

## 2-1-1 Community Resource Database and Volunteer Solutions Inclusion Application

Return completed application to:

Haley Helms, MSW, Manager of Information Resources

1940 Traylor Boulevard, Orlando, FL 32804 **OR** Fax: 407-244-2802

Phone: 407-429-2214 or 407-835-0926 Email: Haley.Helms@hfuw.org

### AGENCY/ ORGANIZATION INFORMATION – PAGE ONE

AGENCY LEGAL NAME: \_\_\_\_\_

AGENCY COMMON NAME (ABBREVIATION, AKA, DBA): \_\_\_\_\_

PARENT ORGANIZATION (IF ANY): \_\_\_\_\_

AFFILIATIONS: \_\_\_\_\_

AGENCY VISION/ MISSION STATEMENT OR MOTTO: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

WEBSITE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

AGENCY DIRECTOR (INCLUDE TITLE): \_\_\_\_\_

DIRECTOR PHONE NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

AGENCY CONTACT (INCLUDE TITLE): \_\_\_\_\_

CONTACT PHONE NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

(Contact person is individual who may be reached by 2-1-1 for additional information and updates)

AGENCY/ FACILITY TYPE: \_\_\_\_\_

AGENCY TAX STATUS (CHECK ONE):

FOR PROFIT \_\_\_\_\_ NON-PROFIT \_\_\_\_\_ GOVERNMENT \_\_\_\_\_ OTHER, PLEASE EXPLAIN: \_\_\_\_\_

MONTH AND YEAR ESTABLISHED/ INCORPORATED: \_\_\_\_\_

DOES AGENCY OFFER VOLUNTEER OPPORTUNITIES? YES / NO

**IF NO, CONTINUE TO NEXT PAGE.**

LIST VOLUNTEER OPPORTUNITIES: \_\_\_\_\_

VOLUNTEER COORDINATOR: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

DOES AGENCY ALLOW COURT-ORDERED VOLUNTEERS? YES / NO

IF YES, WHAT CHARGES/ CONVICTIONS ARE NOT ACCEPTED? (E.G. NO VIOLENT CRIMES)

\_\_\_\_\_

ARE GROUPS OF VOLUNTEERS ACCEPTED? YES / NO

WHAT IS THE MAXIMUM NUMBER OF VOLUNTEERS IN A GROUP YOUR AGENCY CAN ACCOMMODATE? \_\_\_\_\_

WHAT IS THE MINIMUM AGE FOR VOLUNTEERS AT YOUR AGENCY? \_\_\_\_\_

DOES AGENCY ACCEPT VOLUNTEERS IN THE EVENING AND ON WEEKENDS? (CHECK ONE)

NO \_\_\_\_\_ YES, EVENINGS \_\_\_\_\_ YES, WEEKENDS \_\_\_\_\_ YES, BOTH \_\_\_\_\_

## AGENCY LOCATIONS/ SITES AND SERVICES – PAGE TWO

LOCATION A – This is your primary or main location information.  
It will be labeled as “main office” unless you specify otherwise.

LOCATION A – PRIMARY OR MAIN OFFICE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

MAILING ADDRESS (IF DIFFERENT): \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

OTHER NUMBERS: \_\_\_\_\_

ADMINISTRATIVE HOURS (DAYS & HOURS): \_\_\_\_\_

ACCESSIBILITY AT THIS LOCATION (CHECK ALL THAT APPLY):

WHEELCHAIR ACCESSIBLE \_\_\_\_\_ FLASHING LIGHTS FOR HEARING IMPAIRED \_\_\_\_\_ PUBLIC PARKING \_\_\_\_\_

LANGUAGES SPOKEN: \_\_\_\_\_

SITE MANAGER (INCLUDE TITLE): \_\_\_\_\_

MANAGER PHONE NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

SITE CONTACT (INCLUDE TITLE): \_\_\_\_\_

CONTACT PHONE NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

(Contact person is individual who may be reached by 2-1-1 for additional information and updates)

COUNTIES SERVED BY THIS LOCATION (CHECK ALL THAT APPLY):

ALACHUA \_\_ BRADFORD \_\_ CITRUS \_\_ DIXIE \_\_ GILCHRIST \_\_ LAFAYETTE \_\_ LAKE \_\_ LEVY \_\_ MARION \_\_ ORANGE \_\_

OSCEOLA \_\_ PASCO \_\_ SEMINOLE \_\_ SUMTER \_\_ UNION \_\_ OTHER(S): \_\_\_\_\_

NAME OF SERVICE/ PROGRAM A: \_\_\_\_\_

BRIEF DESCRIPTION OF SERVICE/ PROGRAM: \_\_\_\_\_

\_\_\_\_\_

LICENSES: \_\_\_\_\_

PLEASE IDENTIFY TARGET GROUP(S) FOR THIS SERVICE (E.G. ELDERS, PEOPLE WITH DEMENTIA, TEENS, ETC):

\_\_\_\_\_

WHO IS ELIGIBLE? (CHECK ALL THAT APPLY):

AGES ACCEPTED {MIN AGE: \_\_\_\_\_ MAX AGE: \_\_\_\_\_} ALL AGES ACCEPTED \_\_\_\_\_ SERVES CAREGIVERS 18+ \_\_\_\_\_

ACCEPTS ADULTS WITH SPMI 18+ \_\_\_\_\_ FEMALES ONLY \_\_\_\_\_ MALES ONLY \_\_\_\_\_ ONLY SERVES FAMILIES \_\_\_\_\_

ADDITIONAL ELIGIBILITY REQUIREMENTS: \_\_\_\_\_

HOW DOES SOMEONE ACCESS THIS SERVICE? PHONE \_\_ WEBSITE \_\_ WALK IN \_\_ OTHER: \_\_\_\_\_

DOCUMENTATION REQUIRED: \_\_\_\_\_

HOW DOES SOMEONE PAY FOR THIS SERVICE/ PROGRAM? (CHECK ALL THAT APPLY)

FREE SERVICE \_\_\_\_\_ SLIDING SCALE {\$ \_\_\_\_\_ to \$ \_\_\_\_\_} PRIVATE PAY/ FEE FOR SERVICE {\$ \_\_\_\_\_ to \$ \_\_\_\_\_}

MEDICAID ACCEPTED \_\_\_\_\_ MEDICARE ACCEPTED \_\_\_\_\_ INSURANCES ACCEPTED \_\_\_\_\_

## ADDITIONAL SITES AND/OR SERVICES– PAGE THREE

Location B is used for an additional physical location of your agency.  
If you have more than two locations, please make appropriate copies before continuing.

LOCATION B– PRIMARY OR MAIN OFFICE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

MAILING ADDRESS (IF DIFFERENT): \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

OTHER NUMBERS: \_\_\_\_\_

ADMINISTRATIVE HOURS (DAYS & HOURS): \_\_\_\_\_

ACCESSIBILITY AT THIS LOCATION (CHECK ALL THAT APPLY):

WHEELCHAIR ACCESSIBLE \_\_\_\_\_ FLASHING LIGHTS FOR HEARING IMPAIRED \_\_\_\_\_ PUBLIC PARKING \_\_\_\_\_

LANGUAGES SPOKEN: \_\_\_\_\_

SITE MANAGER (INCLUDE TITLE): \_\_\_\_\_

MANAGER PHONE NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

SITE CONTACT (INCLUDE TITLE): \_\_\_\_\_

CONTACT PHONE NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

COUNTIES SERVED BY THIS LOCATION (CHECK ALL THAT APPLY):

ALACHUA \_\_ BRADFORD \_\_ CITRUS \_\_ DIXIE \_\_ GILCHRIST \_\_ LAFAYETTE \_\_ LAKE \_\_ LEVY \_\_ MARION \_\_ ORANGE \_\_

OSCEOLA \_\_ PASCO \_\_ SEMINOLE \_\_ SUMTER \_\_ UNION \_\_ OTHER(S): \_\_\_\_\_

Service/ Program B is used for an additional service or program provided by your agency.  
If you have more than two services/ programs, please make appropriate copies before continuing.

NAME OF SERVICE/ PROGRAM B: \_\_\_\_\_

BRIEF DESCRIPTION OF SERVICE/ PROGRAM: \_\_\_\_\_

\_\_\_\_\_

LICENSES: \_\_\_\_\_

PLEASE IDENTIFY TARGET GROUP(S) FOR THIS SERVICE (E.G. ELDERS, PEOPLE WITH DEMENTIA, TEENS, ETC):

\_\_\_\_\_

WHO IS ELIGIBLE? (CHECK ALL THAT APPLY):

AGES ACCEPTED {MIN AGE: \_\_\_\_\_ MAX AGE: \_\_\_\_\_} ALL AGES ACCEPTED \_\_\_\_\_ SERVES CAREGIVERS 18+ \_\_\_\_\_

ACCEPTS ADULTS WITH SPMI 18+ \_\_\_\_\_ FEMALES ONLY \_\_\_\_\_ MALES ONLY \_\_\_\_\_ ONLY SERVES FAMILIES \_\_\_\_\_

ADDITIONAL ELIGIBILITY REQUIREMENTS: \_\_\_\_\_

HOW DOES SOMEONE ACCESS THIS SERVICE? PHONE \_\_\_\_\_ WEBSITE \_\_\_\_\_ OTHER: \_\_\_\_\_

DOCUMENTATION REQUIRED: \_\_\_\_\_

HOW DOES SOMEONE PAY FOR THIS SERVICE/ PROGRAM? (CHECK ALL THAT APPLY)

FREE SERVICE \_\_\_\_\_ SLIDING SCALE {\$ \_\_\_\_\_ to \$ \_\_\_\_\_} PRIVATE PAY/ FEE FOR SERVICE {\$ \_\_\_\_\_ to \$ \_\_\_\_\_}

MEDICAID ACCEPTED \_\_\_\_\_ MEDICARE ACCEPTED \_\_\_\_\_ INSURANCES ACCEPTED \_\_\_\_\_