

2-1-1 El Dorado

Application



We appreciate your interest in being included in the 2-1-1 El Dorado database. Please read this page carefully and send the completed application form by email to 211eldorado@icfs.org for processing.

This application consists of the three basic sections of required information as listed below:

1. **Organization Information:** This section gathers general information about your organization and the contact information for your main office.
2. **Site Information:** This section gathers more site specific information. Your organization may have a single site or multiple sites. Information provided here would related to the site(s) where your organization delivers services.
3. **Program Information:** This section gathers more information about your services and/or programs offered. This would include information describing the service/program, the eligibility requirements (if any) and the way clients receive services/programs. Each service/program should be linked to at least one site listed in "Section 2 – Site information" section. Please submit one "Program Information" page for each program offered.

Each year, your organization's primary contact (as listed in Section 1 – Organization Information) will receive an auto-verification email. The email will contain instructions on how to verify and/or update the information in the database. Organizations that do not respond to the verification update may be subject to removal from the database.

If you have any questions, or require assistance, please contact us. We are looking forward to receiving your application.

Thank you!

2-1-1 El Dorado
211eldorado@icfs.org

APPLICATION FOR 2-1-1 EL DORADO

ORGANIZATION INFORMATION

Inclusion Criteria

Does your organization provide services that you believe are appropriate for inclusion in the 2-1-1 database, based on the 2-1-1 El Dorado County Inclusion/Exclusion Policy (available at www.211ElDorado.org)? Yes No

Have you been in operation for at least six months? Yes No

Organization Information

Organization Name (Legal):

Is your Organization also commonly known by another name or abbreviation:

Parent Organization (If legally part of another organization, department, division, etc. please provide legal name):

Organization Description (describe your Organization in one or two sentences):

e.g. Nonprofit organization focused on supporting individuals with disabilities.

Organization Type:

- Nonprofit: If Yes, what is your tax designation? 501(c)3 501(a) No formal designation
- Government/Public
- Religiously Affiliated Organization (No formal legal designation)
- Membership Organization (No formal legal designation)
- For Profit/Proprietary Other:

Organization Contact Information

Organization Website/URL:

Organization Email:

Is this physical address:

- Confidential location
- Wheelchair accessible

Organization Physical Address:

City, State:

Zip:

Mailing Address

- Same as above

Organization Mailing Address:

City, State:

Zip:

Organization Administration Phone #:

TDD/TTY #:

Fax #:

Organization Senior Executive (Name & Title)

Phone:

Email:

Organization Primary Contact for 2-1-1 Updates (Name & Title)

Phone:

Email:

Administration Office Hours:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

Which holidays does your Organization close for?

“SITE A” INFORMATION

Site Name (This is the name of the physical location):

It can be specific – i.e. Main Street Family Resource Center, or general – i.e. Placerville Office

Is this physical address: <input type="checkbox"/> Confidential Location <input type="checkbox"/> Wheelchair Accessible	Physical/Street Address:	City, State:	Zip:
Mailing Address <input type="checkbox"/> Same as above	Mailing Address:	City, State:	Zip:

“SITE B” INFORMATION

Site Name:

Is this physical address: <input type="checkbox"/> Confidential Location <input type="checkbox"/> Wheelchair Accessible	Physical/Street Address:	City, State:	Zip:
Mailing Address <input type="checkbox"/> Same as above	Mailing Address:	City, State:	Zip:

“SITE C” INFORMATION

Site Name:

Is this physical address: <input type="checkbox"/> Confidential Location <input type="checkbox"/> Wheelchair Accessible	Physical/Street Address:	City, State:	Zip:
Mailing Address <input type="checkbox"/> Same as above	Mailing Address:	City, State:	Zip:

“SITE D” INFORMATION

Site Name:

Is this physical address: <input type="checkbox"/> Confidential Location <input type="checkbox"/> Wheelchair Accessible	Physical/Street Address:	City, State:	Zip:
Mailing Address <input type="checkbox"/> Same as above	Mailing Address:	City, State:	Zip:

*** Add additional SITE INFORMATION pages if needed.**

PROGRAM INFORMATION (1)
(Please submit one Program Information Page per program)

Organization Name: _____ Program Name: _____

Is this program commonly known by another name or abbreviation? _____

Program Website/URL: _____ Program Email Contact: _____

Program Description/Primary Services
Maximum of 100 words.

e.g. Offers parenting skill classes to parents struggling with managing misbehavior of their children at home or school.

Which sites/locations offer your program (matching Site Information on page 2)?
 Site A Site B Site C Site D Other: _____

Intake Procedure: Apply by Phone Walk-In Call for Appointment Referral Required Other: _____

Documentation Required at Intake: (i.e. ID, SS card, Proof of Income etc.) _____

<p>Program eligibility requirements: <i>e.g. Must be parents with children aged under 18.</i></p> <p>Eligibility requirements based on residency (i.e. program only serves residents of a specific city)? <i>e.g. Must be City of XXX residents.</i></p>	<p>Coverage Area:</p> <input type="checkbox"/> United States <input type="checkbox"/> California <input type="checkbox"/> Specific County: <input type="checkbox"/> Specific City only: <input type="checkbox"/> Specific Zip Code only:
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Fees (check all that apply):

<input type="checkbox"/> No Fee	<input type="checkbox"/> Accepts Medi-Cal
<input type="checkbox"/> Fees vary	<input type="checkbox"/> Accepts Medi-Care
<input type="checkbox"/> Sliding Scale fee \$ _____ to \$ _____ based on _____	<input type="checkbox"/> Accepts most insurance
<input type="checkbox"/> Set program fee \$ _____	<input type="checkbox"/> Membership fee \$ _____ per _____

Program Hours:

Monday _____ Hours vary, please call for information

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

Service is available in:

English Spanish Other: _____ Interpreter Services Available

PHONE NUMBERS

Main Program Phone #: _____ Purpose of other phone (i.e. Afterhours 5pm-8am): _____

Other Phone # (if different from Main): _____

Fax #: _____ TDD/TTY Phone #: _____

PROGRAM INFORMATION (2) – if applicable

Organization Name: _____ Program Name: _____

Is this program commonly known by another name or abbreviation? _____

Program Website/URL: _____ Program Email Contact: _____

Program Description/Primary Services
Maximum of 100 words.

e.g. Offers parenting skill classes to parents struggling with managing misbehavior of their children at home or school.

Which sites/locations offer your program (matching Site Information on page 2)?
 Site A Site B Site C Site D Other:

Intake Procedure: Apply by Phone Walk-In Call for Appointment Referral Required Other:

Documentation Required at Intake: (i.e. ID, SS card, Proof of Income etc.) _____

<p>Program eligibility requirements: <i>e.g. Must be parents with children aged under 18.</i></p> <p>Eligibility requirements based on residency (i.e. program only serves residents of a specific city)? <i>e.g. Must be City of XXX residents.</i></p>	<p>Coverage Area:</p> <input type="checkbox"/> United States <input type="checkbox"/> California <input type="checkbox"/> Specific County: <input type="checkbox"/> Specific City only: <input type="checkbox"/> Specific Zip Code only:
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<p>Fees (check all that apply):</p> <input type="checkbox"/> No Fee <input type="checkbox"/> Fees vary <input type="checkbox"/> Sliding Scale fee \$ _____ to \$ _____ based on <input type="checkbox"/> Set program fee \$ _____	<input type="checkbox"/> Accepts Medi-Cal <input type="checkbox"/> Accepts Medi-Care <input type="checkbox"/> Accepts most insurance <input type="checkbox"/> Membership fee \$ _____ per _____
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Program Hours:

Monday _____ Hours vary, please call for information

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

Service is available in:

 English Spanish Other: _____ Interpreter Services Available

PHONE NUMBERS

Main Program Phone #: _____

Other Phone # (if different from Main): _____ Purpose of other phone (i.e. Afterhours 5pm-8am): _____

Fax #: _____ TDD/TTY Phone #: _____

PROGRAM INFORMATION (3) – if applicable

Organization Name: _____ Program Name: _____

Is this program commonly known by another name or abbreviation? _____

Program Website/URL: _____ Program Email Contact: _____

Program Description/Primary Services
Maximum of 100 words.

e.g. Offers parenting skill classes to parents struggling with managing misbehavior of their children at home or school.

Which sites/locations offer your program (matching Site Information on page 2)?
 Site A Site B Site C Site D Other: _____

Intake Procedure: Apply by Phone Walk-In Call for Appointment Referral Required Other: _____

Documentation Required at Intake: (i.e. ID, SS card, Proof of Income etc.) _____

<p>Program eligibility requirements: <i>e.g. Must be parents with children aged under 18.</i></p> <p>Eligibility requirements based on residency (i.e. program only serves residents of a specific city)? <i>e.g. Must be City of XXX residents.</i></p>	<p>Coverage Area:</p> <p><input type="checkbox"/> United States <input type="checkbox"/> California <input type="checkbox"/> Specific County: <input type="checkbox"/> Specific City only: <input type="checkbox"/> Specific Zip Code only:</p>
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Fees (check all that apply):

<input type="checkbox"/> No Fee	<input type="checkbox"/> Accepts Medi-Cal
<input type="checkbox"/> Fees vary	<input type="checkbox"/> Accepts Medi-Care
<input type="checkbox"/> Sliding Scale fee \$ _____ to \$ _____ based on _____	<input type="checkbox"/> Accepts most insurance
<input type="checkbox"/> Set program fee \$ _____	<input type="checkbox"/> Membership fee \$ _____ per _____

Program Hours:

Monday Hours vary, please call for information

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

Service is available in:
 English Spanish Other: _____ Interpreter Services Available

PHONE NUMBERS

Main Program Phone #: _____

Other Phone # (if different from Main): _____ Purpose of other phone (i.e. Afterhours 5pm-8am): _____

Fax #: _____ TDD/TTY Phone #: _____

PROGRAM INFORMATION (4) – if applicable

Organization Name: _____ Program Name: _____

Is this program commonly known by another name or abbreviation? _____

Program Website/URL: _____ Program Email Contact: _____

Program Description/Primary Services
Maximum of 100 words.

e.g. Offers parenting skill classes to parents struggling with managing misbehavior of their children at home or school.

Which sites/locations offer your program (matching Site Information on page 2)?
 Site A Site B Site C Site D Other: _____

Intake Procedure: Apply by Phone Walk-In Call for Appointment Referral Required Other: _____

Documentation Required at Intake: (i.e. ID, SS card, Proof of Income etc.) _____

Program eligibility requirements:
e.g. Must be parents with children aged under 18.

Eligibility requirements based on residency (i.e. program only serves residents of a specific city)?
e.g. Must be City of XXX residents.

Coverage Area:
 United States
 California
 Specific County:
 Specific City only:
 Specific Zip Code only:

Fees (check all that apply):
 No Fee
 Fees vary
 Sliding Scale fee \$ _____ to \$ _____ based on
 Set program fee \$ _____

Accepts Medi-Cal
 Accepts Medi-Care
 Accepts most insurance
 Membership fee \$ _____ per _____

Program Hours:
Monday _____ Hours vary, please call for information
Tuesday _____
Wednesday _____
Thursday _____
Friday _____
Saturday _____
Sunday _____

Service is available in:
 English Spanish Other: _____ Interpreter Services Available

PHONE NUMBERS

Main Program Phone #: _____
Other Phone # (if different from Main): _____ Purpose of other phone (i.e. Afterhours 5pm-8am): _____
Fax #: _____ TDD/TTY Phone #: _____

*** Add additional PROGRAM INFORMATION (pages 3-6) if needed.**

SIGNATURE

I AUTHORIZE THE VERIFICATION OF THE INFORMATION PROVIDED ON THIS FORM AND AFFIRM THE INFORMATION IS TRUE AND ACCURATE. I UNDERSTAND THAT IN ORDER TO KEEP 2-1-1 EL DORADO'S DATABASE UP TO DATE, I AM REQUIRED TO INFORM 2-1-1 EL DORADO OF CHANGES TO THE ORGANIZATION'S OPERATIONS WITHIN 30 DAYS AND TO VERIFY OUR INFORMATION DURING THE ANNUAL UPDATE PERIOD. I HAVE READ AND UNDERSTOOD 2-1-1 EL DORADO'S INCLUSION/EXCLUSION POLICY. APPLICATIONS/UPDATES WILL BE PROCESSED WITHIN SEVEN (7) DAYS OF RECEIPT.

PRINT NAME:

PHONE:

TITLE:

EMAIL:

DATE:

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

2-1-1 El Dorado County
3057 Briw Road, Suite B • Placerville, CA 95667
(844) 547-3304 • (530) 663-8498 fax
211eldorado@icfs.org * www.211eldorado.org