

**Florida Aging Resource Center  
Database Application**

**Return completed application to:  
The Senior Helpline  
9887 4<sup>th</sup> 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:

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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"/> Limited Access                       |
| <input type="checkbox"/> Fully Accessible          | <input type="checkbox"/> No Access                            |
| <input type="checkbox"/> Designated Parking        | <input type="checkbox"/> Flashing Lights for Hearing Impaired |
| <input type="checkbox"/> Public Parking Available  | <input type="checkbox"/> Ramps                                |
| <input type="checkbox"/> Elevators                 | <input type="checkbox"/> Braille Signage                      |
| <input type="checkbox"/> Lowered Elevator Controls | <input type="checkbox"/> Public Transportation Available      |

If yes, give directions to this location: \_\_\_\_\_

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**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, people with dementia, etc.)

\_\_\_\_\_

Are services provided at the customer's home? Yes \_\_\_\_\_ No \_\_\_\_\_ NA/ Residential facility \_\_\_\_\_

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

- All Ages
- Adults age 18 years +
- Females  Males
- Elders {age \_\_\_\_\_ to \_\_\_\_\_}
- Serves Caregivers 18 yrs.+
- Adults with Mental Illness

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

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

**How does someone access this service/program? (Please ✓ all that apply)**

\_\_\_ Walk-In \_\_\_ By Phone \_\_\_ Other (specify) \_\_\_\_\_

Documentation required to access this service (e.g., physician referral, social security card, proof of income):

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

**How does someone pay for this service/program? Please ✓ all that apply)**

\_\_\_ Free Services      \_\_\_ Private Pay/Fee for Service      \_\_\_ Medicare  
\_\_\_ Donations Accepted      \_\_\_ Sliding Scale      \_\_\_ Medicaid  
\_\_\_ Veterans      \_\_\_ Private Insurance      \_\_\_ Other public benefits

Additional Payment Information: \_\_\_\_\_  
\_\_\_\_\_

Languages (other than English) spoken by staff for this service: \_\_\_\_\_

Does your organization provide transportation as part of your service or to help the client get to your service?

Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, check all that apply: \_\_\_\_\_ Staff/Volunteers drive their own vehicle  
\_\_\_\_\_ Staff/Volunteers drive an agency vehicle  
\_\_\_\_\_ Other \_\_\_\_\_

Review the application for completeness. **In order to be in the database of the Florida Aging Resource Centers, the following acknowledgement must be signed and returned with the application.**

I, \_\_\_\_\_ attest that the information provided on behalf of our  
(Print name)  
agency/organization is true and accurate. I also understand and agree that misrepresentation or omission of pertinent information regarding the agency and/or services provided will result in the deletion of the agency or organization from the database without notice. Furthermore, it is acknowledged and understood that participation in the statewide database does not constitute an endorsement of the agency by the Department of Elder Affairs or by the Aging Resource Centers in Florida.

Signature \_\_\_\_\_  
Title \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*  
Date application received by the Aging Resource Center: \_\_\_\_\_

Aging Resource Center notes: \_\_\_\_\_

3/19/2008