



# Resource Information Form

Please type or print clearly.

**Name:** What is the name of your organization? \_\_\_\_\_

Acronyms: Other names/Former names: \_\_\_\_\_

Are you part of a larger organization? (Example: Idaho Department of Health and Welfare, United Way, etc.)

No  Yes If yes, what is the name and address of that organization?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Address and Contact Information:** What is your physical address and contact information for your program?

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Website: \_\_\_\_\_

**Service Description:** Please be as specific as possible. Callers are referred to your organization based on this description. Use an additional sheet of paper if needed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(In addition to this description, please include a copy of your program brochure for our files.)

Is your organization or are your employees licensed or certified by a regulatory agency?  Yes  No

If yes, what is the regulatory agency? \_\_\_\_\_

License is valid through: \_\_\_\_\_

Please check ONE answer that indicates your program's organizational status.

Non-profit  Non-profit Religious  Government  Military  Volunteer  For profit

**Eligibility:** Can anyone receive services from your program?  Yes  No If No, please explain:

\_\_\_\_\_  
\_\_\_\_\_

**Intake:** What are your intake procedures?

Telephone  Walk-in  By appointment  Referral required, please explain:

\_\_\_\_\_

**Hours/Days:** What are the days and hours of your organization operates?

- Sunday; Hours: \_\_\_\_\_  Thursday; Hours: \_\_\_\_\_  
 Monday; Hours: \_\_\_\_\_  Friday; Hours: \_\_\_\_\_  
 Tuesday; Hours: \_\_\_\_\_  Saturday; Hours: \_\_\_\_\_  
 Wednesday; Hours: \_\_\_\_\_

**Fees:** What are your fees?

- No fee  Sliding scale fee; Details: \_\_\_\_\_  
 Straight fee for services; Details: \_\_\_\_\_  
 Other; Please explain: \_\_\_\_\_

Do you accept insurance?  Yes  No If yes,  Private insurance  Medicaid  Medicare

Do you have a waiting list for your services?  Yes  No If yes, How long? \_\_\_\_\_

**Languages:** What languages are routinely available and spoken by your staff?

- English only  Spanish  American Sign Language  Other, please specify: \_\_\_\_\_

**Area Served:** What geographical area does your program serve? Please specify the city, county, region, statewide or nationwide: \_\_\_\_\_  
\_\_\_\_\_

Would you like 2-1-1 Idaho CareLine cards to give to your clients?  Yes  No If yes, how many? \_\_\_\_\_

**Note: The 2-1-1 Idaho CareLine has a program inclusion/exclusion policy and has the right to refuse or remove an agency at its discretion. Submission of your program to be included in the 2-1-1 Idaho CareLine database assumes your permission is also given for your program to be included in any directory (printed or online) the Idaho Department of Health and Welfare or it's community partners develop, unless otherwise notes.**

I acknowledge the above information is correct and accurately represents the services provided by our agency and its employees.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

**Please submit the form to the 2-1-1 Idaho CareLine:**

Fax: (208) 334-5531

Address: 2-1-1 Idaho CareLine / IDHW

E-mail: [careline@dhw.idaho.gov](mailto:careline@dhw.idaho.gov)

PO Box 83720

Boise, ID 83720-0026

*If you have questions, please call us by dialing 2-1-1 or (800) 926-2588.*