



Bay Arenac Call Center

Community Resource Database

New Organization Survey

INSTRUCTIONS: IF YOUR ORGANIZATION HAS MULTIPLE LOCATIONS, PLEASE DUPLICATE AND COMPLETE THIS FORM (PAGE 1) FOR EACH ADDITIONAL SITE.

ORGANIZATION'S LEGAL NAME: _____

Other Names, AKA's (acronyms): _____

Former Names: _____

SITE NAME (if applicable): _____

STREET ADDRESS: _____

City: _____ State: _____ ZIP: _____

Mailing Address (if different): _____

City: _____ State: _____ ZIP: _____

ORGANIZATION LOCATION (Nearest cross streets, identifiable landmarks, etc.): _____

CONTACT INFORMATION

Main #: () _____ Client Contact # (if different): () _____

FAX: () _____ TTY/TDD: () _____

Other #: () _____ Please specify type: _____

URL/Website Address: _____

General E-Mail: _____

ORGANIZATION TYPE

- | | | |
|---|---|--|
| <input type="checkbox"/> Non-Profit 501c3 | <input type="checkbox"/> Private, Non-Profit –Religious | <input type="checkbox"/> For-Profit |
| <input type="checkbox"/> Support Group | <input type="checkbox"/> Coalition/Other Group | <input type="checkbox"/> Public –City |
| <input type="checkbox"/> Public –County | <input type="checkbox"/> Public –State | <input type="checkbox"/> Public –Federal |

AGENCY DIRECTOR/ADMINISTRATOR

Name: _____ Title: _____

E-mail: _____ Phone: () _____ Fax: () _____

RESOURCE CONTACT PERSON (if not the director)

Name: _____ Title: _____

E-mail: _____ Phone: () _____ Fax: () _____

AREA SERVED: _____

ADMINISTRATIVE/OFFICE HOURS:

M _____ TU _____ W _____ TH _____ F _____ SAT _____ SUN _____

ACCESSIBILITY (check all that apply)

- | | | | |
|---|---|------------------------------------|---|
| <input type="checkbox"/> Full Wheelchair Access | <input type="checkbox"/> Limited Access | <input type="checkbox"/> No Access | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Designated Parking | <input type="checkbox"/> Ramps | <input type="checkbox"/> Elevators | <input type="checkbox"/> No Stairs |
| <input type="checkbox"/> Automated Doors | <input type="checkbox"/> Accessible Restrooms | | |

ORGANIZATION DESCRIPTION/MISSION: _____

YEAR OF INCORPORATION: _____

FEDERAL IDENTIFICATION NUMBER (EIN): _____

Survey completed by:

Name: _____ Title: _____

Phone: _____ Date: _____

PROGRAM SURVEY FORM

Organization Name: _____

INSTRUCTIONS: Complete one program survey form for each service or program that your organization provides. Please duplicate this form as needed.

PROGRAM/SERVICE NAME: _____

PROGRAM/SERVICE DESCRIPTION: _____

PROGRAM LOCATION:

Please check and list the site name(s) and/or address at which this program is offered.

Site 1: Main/Administrative Office: _____

Site 2: _____

Site 3: _____

Site 4: _____

PROGRAM CONTACT INFORMATION

Contact Name: _____ Title: _____

Program Phone: () _____ Fax: () _____

TDD/TYY: () _____ Other: _____

PROGRAM/SERVICE DAYS AND HOURS:

M _____ TU _____ W _____ TH _____ F _____ SAT _____ SUN _____

Check here if this service is not available year round on a consistent basis*. Please

Explain: _____

APPLICATION/INTAKE PROCESS

Walk-in ____ Call ____ Appointment required ____ Referrals from: _____

Other, please describe: _____

DOCUMENTATION REQUESTED (Picture ID, proof of income, etc.): _____

FEES AND PAYMENT METHODS: _____

ELIGIBILITY REQUIREMENTS/TARGET POPULATION (Income, age, gender, etc.): _____

LANGUAGES/TRANSLATION SERVICES: (other than English): _____

Survey completed by:

Name: _____ Title: _____

Phone: _____ Date: _____

THANK YOU, FOR PROVIDING YOUR ORGANIZATIONAL AND SERVICE INFORMATION.
PLEASE RETURN ALL FORMS TO:

**Vicki Ribble
United Way of Bay County
909 Washington Ave.
Bay City, MI 48708
(989) 893-2211
FAX: (989) 893-0087**