | |
| Main Contact Name: | Title: | Phone: |
| Email: | | |
| Director Name: | Title: | Phone: |
| Email: | | |
| Fax: | Main/Toll Free Number: | |
| Website: | TDD/TTY: | |
| Agency Type (check one): ☐For Profit ☐Non-Profit ☐United Way Member ☐Faith-Based ☐City  ☐County ☐State ☐ Federal ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  IRS Status: \_\_\_\_\_\_\_\_\_\_\_ Tax ID: \_\_\_\_\_\_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Attach copy of license) | | |
| Funding Source: ☐City ☐County ☐State ☐Federal ☐Fee for Service ☐United Way  ☐Fund Raising ☐Donations ☐Private ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Has your organization been in business at least one year? ☐Yes ☐No Month/Year Incorporated: | | |
| Accessibility Features: ☐Fully Accessible ☐Limited Access ☐Designated Parking ☐Full Wheelchair Access ☐Elevators ☐No Access ☐Close to public transportation? | | |
| Programs available at this location: | | |
| **AGENCY & SERVICES OVERVIEW** | | |
| Briefly describe services available at this location (attach additional sheets, if needed): | | |

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| Office Hours: |
| Eligibility: |
| Intake Procedures: |
| Fees: |
| Payment Options Available:  ☐Private Pay ☐Private Insurance ☐Medicare ☐Medicaid ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Languages Spoken: ☐English ☐Spanish ☐Creole ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *The information below is obtained solely to better match client needs with the appropriate service providers and will not affect your application to enlist in our database as a resource.*  Population served: ☐18+ ☐Specific Ages \_\_\_\_\_ to \_\_\_\_\_\_ ☐Women Only ☐Men Only ☐Alzheimer’s/Dementia ☐LGBTQ ☐Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you offer discounted pricing or a sliding fee for seniors/disabled adults? ☐Yes ☐No Explain: |
| Would you be willing to offer any pro bono services on a short term basis? ☐Yes ☐No Explain: |
| Service Area (City & County): |

OTHER LOCATION(S) INFORMATION:

DO NOT complete this section if you only have one location. Use additional sheets, if needed, for additional locations

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| **Physical Address:** Confidential? ☐ | **Mailing Address:** Confidential? ☐ |
| Line 1: | Line 1: |
| Line 2: | Line 2: |
| City, State, Zip: | City, State, Zip: |
| **Location Overview** | |
| Main Phone/Reception: | |
| Public Email: | |
| Website: | |
| Accessibility Features: ☐Fully Accessible ☐Limited Access ☐Designated Parking ☐Full Wheelchair ☐Access ☐Elevators ☐No Access ☐Close to Public Transportation? | |
| Office Hours: | |
| Eligibility: | |
| Intake Procedures: | |

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| Fees: |
| Payment Options Available:  ☐Private Pay ☐Private Insurance ☐Medicare ☐Medicaid ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Programs available at this location: |
| Service Area (City & County): |
| Services available at this location: |

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| Any additional details or information about your agency? |
| ACKNOWLEDGMENT    I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ attest that the information provided on behalf of our agency/organization is true and accurate. I also understand and agree that misrepresentation or omission of pertinent information regarding the agency and/or services provided will result in the deletion of the agency or organization from the database without notice. Furthermore, it is acknowledged and understood that participation in the statewide database does not constitute an endorsement of the agency by the Department of Elder Affairs or by the Aging & Disability Resource Centers in Florida.    Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **\*\*\*This form must be signed before information can be entered in Refer Database\*\*\*** |