ADRC
Aging & Disability Resource Center of Broward County
Pointing You in the Right Direction!

AGING & DISABILITY RESOURCE CENTERS
STATEWIDE INTEGRATED DATABASE APPLICATION
Please clearly fill out all items. If not applicable, please mark N/A.

Agency's Legal Name:
_____

Agency's Common Name (AKA):
_____

Physical Address: _____
City: _____ State: _____ Zip Code: _____
Is this location confidential? □ Yes □ No
Is this location close to public transportation? □ Yes □ No

Mailing Address (If Different): _____
City: _____ State: _____ Zip Code: _____
Is this location confidential? □ Yes □ No
Is this location close to public transportation? □ Yes □ No

Main/Toll Free Phone Number: _____
Fax: _____ TDD/TTY: _____ Other: _____

Website: _____
E-Mail: _____

Agency Type: ☐ For Profit ☐ Non-Profit ☐ United Way Member ☐ Faith-Based
☐ City ☐ County ☐State ☐ Federal ☐ Other
Please explain: _____

CONTACT INFORMATION

Director Name: _____Title: _____
Phone Number: _____Ext:_____ E-Mail: _____

Main Contact Name: _____Title: _____
Phone Number: _____Ext:_____ E-Mail: _____

Alternate Contact Name: _____Title: _____
Phone Number: _____Ext:_____ E-Mail: _____

Other (Please include Type: Intake, Toll Free, Cell, etc.): _____

IRS Status: _____ Tax ID: _____ License #: _____ (*Attach copy of License)*

Has your organization been in business at least one year? □ Yes □ No

Month/Year Incorporated: _____

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☐ Primary / Main Office ☐ OR Satellite Office/Site

Please list the accessibility features available at this location:
☐ Fully Accessible ☐ Limited Access ☐ No Access
☐ Designated Parking ☐ Full Wheelchair Access ☐ Elevators

Funded By: ☐ City Funding ☐ County Funding ☐State Funding ☐ Federal Funding
☐ Fees ☐ United Way ☐ Fund Raising ☐Donations ☐ Private Funding
☐ Other Please explain: _____

AGENCY OVERVIEW

Brief Agency Description:
_____
_____
_____
_____
_____

Days and Hours of Operation:
_____

Service Area (City/County): _____
_____
_____
_____

Languages Spoken: ☐ English ☐ Spanish ☐ Creole ☐ Other(s) _____

Fees / Payment Options: ☐ Private Pay/Fee for Service ☐ Private Insurance
☐ Medicare ☐ Medicaid ☐ Other _____

The information below is obtained solely to better match client needs with the appropriate service providers and will not affect your application to enlist in our database as a resource.
Serves: ☐ 18+ ☐ Specific Ages _____ to _____ ☐ Women Only ☐ Men Only
☐Alzheimer's/Dementia ☐ Other _____

-Do you offer discounted pricing or a sliding fee for seniors/disabled adult? ☐ Yes ☐ No
If Yes, please explain: _____

-Would you be willing to offer any pro bono services on a short term basis? ☐ Yes ☐ No
If Yes, please explain: _____

-Is your agency Lesbian, Gay, Bisexual, and Transgender (LGBT) Friendly? ☐ Yes ☐ No

-Does your agency provide staff with sensitivity training? ☐ Yes ☐ No

☐ Other
_____
_____

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PROGRAMS AND SERVICES

Name of Service/Program (1):

_____

Service Description:

_____
_____
_____
_____

Eligibility / Criteria: _____
_____

Intake Procedures _____
_____

Name of Service/Program (2):

_____

Service Description:

_____
_____
_____
_____

Eligibility / Criteria: _____
_____

Intake Procedures _____
_____

*****Please attach all requested information for any additional Programs / Services*****

OTHER SITES & LOCATIONS

Site (2) Name:

_____

☐ Primary / Main Office ☐ OR Satellite Office/Site

Please list the accessibility features available at this location:
☐ Fully Accessible ☐ Limited Access ☐ No Access
☐ Designated Parking ☐ Full Wheelchair Access ☐ Elevators

Site Address: _____
City: _____ State: _____ Zip Code: _____

Is this location confidential? □ Yes □ No
Is this location close to public transportation? □ Yes □ No

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

Site Phone Number(s) – *Please indicate Phone Type* (Intake, Toll Free, Cell, etc.):
(1) _____ (2) _____ (3) _____
Site or Service Contact:
_____

Specify if this location has different Eligibility, Programs and Services than the main office:
_____
_____
_____

Site (3) Name:
_____
☐ Primary / Main Office ☐ OR Satellite Office/Site

Please list the accessibility features available at this location:
☐ Fully Accessible ☐ Limited Access ☐ No Access
☐ Designated Parking ☐ Full Wheelchair Access ☐ Elevators

Site Address: _____
City: _____ State: _____ Zip Code: _____
Is this location confidential? □ Yes □ No
Is this location close to public transportation? □ Yes □ No

Site Phone Number(s) – *Please indicate Phone Type* (Intake, Toll Free, Cell, etc.):
(1) _____ (2) _____ (3) _____
Site or Service Contact:
_____
Specify if this location has different Eligibility, Programs and Services than the main office:
_____
_____
_____ **

Please attach all requested information for any additional Sites / Locations**

ACKNOWLEDGEMENT

I, _____attest that the information provided on behalf of our 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 & Disability Resource Centers in Florida.

Signature_____
Title _____ Date: _____

***** This form must be signed before information can be entered in Refer Database *****

Administrative Information *(Information below to be completed by ADRC Administrator)*
Date Provider Added: _____Date Provider Information Updated: _____