

211 L A COUNTY USE
ID _____
Date Rec'd _____
Date Ent'd _____
Ent'd By _____
IRS letter included _____

Agency Profile

(Check one)

Administrative Site

Satellite or Service Site

Legal Name

AKA/DBA (If Applicable)

Street Address

City State Zip Code

Mailing Address

City State Zip Code

E-Mail Address

Agency URL

Legal Status (Choose one)

Attach copy of IRS letter if non-profit

Private, Non-profit	Proprietary/For-profit
Coalition/Other Group	Faith-based Organization
Foreign Government	Individual/Group Practice
Public-City	Public-County
Public-Federal	Public-State
Special District (specify)	_____

Phone Number(s)

() _____ - _____ ext. _____

Confidential? Yes No

(Click all that apply)

Admin	Service	Intake
Fax	Hotline	Messages
Emergency	Talkline	TTY
After Hours	Information Only	

Other _____

() _____ - _____ ext. _____

Confidential? Yes No

(Click all that apply)

Admin	Service	Intake
Fax	Hotline	Messages
Emergency	Talkline	TTY
After Hours	Information Only	

Other _____

Federal Employer I.D. number (EIN)

Tax Status (please attach a copy of nonprofit status, if applicable)

Year of Incorporation _____

Annual Budget _____

Licenses/Certifications

Licensed by Whom

Date Services Started (mm/dd/yy)

Funding (Click all that apply and specify department where appropriate)

Client Donations
Corporation/Foundation
Emergency Food/Shelter Program
Fees
Grants
Independent Fund Raising
In-Kind Donations
Membership Dues
Other City Funding _____
Other County Funding _____
Other Federal Funding _____
Other State Funding _____
Special District _____
United Way
LAHSA
SAMHSA
First 5 LA

Access

Public transportation within 3 blocks?

Yes No

Closest major cross street:

Physical

Wheelchair access:

(Click all that apply)

Elevators Designated Parking
Hand Rails Ramps Wide Doors
Bathrooms-Fully Accessible

Communication

TTY Interpreters
Signs for Goods and Services
Raised Letters
Mounted as close as possible

Program Name _____

Hours

Service Hours

Office/Administrative Hours

Mon _____ to _____ _____ to _____

Tues _____ to _____ _____ to _____

Wed _____ to _____ _____ to _____

Thurs _____ to _____ _____ to _____

Fri _____ to _____ _____ to _____

Sat _____ to _____ _____ to _____

Sun _____ to _____ _____ to _____

What provisions are there for contacting staff in after-hours emergencies?

Languages

In what languages are services provided? (Indicate if available only at certain times and dialect, e.g. Cantonese rather than Chinese)

Fees and Forms of Payment (Click all that apply)

Free

Donations requested \$ _____

Fixed fee \$ _____

Sliding scale \$0 to \$25 _____ or \$25+ _____

Membership fee \$ _____ per _____

Attendance at religious service

Private insurance

Medi-Cal

TRICARE

Medicare

Vendor/Voucher

Veterans Administration

Champus

Work for service

Other _____

To who are services targeted? (Please indicate any requirements or exclusions, such as age, family-structure, gender, ethnicity, income, etc.)

What area is served? (Indicate restrictions. Give city, zip code or other boundaries)

Who provides services? (Indicate professional credentials or degrees, if any)

If volunteers or interns provide service, who supervises them?

How do people apply for service? (Click all that apply)

Appointment preferred

Telephone to apply

Telephone for service

Appointment required

Walk-in to apply

Write to apply

Walk in for service

Referral required from _____

Court Approved? Yes No N/A

Is a certificate provided at completion of service? Yes No

Does the agency provide transportation? Yes No

Does the agency provide child care? Yes No

Does the agency make home visits? Yes No

What forms of documentation is required?
(please indicate types required)

ID _____

Proof of residence _____

Proof of income _____

Proof of age _____

Other _____

Name of Administrator/Director

Title

E-Mail Address

Agency Contact
Name _____
Title _____
Phone No. () _____ - _____

Program and Service Description

Please describe the programs and services your agency provides. Indicate if the agency or its staff is licensed and by whom. Please distinguish between primary and secondary services; i.e. services available to new applicants as opposed to auxiliary services available only to people involved in the program. Please describe the geographic area served.

Mission statements and program goals are good descriptive tools, but also list the actual services people might access through the program. Please enclose organizational charts, brochures, or other materials that describe your program.

Please complete this section. Do not leave blank.

Please submit this form by email to ResourceMailingList@211LA.org. Forms may also be faxed to (626) 442-6940 or mailed to P.O. Box 726, San Gabriel, CA 91778. If you have any questions please call our Resource Department at (877) 463-6929, Monday through Friday. 8:00am to 5:00pm.