



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

PO Box 83720

Boise, ID 83720-0026

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