

AGING & DISABILITY RESOURCE CENTERS STATEWIDE INTEGRATED DATABASE APPLICATION

Please clearly fill out all items and sign on last page. If not applicable, please mark N/A.

After completion, please send By mail to: Senior Resource Alliance/Area Agency on Aging of Central Florida/Aging and Disability Resource Center

By fax to: 407-228-1835 By email to: lyndsey.taylor@sraflorida.org

For questions, call **407-514-1800** or **1800-96ELDER**

YOUR CONTACT INFORMATION (Person completing this form.)

Name:	Title:
Telephone:	Email:

AGENCY INFORMATION

Agency Legal Name:	
Also known as:	
Physical Address: Confidential? <input type="checkbox"/>	Mailing Address (if different): Confidential? <input type="checkbox"/>
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: <input type="checkbox"/> Private Pay <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____
Languages Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other: _____
<i>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.</i>
Population served: <input type="checkbox"/> 18+ <input type="checkbox"/> Specific Ages _____ to _____ <input type="checkbox"/> Women Only <input type="checkbox"/> Men Only <input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> LGBTQ <input type="checkbox"/> Other _____
Do you offer discounted pricing or a sliding fee for seniors/disabled adults? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:
Would you be willing to offer any pro bono services on a short term basis? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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

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Fees:
Payment Options Available: <input type="checkbox"/> Private Pay <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____
Programs available at this location:
Service Area (City & County):
Services available at this location:

Any additional details or information about your agency?
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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*****