

# Human Services Directory Information Form

Please type or print clearly. Referrals to your organization  
depend on the accuracy of information you provide.

## General Information

Organization name \_\_\_\_\_

Other names (former, acronym) \_\_\_\_\_

Address \_\_\_\_\_

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

Mailing address (if different) \_\_\_\_\_

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

Main telephone number \_\_\_\_\_ Toll Free \_\_\_\_\_

FAX \_\_\_\_\_

Organization email address \_\_\_\_\_

Website \_\_\_\_\_

## Director/Contact Information

Director/contact person \_\_\_\_\_

Title \_\_\_\_\_

Director/contact telephone number \_\_\_\_\_

Mobile \_\_\_\_\_

Director/contact FAX (if different) \_\_\_\_\_

Director/contact email address \_\_\_\_\_

## Organization's Purpose

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## Services Information

Please be as clear and concise as possible; use additional sheet(s) if necessary. Also, attach pamphlets or flyers about your organization to aid in a better understanding of services provided.

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- **Eligibility requirements** Include requirements based on age, income, residence, etc.  

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- **Fees**      No fee      Set fee (please specify) \_\_\_\_\_  
 Sliding fee scale based on income    Medicaid    Medicare    Private Insurance  
 Scholarships available

- **Gender served**    Male    Female    Both

- **Area served** Geographical boundaries, zip codes, etc. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ **No boundaries:** \_\_\_\_\_

- **Branches** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Agency Information**

- **Intake procedures**  Walk-in  Telephone  Appointment only  
 Referral only by: \_\_\_\_\_  Email  Internet/online  
 Other (specify) \_\_\_\_\_
- **Required documentation**  None  Picture ID, Driver's License  Social Security Card  
 Birth Certificate  Medical/Psychiatric records
- **Languages** Which ones are regularly available and spoken by your staff?  
 English only  Spanish  Other(s) specify \_\_\_\_\_
- **Your facility's accessibility** How does your facility accommodate people with disabilities as defined by the Americans with Disabilities Act?  
 Completely  Entry only  Entry and bathroom(s)  Elevators  Outside ramps  
 Indoor wheelchair access  Designated parking  No Access
- **Healthcare facility license date** \_\_\_\_\_
- **Organization status**  Private, non-profit 501(c)(3)  Private  Public  
 Other specify \_\_\_\_\_
- **Hours/Days of operation** \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm

Mon Tues Wed Thurs Fri Sat Sun (please circle)

Please list services that have different hours/days or special intake hours if applicable.

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