

**211 SERVICE PROVIDER APPLICATION**

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Thank you for your interest in having your agency included in the 211 database. Please review the information below for an overview of the application process. Once complete, email the application form to us for processing.

The application consists of the three key categories of required information:

**1. Agency Information:** The general information for your agency, including the primary contact details for updates.

**2.** **Site Information:** Physical locations where your services are delivered. If any location is confidential, please indicate this—confidential locations will not be listed in the database.

**3.** **Program Information:** Details about the services your agency offers. This includes program descriptions, eligibility criteria, and contact information. Each program must be linked to at least one site listed in the “Site Information” section.

Each entry in the 211 service directory is updated, at minimum, each 12 months as part of the 211 Annual Update. The Annual Update involves the 211 Resource Team sending an email to every agency included in the 211 service directory with a request that an agency representative review and either update or confirm their service information. If the agency does not respond to this request, the 211 Resource Team reaches out with additional emails and phone calls to verify the agency's information

If you have any questions or need any assistance, please feel free to contact us. We look forward to receiving your application.

Thank you,

211 San Benito County Resource Team

211sanbenito@icfs.org

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| **SERVICE PROVIDER APPLICATION/UPDATE FOR 211 San Benito** | | | | | | | | |
| **AGENCY INFORMATION** | | | | | | | | |
| **Inclusion Criteria** | | | | | | | | |
| Does your organization provide services that you believe are appropriate for inclusion in the 211 database, based the 211 San Benito County Inclusion/Exclusion Policy (available at www.211sanbenitocounty.org)?   Yes  No | | | | | | | | |
| Have you been in operation for at least six months?  Yes  No | | | | | | | | |
| **Agency Information** | | | | | | | | |
| Agency Name: | | | | | | | | |
| Is your agency also commonly known by another name or abbreviation: | | | | | | | | |
| Parent Agency (If legally part of another organization, department, division, etc. please provide legal name): | | | | | | | | |
| Agency Description (describe your agency in one or two sentences):  *e.g. Nonprofit organization focused on supporting individuals with disabilities.* | | |  | | | | | |
| Agency Type:  Nonprofit: If Yes, what is your tax designation?  501(c)3  501(a)  No formal designation  Other:  Government/Public  Religiously Affiliated Organization (No formal legal designation)  Membership Organization (No formal legal designation)  For Profit/Proprietary | | | | | | | | |
| **Agency Contact Information** | | | | | | | | |
| Agency Website/URL: | | | | | | Agency Email: | | |
| Is this physical address:  Confidential location   Wheelchair accessible | | Agency Physical Address: | | | | City, State: | | Zip: |
| Mailing Address  Same as above | | Agency Mailing Address: | | | | City, State: | | Zip: |
| Agency Administration Phone #: | | | | | | TDD/TTY #:       Fax #: | | |
| **Agency Senior Executive** (Name & Title) |  | | | Phone: | | | Email: | |
| **Agency Primary Contact** for 2-1-1 Updates  (Name & Title) |  | | | Phone: | | | Email: | |
| Administration Office Hours:  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday | | | | | What holidays does your agency close for? | | | |

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| **“SITE A” INFORMATION** | | | |
| Site Name (This is the name of the physical location):        It can be specific – i.e. ABC Family Resource Center, or general – i.e. Salinas Office | | | |
| Is this physical address:    Confidential Location  Wheelchair Accessible | Physical/Street Address: | City, State: | Zip: |
| Mailing Address  Same as above | Mailing Address: | City, State: | Zip: |
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| **“SITE B” INFORMATION** | | | |
| Site Name: | | | |
| Is this physical address:    Confidential Location  Wheelchair Accessible | Physical/Street Address: | City, State: | Zip: |
| Mailing Address  Same as above | Mailing Address: | City, State: | Zip: |
| **“SITE C” INFORMATION** | | | |
| Site Name: | | | |
| Is this physical address:    Confidential Location  Wheelchair Accessible | Physical/Street Address: | City, State: | Zip: |
| Mailing Address  Same as above | Mailing Address: | City, State: | Zip: |
| **“SITE D” INFORMATION** | | | |
| Site Name: | | | |
| Is this physical address:   Confidential Location  Wheelchair Accessible | Physical/Street Address: | City, State: | Zip: |
| Mailing Address  Same as above | Mailing Address: | City, State: | Zip: |
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| **PROGRAM INFORMATION**  **(Please submit one Program Information Page per program)** | | |
| Agency Name: | | Program Name: |
| Is this program commonly known by another name or abbreviation? | | |
| Program Website/URL: | | Program Email Contact: |
| **Program Description/Primary Services**  *Maximum of 100 words.*  *e.g. Offers parenting skill classes to parents struggling with managing misbehavior of their children at home or school.* |  | |
| Which sites/locations offer your program (matching Site Information on page 2)?  Site A  Site B  Site C  Site D  Other: | | |
| Intake Procedure:  Apply by Phone  Walk-In  Call for Appointment  Referral Required Other: | | |
| Documentation Required at Intake: (i.e. ID, SS card, Proof of Income etc.) | | |
| Program eligibility requirements:  *e.g. Must be parents with children aged under 18.*  Eligibility requirements based on residency (i.e. program only serves residents of a specific city)?       *e.g. Must be resident of City of XXX.* | | Coverage Area:  United States  California  Specific County:  Specific City only:  Specific Zip Code only: |
| Fees *(check all that apply)***:**  No Fee  Fees vary  Sliding Scale fee $       to $       based on  Set program fee $ | | Accepts Medi-Cal  Accepts Medi-Care  Accepts most insurance  Membership fee $       per |
| Program Hours:  Monday        Hours vary, please call for information  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday | | |
| Service is available in:  English Spanish Other:        Interpreter Services Available | | |
| **PHONE NUMBERS** | | |
| Main Program Phone #:  Other Phone # (if different from Main):       Purpose of another phone (i.e. Afterhours 5pm-8am):  Fax #:       TDD/TTY Phone #: | | |

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| **SIGNATURE** | |
| **I AUTHORIZE THE VERIFICATION OF THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE. I UNDERSTAND THAT IN ORDER TO KEEP 211 SAN BENITO’S DATABASE ACCURATE AND UP TO DATE, AGENCIES ARE ASKED TO INFORM 211 SAN BENITO OF CHANGES TO THE AGENCY’S OPERATIONS WITHIN 30 DAYS AND TO PROVIDE CURRENT INFORMATION DURING OUR ANNUAL UPDATE PERIOD. I HAVE READ AND UNDERSTOOD 211 SAN BENITO’S INCLUSION/EXCLUSION POLICY. APPLICATIONS/UPDATES WILL BE PROCESSED WITHIN 7 DAYS OF RECEIPT.** | |
| **PRINT NAME:** | **PHONE:** |
| **TITLE:**  **DATE:** | **EMAIL:** |

***SUBMIT APPLICATIONS/UPDATES VIA EMAIL***

**211 San Benito**

**628-400-9330**

[211sanbenito@icfs.org](mailto:211sanbenito@icfs.org)