

**211 ST. CROIX VALLEY SERVICE PROVIDER APPLICATION**

Thank you for your interest in having your agency included in the 211 database.

The application includes two basic areas:

**1. Agency Information:** This includes general information about your organization. This does not include information about specific services you provide.

**2.** **Service Information:** Services are the programs your agency offers. Please complete one program section for each program you are submitting for the 211 database.

**Send the completed application by email (****resourcemanager@unitedwaystcroix.org****)**

Please do not hesitate to call the 211 Resource Team if you have questions or need assistance with this process.

We look forward to receiving your application.

Thank you,

211 St. Croix Valley Resource Management Team

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| **SERVICE PROVIDER APPLICATION/UPDATE FOR 211 ST CROIX VALLEY** |
| **AGENCY INFORMATION** |
| **Inclusion Criteria** |
| Does your organization provide services that are appropriate for inclusion in the 211 database, based on the 211 St. Croix Valley Inclusion/Exclusion Policy (available [HERE](https://211wisconsin.communityos.org/inclusion-exclusion-policy))?  [ ]  Yes [ ]  No |
| Have you been in operation for at least six months? [ ]  Yes [ ]  No |
| **General Agency Information** |
| **Agency Name:**        |
| Is your agency also commonly known by another name or abbreviation:       |
| Parent Agency (If legally part of another organization:       |
| **Agency Description (describe your agency in one or two sentences):** *e.g. Nonprofit organization focused on supporting individuals with disabilities.* |       |
| **Agency Type:** [ ]  Not-for-profit (incorporated) - tax designation [ ]  501(c)(3) [ ]  501(a) [ ]  Other:       [ ]  Not-for-profit (not incorporated) [ ]  Government: If Yes, which level? [ ]  Federal [ ]  State [ ]  County [ ]  City[ ]  For Profit/Commercial |
| **Agency Contact Information** |
| **Agency Website/URL:**       | **Agency Email:**      *(for general questions from the public)*  |
| **Physical Address**Agency Physical Address:      City, State:       Zip:       | Is this office:  A confidential location? [ ]  Yes / [ ]  No  Wheelchair accessible? [ ]  Yes / [ ]  No |
| **Mailing Address**  [ ]  Same as above (if mailing address is different, add address below)Agency Mailing Address:      City, State:       Zip:       |
| **Administration Office Hours:** Mon       Tues       Wed       Thurs       Fri       Sat       Sun      What holidays does your agency close for?       |
| **Agency General Information Phone #:**       Fax #:       TDD/TTY #:        |
| **Agency Senior Executive** Name:       Title:       Phone:      Email:       |
| **Agency Primary Contact for 211** This person will receive the 211 annual update request to confirm and/or update your agency’s information in the 211 database and will be contacted if there are questions about your agency’s information in the 211 database. To ensure the accuracy of referrals, agencies that do not respond to the annual update will be subject to removal.**Name:**       **Title**:      **Phone**:       **Email**:       |

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| **PROGRAM INFORMATION****(Please submit one Program Information section per program)** |
| **Agency Name**:  | **Program Name**:  |
| Is this program commonly known by another name or abbreviation?  |
| **Program Website/URL**:  |
| **Program Manager Name**:  | **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.* |  |
| **Intake Procedure**: [ ]  Walk-In  [ ]  Call for appointment [ ]  Referral required from  [ ]  Other:  |
| **Documentation Required at Intake** (i.e. ID, SS card, Proof of Income etc.) Please specify:  |
| **Program eligibility requirements:** [ ]  No restrictions or eligibility criteria.[ ]  Other: *e.g. Must be parents with children under 18 years old.*  | **Residency requirement**: [ ]  No residency requirement [ ]  Must be a citizen of United States[ ]  Must be a Wisconsin resident[ ]  Must be resident of specific county: [ ]  Must be resident of specific city: [ ]  Must be resident of specific zip code:  |
| **Fees** *(check all that apply)***:** [ ]  No Fee[ ]  Fees vary[ ]  Sliding Scale fee $  to $  based on [ ]  Set program fee $  per  | [ ]  Accepts Medicaid[ ]  Accepts Medicare[ ]  Accepts most insurance[ ]  Membership fee $  per  |
| **Program Hours:** Mon  Tues  Wed  Thurs  Fri  Sat  Sun  [ ]  Hours vary  |
| **Language** - Service is available in: [ ] English [ ] Spanish [ ] Other:  [ ]  Interpreter Services Available for:       |
| **PHONE NUMBERS** |
| **Main Program Phone #**: Other Phone #:  Purpose of other phone (i.e. Afterhours 5pm-8am): TDD/TTY Phone #:  |

**Agency Name**:  **Program Name**:

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|  **Program is offered at this location (“Site A”)**  |
| **Site Name:** *e.g. Family Resource Center, Waukegan Site, Zion Clinic* |
| **Physical Address**Agency Physical Address:      City, State:       Zip:       | Is this office:  A confidential location? [ ]  Yes / [ ]  No  Wheelchair accessible? [ ]  Yes / [ ]  No |
| **Mailing Address**  [ ]  Same as above (if mailing address is different, add address below)Agency Mailing Address:      City, State:       Zip:       |
| **Program is offered at this location (“Site B”)** |
| **Site Name:**   |
| **Physical Address**Agency Physical Address:      City, State:       Zip:       | Is this office:  A confidential location? [ ]  Yes / [ ]  No  Wheelchair accessible? [ ]  Yes / [ ]  No |
| **Mailing Address**  [ ]  Same as above (if mailing address is different, add address below)Agency Mailing Address:      City, State:       Zip:       |
| **Program is offered at this location (“Site C”)** |
| **Site Name:**   |
| **Physical Address**Agency Physical Address:      City, State:       Zip:       | Is this office:  A confidential location? [ ]  Yes / [ ]  No  Wheelchair accessible? [ ]  Yes / [ ]  No |
| **Mailing Address**  [ ]  Same as above (if mailing address is different, add address below)Agency Mailing Address:      City, State:       Zip:       |
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| **\*\* Add information for additional physical locations as needed.**  |

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| **SUBMITTED BY** |
| **NAME:       DATE:**  |
| **TITLE:** **EMAIL:       PHONE:**  |

**Send the completed application by email to** **resourcemanager@unitedwaystcroix.org**