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 with completing your application, please contact us at 211eldorado@icfs.org or (844) 547-3304. 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:	Which holidays does your Organization close for?
Monday Tuesday Wednesday Thursday Friday Saturday Sunday	

"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: ☐ Confidential Location ☐ Wheelchair Accessible	Physical/Street Address:	City, State:	Zip:
Mailing Address ☐ Same as above	Mailing Address:	City, State:	Zip:

"SITE B" INFORMATION			
Site Name:			
Is this physical address: ☐ Confidential Location ☐ Wheelchair Accessible	Physical/Street Address:	City, State:	Zip:
Mailing Address ☐ Same as above	Mailing Address:	City, State:	Zip:

"SITE C" INFORMATION			
Site Name:			
Is this physical address: ☐ Confidential Location ☐ Wheelchair Accessible	Physical/Street Address:	City, State:	Zip:
Mailing Address ☐ Same as above	Mailing Address:	City, State:	Zip:

"SITE D" INFORMATION			
Site Name:			
Is this physical address: ☐ Confidential Location ☐ Wheelchair Accessible	Physical/Street Address:	City, State:	Zip:
Mailing Address ☐ 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.)

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	☐ Accepts Medi-Cal
☐ Fees vary	☐ Accepts Medi-Care
☐ Sliding Scale fee $ to $ based on	☐ Accepts most insurance
☐ Set program fee $	☐ Membership fee $ per

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

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 (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.)

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
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday
☐ Hours vary, please call for information

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.)

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
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday
☐ Hours vary, please call for information

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
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday
☐ Hours vary, please call for information

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: **DATE:**	**EMAIL:**

SUBMIT APPLICATIONS/UPDATES VIA EMAIL

2-1-1 El Dorado County

211eldorado@icfs.org

If you have any questions or require assistance with completing your application, please contact us at 211eldorado@icfs.org or (844) 547-3304.