



Central Michigan 2-1-1 Program

Agency Name:

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 (Private insurance, Medicaid, set fees, sliding scale):

- Languages Offered:
- English
 - Spanish
 - Other, as follows: _____

- Waiting List for Service:
- Yes
 - No