Form A - ORGANIZATION INFORMATION FORM
Please use this form to describe your agency or organization’s main administrative office.

1. Organization Name
   __________________________________________________________

2. Other names (such as AKA, acronyms, former names, etc.)
   __________________________________________________________

3. Organization type
   ___ Non-profit 501(c)(3) ___ Other Non-Profit ___ City Government
   ___ County Government ___ State Government ___ Federal Government ___
   Educational ___ For-profit ___ Other_____________________

4. Person in charge of organization Name and Title
   __________________________________________________________

5. Person filling out forms Name________________________
   Phone #_________________ Email____________________

6. Physical address of agency
   (The "headquarters" address, where the administration is located) ___ Check here if physical location is confidential.
   Street ____________________________________ Suite # ______________________
   City State Zip _____________________

7. Mailing address
   (if different from physical address listed above)
   Street/PO Box _____________________________ City ______________________
   State ___________ Zip ____________

8. Phone numbers for agency
   Main/Intake ___________________________
   Administrative _______________________
   Toll-free Fax TDD _____________________ Other __________________________

9. Internet access
   E-mail____________________________________
   Web Site
   http://_____________________________________
10. **Business days/hours** (Please fill in hours for individual programs on Form B below)

11. **Brief description of organization’s services** (Please use Form B below to provide a full description of services offered) – please use additional pages if required.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

12. **Please identify whether the tax status of your organization is a:** 501(a), 501(c)(3), Registered Charity, Corporation, Limited Liability Company, Professional Corporation, and/or Doing Business As. ________________________________

13. **Please identify your legal status of your organization? Is it:**
   - Non-Profit (Unincorporated) __________
   - Non-Profit (Incorporated) __________
   - Faith Based __________
   - Private Practice __________
   - Commercial __________
   - Federal Government __________
   - State Government __________
   - Municipal Government __________
   - Tribal __________

14. **If your business is commercial, please provide the year it was formed?**

______________________________________________________________________

15. **If there are volunteer opportunities at your organization, please provide the requirements and duties for the volunteer position(s) that are available?** __________

______________________________________________________________________

______________________________________________________________________

January 2021
Form B – PROGRAM/SERVICES INFORMATION FORM

Please use this form to describe your organization’s services and programs.

Multiple programs: If your organization offers multiple services or programs, with different eligibility requirements, target groups, service areas, etc., please fill out one Form B for each service or program offered.

Multiple locations: If services are identical, but are offered at multiple locations, you may simply provide the contact information for each branch either on this form or on a separate sheet of paper.

1. Parent Organization name ________________________________________________

2. Program name __________________________________________________________

3. Person in charge of program (Program Director, Program Coordinator, etc.)

Name and Title __________________________________________________________

4. Person filling out forms Name __________________________________________

Phone #__________ Email _________________________

5. Physical address of program ___ Check here if physical location is confidential.

Street _________________________________________________________________

City___________________ State____ Zip________

Travel instructions/location description (such as “corner of Congress Ave. and 6th St.” or “2 blocks east of I-35”)

_______________________________________________________________________

What accommodations does this location provide to people with disabilities?

___ Designated parking ___ Indoor wheelchair access ___ Outside ramps ___

Elevators ___ None

Is this location on a bus line? ___Yes ___No If yes, which bus line(s)?

_______________________________________________________________________

6. Mailing address for program (if different from physical address listed above)

PO Box/Street__________________________________________________________

City___________________ State ____ Zip_______

January 2021
7. Phone numbers for program
Main/Intake ______________________
Administrative_____________________
Toll-free __________________ Fax __________________
TDD__________________ Other __________________

8. Internet access
Email_________________________________________________
Web Site____________________________
http://___________________________________________

9. Hours/Days of operation
(Please indicate if service hours differ from office hours)
____________________________________________________________________
____________________________________________________________________

10. Eligibility
(List criteria required to obtain services, such as “must have low-income
and be over 65”)____________________________________________________________________

11. Fees
___ Free (No fee) ___ Flat fee; please specify
Sliding scale; please specify eligibility and range
____________________________________________________________________

12. Health Coverage
Accepts: ___ Medicare ___ Medicaid ___ CHIP
___ Private insurance ___ Self-pay
Other, please describe_____________________________________________________

13. Intake
___ Appointment required ___ Walk-ins accepted (without prior phone call)
___ Call for information___ Referral required;
By whom?_______________________________________________________________
Other, please describe_____________________________________________________

14. Documents required
(Birth certificate, proof of residence, picture I.D., Social
Security card, etc.)
____________________________________________________________________

15. Languages spoken by staff
(other than English) ___ ASL ___ Spanish
Other: ______________________________
Please list days/times bilingual staff are available
16. Does this program maintain a waiting list?

17. What is the average length of time between application process and receipt of services?

18. Program Transportation ___ Program provides transportation ___ Program will arrange for transportation ___ Program conducts home deliveries ___ Other ______________________________

19. Geographic area served ___ Nationwide ___ Kern County ___ Part of Kern County
This 2-1-1 Kern County call center serves Kern County. If you serve only part of the county please indicate which cities you serve:

20. Please describe the primary services offered to anyone meeting your program’s eligibility requirements and other Criteria. (Please use additional paper if necessary; we want to provide callers with a complete and accurate description of the program)

BASIC NEEDS ASSISTANCE
If your organization, agency, or church provides services covering basic needs, please look through the list of services below and place a check next to those you provide. Also indicate if these services are accessible on different days and at different times from your normal business hours, and/or if they have different eligibility criteria or intake procedures. Please mail this form back with your program/agency forms. Thank you for your help!

FINANCIAL ASSISTANCE
Hours: ______________________________
Intake: ___Call for appointment ___Walk-ins accepted ___Rent ___Gasoline Assistance ___Long-Distance Bus Tickets ___Rental Deposit ___Medical Bills ___Motel Vouchers ___1st Month’s Rent ___Prescription Drugs ___Criminal Background Check Fees ___Mortgage ___Eyeglasses ___Cost of GED Test ___Utilities (electric, water, gas) ___IDs/Birth Certificates ___Telephone Bill ___Local Bus Passes (single-use) ___Utility/Telephone Hookup Fees ___Local Bus passes (monthly) ___Other ______________________________
FOOD ASSISTANCE
Hours: __________________________
Intake: ___Call for appointment ___Walk-ins accepted
___ grocery store vouchers, to be used for: ___food ___over-the-counter medicine
___ hygiene ___ food pantry onsite

CLOTHING ASSISTANCE
Hours: __________________________
Intake: ___Call for appointment ___Walk-ins accepted
___ clothing vouchers, to be used at
___ clothing closet onsite contains, depending on current stock:
___ baby clothing ___ diapers ___ children’s clothing ___ adult clothing
___ work clothing ___ work shoes/boots
___ other

FURNITURE ASSISTANCE
Hours: __________________________
Intake: ___Call for appointment ___Walk-ins accepted
___ furniture vouchers, to be used at
___ furniture, available onsite, depending on current stock:
___ beds ___ kitchenware ___ living room furniture ___ baby furniture ___ car seats
___ other

HOLIDAY SERVICES
___ Holiday food baskets ______ Thanksgiving ______ Christmas ______ Easter
Application process/
Eligibility criteria
Deadline to apply __________________________
When/how distributed __________________________

___ Holiday meals ______ Thanksgiving ______ Christmas ______ Easter
Time/Date __________________________
Eligibility criteria __________________________
Walk-ins accepted? __________________________

OTHER ASSISTANCE:__________________________________________________
MEMORANDUM OF UNDERSTANDING

Organization Name

In addition to relaying information about your organization’s services over the telephone, 2-1-1 Kern County may disseminate information in printed directories and publish in an online database. Many social service professionals and volunteers at churches, nonprofit organizations, schools, and government agencies use this information to refer their clients to your organization and programs. Please feel free to call us if you have concerns related to this form.

This signed release form will be kept on file as an ongoing authorization that 2-1-1 Kern County may provide information to the public regarding the services of the above-named agency.

___Yes, I hereby authorize 2-1-1 Kern County to utilize my organization’s information for inclusion in any print or online publications of community resources. Information that is noted as confidential on the agency/program forms (such as physical location) will not be given to callers, nor will it be published in other formats.

___No, 2-1-1 Kern County does not have authorization to print my organization’s information in any print or online publication of community resources. The information will continue to be provided to individuals who call 2-1-1.

Name

Title

Signature_________________________ Date __________