



LIVE UNITED



United Way of Central Georgia

NON-PROFIT—AGENCY SURVEY

How did you learn about United Way 2-1-1?		
Agency's Legal Name:		
Other Names (AKA, acronyms, former, etc.):		
IRS Status:	Tax ID#:	Secretary of State Control #:
Physical Location of Organization — *Please photocopy & complete a separate form for each additional branch/location.		
Address:		County:
City:	State:	Zip Code:
Physical address is confidential: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mailing Address (If different from physical address):		County:
City:	State:	Zip Code:
Mailing address is confidential: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Administrative Hours:	Days: <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN	
<b>CONTACT INFORMATION</b>		
Agency Phone Number:		
Fax #:	Text Short Code:	TDD (Telecommunication Device for the Deaf) #:
Website:	Agency E-Mail:	
Director Name/Title:	Phone:	E-Mail:
Other Contact Name/Title:	Phone:	E-Mail:
<b>Organizational Status</b> —Please check the one that indicates your agency's organizational status:		
<input type="checkbox"/> Federal	<input type="checkbox"/> State	
<input type="checkbox"/> City	<input type="checkbox"/> County	
<input type="checkbox"/> Private Nonprofit	<input type="checkbox"/> Proprietary/Commercial/For-Profit	
<input type="checkbox"/> Other—Specify:		
<b>NOTE: Include a copy of your agency's 501c3 to this form. If you do not have a 501c3, you are automatically seen as a for-profit entity and will need to request our for-profit agency form and pay a fee of \$400.00 per year to join the 2-1-1 database.</b>		

**AGENCY SURVEY CONT.**

**Directions** — Please provide basic directions to your facility—Indicate name of office complex, subdivision, apartment, etc. Please include nearest visual intersection, names of adjacent buildings, any helpful landmarks:

**Public Transportation**—Facility accessible by public transportation:  Yes  No Bus #:

**Accessibility**—Accommodations for people with disabilities:

Designated Parking  Indoor Wheelchair Access  Outside Ramps  Elevators  No Access

**Services:** Please list the primary services offered to ANYONE meeting your eligibility requirements (i.e. food pantry, shelter, transitional home, tutoring, mentoring, community clinic, counseling, etc.)

**NOTE:** All services listed must be active & currently running—not a vision for the future. Please attach flyers/pamphlets about your organization to aid in a better understanding of services provided.

**NOTE:** If services have different hours/days or special intake hours, please specify below.

**Brief Program Description:**

**Service Hours:** Days:  MON  TUE  WED  THU  FRI  SAT  SUN

Other—Specify:

**Eligibility** (Who is eligible for your services?) - CHECK ALL THAT APPLY:

- No Restrictions  Battered Women
- Individuals & Families with Low Income  Residents of Service area only
- Disabled Veteran / Veterans  Seniors/Older Adults
- Military Personnel / Military Families  Women with Children
- Children (specify age &/ gender) — Age(s): \_\_\_\_\_ Gender: \_\_\_\_\_
- Youth (specify age &/ gender) — Age(s): \_\_\_\_\_ Gender: \_\_\_\_\_
- Teens (specify age &/ gender) — Age(s): \_\_\_\_\_ Gender: \_\_\_\_\_
- Varies by program; call for details
- Anyone regardless of their immigration status
- Other (specify age/gender eligibility or specific geographic area): \_\_\_\_\_

**Intake** (What are your service intake procedures?) - CHECK ALL THAT APPLY:

Walk In  Telephone  By Appointment Only  E-Mail  Internet/Online  Voicemail

Referral required from (specify): \_\_\_\_\_  Other (specify): \_\_\_\_\_

**Required Documentation** (What documents do you required before services are rendered?) - CHECK ALL THAT APPLY:

- No Documents Required  Birth Certificate  Social Security Card  Eviction Notice
- Applications Form  Proof of Residence  Proof of Income  Picture ID/Driver's License
- Medical/Psychiatric Records  Utility Cut-off Notice  Case Worker Referral  Proof of Legal Status
- Other Document(s) - Specify:

**AGENCY SURVEY CONT.****Fees**—Please choose appropriate fee type:

- No Fee                       Straight Fee                       Sliding Fee Scale—Based on client's income                       Other:  
Specify:

**Payment Subsidies Accepted:**  Medicaid    Medicare    PeachCare    Private Insurance    Other  
 Scholarships Available

**Languages**—Indicate which languages are routinely spoken by your staff:

- English Only    Spanish    French    Chinese    American Sign Language    Other(s)-Specify:

Do you distribute literature available in Spanish?  Yes    No

**Service Area**—Check the area(s) you serve:

- Baldwin    Bibb    Crawford    Hancock    Houston    Jasper    Jones  
 Macon    Monroe    Peach    Putnam    Twiggs    Washington    Wilkinson  
 State of GA

If you restrict to certain cities, zip codes, or neighborhoods, please indicate these below:

Cities:

Zip Codes:

Neighborhoods:

- Please check if you do **NOT** wish for your organization to be included in our written products/publications.
- Please check if you do **NOT** wish to be included on our 2-1-1 website.
- ⇒ Does your organization discriminate in providing service or volunteer opportunities based on sex, race, age, disability, color, creed, national origin, or religion?  Yes    No
- ⇒ Is your business home-based?  Yes    No

We meet all federal, state, and local laws, requirements, and regulations including fire, health, and zoning codes.  
To the best of my knowledge, all of the proceeding information is true and correct.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date**Please mail completed form and the agency's 501c3 to:**

United Way of Central Georgia  
ATTN: Carmen Hughey  
P.O. Box 1302  
Macon, GA 31202

**Or fax the form and the agency's 501c3 to:**

478.741.1731  
Carmen Hughey

**If you have any questions, contact:**

Carmen Hughey  
2-1-1 Resource Coordinator  
chughey@unitedwaycg.com  
478.621.7793



**United Way**  
of Central Georgia

## MEMORANDUM OF UNDERSTANDING

I have read the important information at the bottom of this form.

I hereby authorize the United Way of Central Georgia to utilize my organization's information for inclusion in its community resource database and all printed and electronic materials that it publishes and/or sells to others.

Organization Name: \_\_\_\_\_  
 Non-Profit    For-Profit    Government

Executive Director: \_\_\_\_\_  
(Please Print)

Title (if not Executive Director): \_\_\_\_\_

Please provide us with the name, number, and e-mail of a contact person we can call if we have questions or need additional information.

Contact's Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

In order for us to conduct a web-based process for your agency's information, we request that you provide us with a primary and secondary (if available) e-mail address that will be used to allow your agency access to review the database entry, submit, change, and/or add information as requested, as well as when you become aware of changes to your information. If, at this time, your agency does not have an e-mail address, your annual update will be mailed to you.

Primary Contact: \_\_\_\_\_  
Primary E-mail: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_  
Secondary E-mail: \_\_\_\_\_

No e-mail at this time.

**IMPORTANT INFORMATION**

The information you provide for the United Way's community resource database may be sold in a printed directory format, directory on CD format, and special reports. The information in the database may also be made available on the Internet and in other printed or electronic formats. Many organizations and individuals use this information to refer others to your organization and program based on your information.

**Please do not include any organization or program information that you do not want released to the public. All information we request is optional and should be provided at your discretion.**

**We reserve the right to edit your information.**