

**Aging and Disability Resource Center
Database Application**

**Return completed application to:
The Area Agency On Aging of Pasco-Pinellas, Inc.
9887 4th Street North, Suite 100, St. Petersburg, FL 33702
Fax – 727-217-7615**

Date of application _____

AGENCY/ORGANIZATION INFORMATION

Please clearly fill out all items. If not applicable, please mark N/A.

Organization's Legal Name: _____

Organization's Common Name (*i.e. Abbreviation, AKA, DBA*)

In business at least one year? Yes _____ No _____

Tax Status (Please \checkmark one):

_____ For Profit _____ Non-Profit (please attach status form)

_____ Public – City _____ Public – County

_____ Public – State _____ Public – Federal

_____ Other, please explain: _____

What credentials does the organization have? (Enclose copy of license(s), certifications, etc.) _____

License number _____ Expiration date: _____

Funding Sources (Please \checkmark all that apply):

___ United Way ___ State ___ Federal ___ Local Gov't ___ Foundation ___ Private ___ Fundraising ___ Fees

___ Area Agency on Aging ___ Individual Donations ___ Corporate Sponsor

___ Other _____

Background Checks on Employees? Yes ___ No ___ If yes, describe type: _____

CEO/Owner/Director - Name: _____

Title: _____

E-Mail: _____

Phone Number: _____ ext _____

Person completing the application - Name: _____

Title: _____

E-Mail: _____

Phone Number: _____ ext _____

ORGANIZATION LOCATIONS/SITES

*If you have more than one office or service location,
please complete a copy of this section for every location.*

Select one: This is the Primary or Main Office _____ OR Satellite Office/ Site _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

This location is confidential and not to be shared with clients: No _____ Yes _____

Mailing Address (if different): _____

Phone Number for Consumer Inquiries: _____

Fax Number: _____

Other Contact Telephone Numbers (include type: Administration, cell, TDD/TTY, etc):

E-Mail Address for customer inquiries: _____

Web Address: _____

Days and hours for customer inquiries: _____

Days and hours of Operation: _____

Site Director Name: _____ Title: _____

Site Director E-Mail: _____ Phone Number: _____

Site Contact Person: _____ Title: _____

Site Contact Person's E-Mail: _____ Phone Number: _____

Languages (other than English) spoken by staff at this location: _____

Does this site offer volunteer opportunities? Yes _____ No _____

Area Served:

Check: 1) This site serves to the entire state of Florida _____ OR 2) This site serves the county or counties checked below:

- Alachua
- Baker
- Bay
- Bradford
- Brevard
- Broward
- Calhoun
- Charlotte
- Citrus
- Clay
- Collier
- Columbia
- DeSoto
- Dixie
- Duval
- Escambia
- Flagler
- Franklin
- Gadsden
- Gilchrist
- Glades
- Gulf
- Hamilton
- Hardee
- Hendry
- Hernando
- Highlands
- Hillsborough
- Holmes
- Indian River
- Jackson
- Jefferson
- Lafayette
- Lake
- Lee
- Leon
- Levy
- Liberty
- Madison
- Manatee
- Marion
- Martin
- Miami-Dade
- Monroe
- Nassau
- Oskaloosa
- Okeechobee
- Orange
- Osceola
- Palm Beach
- Pasco
- Pinellas
- Polk
- Putnam
- Santa Rosa
- Sarasota
- Seminole
- St. Johns
- St. Lucie
- Sumter
- Suwannee
- Taylor
- Union
- Volusia
- Wakulla
- Walton
- Washington

OR – 3) If the area served is **smaller than a county**, please list the **zip codes** where service is available:

Do customers come to this location, either to receive service(s) or to arrange for service(s)?

Yes _____ No _____

If yes, please list the accessibility features available at this location (Please √ all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Full Wheelchair Access | <input type="checkbox"/> Residential - Flashing Lights for Hearing Impaired |
| <input type="checkbox"/> Designated Parking | <input type="checkbox"/> Ramps |
| <input type="checkbox"/> Public Parking Available | <input type="checkbox"/> Braille Signage |
| <input type="checkbox"/> Elevators | <input type="checkbox"/> Public Transportation Available |
| <input type="checkbox"/> Lowered Elevator Controls | |

If yes, give directions to this location: _____

SERVICES PROVIDED

Please describe the services/programs that your agency/organization provides. There is one service type per page - **if you have more than one service, please make additional copies of this page before continuing.** Service examples: homemaker/companion, home health, adult day care, legal, transportation.

Name of Service/Program: _____

Which location(s) listed on this application should customers contact about this service/program? _____

Is this service available in the entire service area for these locations? (See page 3)

Yes _____ No _____

If no, please describe the area where this service is available (state, county or zip codes) _____

Brief Paragraph Describing the Primary Services/Program (primary = available as a single service)

List any Secondary or Optional Services Available (available as an extra for those who get a primary service)

Hours/days of operation for this service/program:

Please identify the target group(s) for this service (e.g., elders, Developmental Disabilities, dementia, etc.)

Are services provided at the customer's home? Yes _____ No _____ N/A or Residential facility _____

Who is eligible for this service/program? (Please all that apply)

All Ages

Adults age 18 years +

Adults with Mental Illness

Adults with Developmental Disabilities

Elders {age _____ to _____}

Caregivers 18 yrs.+

Females only

Males only

Additional Eligibility Info (e.g., other eligibility criteria related to age, income, service area, diagnosis, etc):

