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| **AGENCY APPLICATION/UPDATE FOR 2-1-1 SANTA CRUZ COUNTY** |
| **AGENCY INFORMATION** |
| **Inclusion Criteria** |
| Does your organization provide services that you believe are appropriate for inclusion in the 2-1-1 database, based the 2-1-1Santa Cruz County Inclusion/Exclusion Policy ? Yes No |
| Have you been in operation for at least six months? Yes No |
| **Agency Information** |
| Agency Name (Legal): |
| Is your agency also commonly known by another name or abbreviation: |
| Parent Agency (If legally part of another organization, department, division, etc. please provide legal name): |
| Agency Description: (describe your agency in one or two sentences): |
| Agency Type:Nonprofit: If Yes, what is your tax designation? 501(c)3 501(a) No formal designation Other: Government/PublicReligiously Affiliated Organization (No formal legal designation) Membership Organization (No formal legal designation)For Profit/Proprietary |
| **Agency Contact Information** |
| Agency Website/URL: | Agency Email: |
| Is your physical address:A confidential location Yes No | Agency Physical Address : | City, State: | Zip: |
| Wheelchair accessible |  | Yes |  | No |
| Mailing Address is same as above | Agency Mailing Address : | City, State: | Zip: |
| Agency Administration Phone #: | TDD/TTY #: Fax #: |
| Agency Senior Executive(Name & Title) |  | Phone: | Email: |
| Agency Primary Contact for2-1-1 Updates(Name & Title) |  | Phone: | Email: |
| Administration Office Hours: MondayTuesdayWednesday Thursday Friday Saturday Sunday | What holidays does your agency close for? |

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| **PROGRAM INFORMATION****(Please submit one Program Application per program)** |
| Agency Name: | Program Name: |
| Is this program commonly known by another name or abbreviation? |
| Program Website/URL (only if different than agency): | Program Email Contact: |
| **Program Description/Primary Services***Maximum of 100 words.* |  |
| Name(s) of the sites/locations offer your program? , , ( i.e. Santa Cruz Office, Watsonville Office)***Please include address information about each physical location(s) in the Program Site form below.*** |
| Intake Procedure: Telephone Intake Walk-In Call for Appointment Referral Required Other: |
| Documentation Required at Intake: (i.e. ID, SS card, Proof of Income etc.) |
| Program eligibility requirements (i.e. must be 18 years old or younger):Is this service available to all Santa Cruz County residents or is it only available to residents of a specific area?All Santa Cruz County residents Residents of a specific city/cities only: Residents of a specific zip code(s) only: |
| Fees *(check all that apply)***:**No Fee Accepts Medi-CalSliding Scale fee $ to $ based on Accepts Medi-CareSet program fee: Accepts most insurance |
|  |  | Fees vary from to based on |  | Membership fee $ per |
| Program Hours: Monday Tuesday Wednesday ThursdayFriday Saturday Sunday |
| Service is available in:English Spanish Other: Interpreter Services Available *(list languages)*: |
| **PHONE NUMBERS** |
| Main Program Phone #:Other Phone # (if different from Main): Purpose of other phone (i.e. Afterhours 5pm-8am): Fax # *(if needed for intake)*: TDD/TTY Phone #: |

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| **PROGRAM SITE 1 INFORMATION****(Please submit one Site Application for each physical location where services are offered)** |
| Site Name (This is the name of the physical location. It can be specific – i.e. ABC Family Resource Center – or general – i.e. Santa Cruz Office) : |
| Is this location:A confidential location Yes No | Physical/Street Address: | City, State: | Zip: |
| Wheelchair accessible |  | Yes |  | No |
| Mailing Address same as physical address | Mailing Address: | City, State: | Zip: |
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| **PROGRAM SITE 2 INFORMATION****(Please submit one Site Application for each physical location where services are offered)** |
| Site Name (This is the name of the physical location. It can be specific – i.e. ABC Family Resource Center – or general – i.e. Santa Cruz Office) : |
| Is this location:A confidential location Yes No | Physical/Street Address: | City, State: | Zip: |
| Wheelchair accessible |  | Yes |  | No |
| Mailing Address same as physical address | Mailing Address: | City, State: | Zip: |

**\*\* Submit additional PROGRAM SITE INFORMATION pages as needed.**

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| **SIGNATURE** |
| **I VERIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE.****I AGREE THAT, IN ORDER TO KEEP THE 2-1-1 SANTA CRUZ COUNTY DATABASE ACCURATE AND UP TO DATE, MY AGENCY WILL INFORM 2-1-1 SANTA CRUZ PROMPTLY REGARDING CHANGES TO AGENCY OPERATIONS THAT MAY IMPACT 2-1-1****REFERRALS. I AGREE TO PROVIDE UPDATED AGENCY INFORMATION AS REQUESTED BY 2-1-1 (i.e. during the annual 2-1-1 update cycle). I HAVE READ AND UNDERSTOOD 2-1-1 SANTA CRUZ COUNTY’S INCLUSION/EXCLUSION POLICY.** |
| **PRINT NAME:** | **PHONE:** |
| **TITLE:****DATE:** | **EMAIL:** |

***SUBMIT APPLICATIONS/UPDATES VIA EMAIL, FAX, OR U.S. MAIL***

*APPLICATIONS/UPDATES WILL BE PROCESSED WITHIN 7 DAYS OF RECEIPT.*

**2-1-1 Santa Cruz County / United Way of Santa Cruz County**

**4450 Capitola Rd., Suite 106, Capitola CA 95010 (831) 465-2201**  **(831) 479-5477 fax**

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