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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 2-1-1  Santa 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/Public  Religiously 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 for  2-1-1 Updates  (Name & Title) | | |  | | | | Phone: | | | Email: | |
| Administration Office Hours: Monday  Tuesday  Wednesday 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-Cal  Sliding Scale fee $ to $ based on Accepts Medi-Care  Set program fee: Accepts most insurance | | | | | | |
|  |  | Fees vary from to based on | | |  | Membership fee $ per |
| Program Hours: Monday Tuesday Wednesday Thursday  Friday 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: |
|  | | | | | | | |
| **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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