



This survey will help us to direct appropriate referrals to your agency. Please make sure to fill in the survey as completely as possible. Thank you for your cooperation!

Organization's Legal Name:

AKA (if applicable):

Address:

Mailing Address (If Different):

Travel Instructions (Example: Two blocks south of First and Main Street, across from the Post Office):

Is there public transportation to this location? Yes No

Telephone: (____) _____ ext. _____

Toll-Free: (____) _____ ext. _____

FAX: (____) _____ ext. _____

TDD/TTY: (____) _____ ext. _____

Other: (____) _____ ext. _____

Hours: _____

Agency Director/Title:

Phone: (____) _____ ext. _____

Email Address: _____

General Information

Please mark the category/categories that best describes your organization.

- | | |
|---|---|
| <input type="checkbox"/> Church Affiliated | <input type="checkbox"/> Coalition/Other Group |
| <input type="checkbox"/> Private/Non-Profit | <input type="checkbox"/> Proprietary |
| <input type="checkbox"/> Public – City | <input type="checkbox"/> Public – County |
| <input type="checkbox"/> Public – Federal | <input type="checkbox"/> Public – State |
| <input type="checkbox"/> Special District | <input type="checkbox"/> Other, as follows: _____ |

Facility Type

Please mark the category/categories that best describes your organization.

- Church Clinic/Hospital County Office
- School Private Practitioner Other, as follows: _____

Website Address:

General Email Address (e.g. info@youragency.org):

Federal ID (EIN) # _____

Year Incorporated: _____

Accessibility:

- | | |
|---|--|
| <input type="checkbox"/> Designated Parking | <input type="checkbox"/> Ramps |
| <input type="checkbox"/> Elevators | <input type="checkbox"/> Full Wheelchair Access |
| <input type="checkbox"/> Limited Access | <input type="checkbox"/> Lowered Elevator Controls |
| <input type="checkbox"/> No Access | <input type="checkbox"/> No Stairs in Service Area |
| <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Other _____ |

Funding Info:

- | | | |
|--|--|--|
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Donations | <input type="checkbox"/> Fees |
| <input type="checkbox"/> FEMA | <input type="checkbox"/> HUD | <input type="checkbox"/> Independent Fundraising |
| <input type="checkbox"/> JTPA | <input type="checkbox"/> City Funding | <input type="checkbox"/> County Funding |
| <input type="checkbox"/> Private Funding | <input type="checkbox"/> State Funding | <input type="checkbox"/> United Way Funding |

Administrative Description/Mission:

Administrative Hours:

Does your organization have any other locations/sites? Yes No
 (If yes, please copy first two pages and complete information for each individual site.
 If no, continue to page three.)

PROGRAM INSTRUCTIONS: Complete page three for each service or program that your organization provides. Please duplicate this page as needed.

Program/Service Name: _____

Program/Service Description: (attach additional sheet(s) as necessary):

Program/Service Location (Please check and list the location(s) at which this program/service is offered):

- Site 1: Main/Administrative Office
- Site 2: _____
- Site 3: _____
- Site 4: _____
- Site 5: _____

Program/Service Contact Information (Name/Title):

Phone: (_____) _____ ext. _____

Email Address: _____

Program Hours:

 Check here if this service is not available year-round or on a consistent basis.
Explanation: _____

Application: Referral Required From: _____
 Appointment Required
 Walk-Ins

Documentation Required (Photo ID, Proof of Income or Residence, etc.):

Eligibility Requirements (Income, Age, Gender, Location, etc.):

Fees/Payment Methods (Set fees, Sliding scale, Medicaid, Medicare, etc.):

Languages Offered: English Other, as follows: _____

Waiting List for Service: Yes No

Form Completed By (Name/Title):

Phone: (_____) _____ ext. _____

Email Address: _____

Date Completed: _____

Check here to be included on the 2-1-1 Community Announcement list-serv.

Has 2-1-1 expanded your knowledge of community resources?

Yes No, please explain.

Contact for Future Organizational Updates/Surveys, If Different (Name/Title):

Phone: (_____) _____ ext. _____

Email Address: _____

Thank you for taking the time to provide this information. Your responses will help us to better meet the needs of the people in our communities.

If you have questions or comments, contact:

Central Michigan 2-1-1
Toll-Free (866) 561-2500, ext 2

For Administrative Use Only

Date info taken: _____

Staff/Volunteer receiving info: _____

Date entered into database: _____

Entered By: _____

Record Number: _____

Please send the completed form to:

Jennifer Pollak, Resource Specialist
LifeWays
1200 North West Avenue
Jackson, MI 49202
Jennifer.pollak@lifewaysmco.com
Fax: (517) 789-1276