



**AGING & DISABILITY RESOURCE CENTERS
STATEWIDE INTEGRATED DATABASE APPLICATION**
Please clearly fill out all items. If not applicable, please mark N/A.

Agency's Legal Name: _____

Agency's Common Name (AKA): _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Is this location confidential? Yes No

Is this location close to public transportation? Yes No

Mailing Address (If Different): _____

City: _____ State: _____ Zip Code: _____

Is this location confidential? Yes No

Is this location close to public transportation? Yes No

Main/Toll Free Phone Number: _____

Fax: _____ TDD/TTY: _____ Other: _____

Website: _____

E-Mail: _____

Agency Type: For Profit Non-Profit United Way Member Faith-Based
 City County State Federal Other

Please explain: _____

CONTACT INFORMATION

Director Name: _____ **Title:** _____

Phone Number: _____ Ext: _____ E-Mail: _____

Main Contact Name: _____ **Title:** _____

Phone Number: _____ Ext: _____ E-Mail: _____

Alternate Contact Name: _____ **Title:** _____

Phone Number: _____ Ext: _____ E-Mail: _____



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Please clearly fill out all items. If not applicable, please mark N/A.

Other (Please include Type: Intake, Toll Free, Cell, etc.): _____

IRS Status: _____ Tax ID: _____ License #: _____ (Attach copy of License)

Has your organization been in business at least one year? **Yes** **No**

Month/Year Incorporated: _____

Primary / Main Office OR Satellite Office/Site

Please list the accessibility features available at this location:

- Fully Accessible Limited Access No Access
 Designated Parking Full Wheelchair Access Elevators

- Funded By: City Funding County Funding State Funding Federal Funding
 Fees United Way Fund Raising Donations Private Funding
 Other Please explain: _____

AGENCY OVERVIEW

Brief Agency Description:

Days and Hours of Operation:

Service Area (City/County): _____

Languages Spoken: English Spanish Creole Other(s) _____

Fees / Payment Options: Private Pay/Fee for Service Private Insurance
 Medicare Medicaid Other _____



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Please clearly fill out all items. If not applicable, please mark N/A.

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.

Serves: 18+ Specific Ages _____ to _____ Women Only Men Only
 Alzheimer's/Dementia Other _____

-Do you offer discounted pricing or a sliding fee for seniors/disabled adult? Yes No
 If Yes, please explain: _____

-Would you be willing to offer any pro bono services on a short term basis? Yes No
 If Yes, please explain: _____

-Is your agency Lesbian, Gay, Bisexual, and Transgender (LGBT) Friendly? Yes No

-Does your agency provide staff with sensitivity training? Yes No

Other _____

PROGRAMS AND SERVICES

Name of Service/Program (1): _____

Service Description:

Eligibility / Criteria: _____

Intake Procedures _____



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Please clearly fill out all items. If not applicable, please mark N/A.

Name of Service/Program (2): _____

Service Description:

Eligibility / Criteria: _____

Intake Procedures _____

*****Please attach all requested information for any additional Programs / Services*****

OTHER SITES & LOCATIONS

Site (2) Name: _____

Primary / Main Office OR Satellite Office/Site

Please list the accessibility features available at this location:

Fully Accessible Limited Access No Access

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Site Address: _____

City: _____ State: _____ Zip Code: _____

Is this location confidential? Yes No

Is this location close to public transportation? Yes No



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Please clearly fill out all items. If not applicable, please mark N/A.

Site Phone Number(s) – Please indicate Phone Type (Intake, Toll Free, Cell, etc.):

(1) _____ (2) _____ (3) _____

Site or Service Contact:

Specify if this location has different Eligibility, Programs and Services than the main office:

Site (3) Name:

Primary / Main Office OR Satellite Office/Site

Please list the accessibility features available at this location:

Fully Accessible Limited Access No Access

Designated Parking Full Wheelchair Access Elevators

Site Address: _____

City: _____ State: _____ Zip Code: _____

Is this location confidential? Yes No

Is this location close to public transportation? Yes No

Site Phone Number(s) – Please indicate Phone Type (Intake, Toll Free, Cell, etc.):

(1) _____ (2) _____ (3) _____

Site or Service Contact:

Specify if this location has different Eligibility, Programs and Services than the main office:

*****Please attach all requested information for any additional Sites / Locations*****



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ACKNOWLEDGEMENT

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 *****