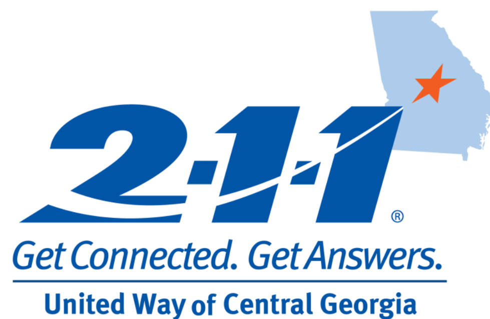
NON-PROFIT AGENCY FORM



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: ☐ Yes ☐ No		
Mailing Address (If different from physical address):		County:
City:	State:	Zip Code:
Mailing address is confidential: ☐ Yes ☐ No		
Administrative Hours:	Days: ☐MON ☐TUE ☐WED ☐THU ☐FRI ☐SAT ☐SUN	
CONTACT INFORMATION 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:

Organizational Status—-Please check the one that indicates your agency's organizational status:

☐Federal ☐State
☐City ☐County
☐Private Nonprofit ☐Proprietary/Commercial/For-Profit
☐Other—Specify:

NOTE: <u>Include a copy of your agency's 501c3 to this form.</u> 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

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 or 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

☐Individuals & Families with Low Income

☐Disabled Veteran / Veterans

☐Military Personnel / Military Familes

☐Battered Women

☐Residents of Service area only

☐Seniors/Older Adults

☐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 Specify: ☐Sliding Fee Scale—Based on client's income ☐Other:

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
478.621.7834

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.