

## RESOURCE DIRECTORY FORM

- For New Listings
- For those who are already listed but who do not have Microsoft Excel

Please complete this page. If your organization is not already listed in the directory, please ALSO complete the following pages for inclusion in the 2-1-1 Idaho CareLine database. If you are a new listing and wish to be included ONLY in the Region IV Development Regional Resource Directory, complete this page and page 5 (KEYWORDS).

Entire form must be mailed to Region IV Development Resource Directory, P.O. Box 5079, Twin Falls, Idaho, 83303-5079

### THANK YOU FOR PRINTING

PROGRAM NAME \_\_\_\_\_

PHYSICAL ADDRESS \_\_\_\_\_ P.O. BOX \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ WEBSITE ADDRESS \_\_\_\_\_

MAIN TELEPHONE ( ) \_\_\_\_\_ FAX ( ) \_\_\_\_\_

TOLL FREE OR OTHER 2<sup>ND</sup> PHONE ( ) \_\_\_\_\_

DESCRIPTION OF OTHER PHONE (toll-free, 24 hour hotline, direct line, etc.)  
\_\_\_\_\_

HOURS / DAYS OF OPERATION (Example: 8:00 a.m. – 5:00 p.m. M-F) \_\_\_\_\_

NOTES/DETAILS (give a brief description of your services) \_\_\_\_\_  
\_\_\_\_\_

ELIGIBILITY PARAMETERS (if any – Example: Serve youth under 21, low-income)  
\_\_\_\_\_

FEES (if any, and based on what? Example: Sliding scale, based on income. Example 2: fees vary)  
\_\_\_\_\_

LANGUAGE SPOKEN AT LOCATION – E = English, S=Spanish, I=Interpreters on call, O=Other (specify other; ex: O-Bosnian..... Example 1: E, S, I Example 2: E Example 3: E, O-German, I  
\_\_\_\_\_

AREAS SERVED (“South Central Idaho” refers to the 8 county region of Magic Valley, including Mini-Cassia. Example 1: City of Burley Example 2: Twin Falls, Gooding counties Example 3: South Central Idaho  
\_\_\_\_\_  
\_\_\_\_\_

Please print your name and email address below. Names and email addresses will not be posted on our Regional Resource Directory, but will be used to send requests for updated information.

Your Name \_\_\_\_\_

Your Email Address \_\_\_\_\_

# IDAHO 2-1-1

## Get Connected. Get Answers.

Please mail to Region IV Development  
P.O. Box 5079  
Twin Falls, ID 83303-5079

(First 5 pages will be forwarded to Idaho 2-1-1 CareLine)

For internal use only.

Site mailing date: \_\_\_\_\_  
CAPAI \_\_\_\_\_ CareLine \_\_\_\_\_ Date Rec'd \_\_\_\_\_  
Data entry complete: \_\_\_\_\_ Initials \_\_\_\_\_  
TOW# \_\_\_\_\_

THANK YOU FOR PRINTING CLEARLY!

### SERVICE INVENTORY QUESTIONNAIRE – SECTION 1

(Information in this section to be included in the Idaho CareLine database, on-line and on the RUPRI internet site)

1. OPERATING AGENCY: \_\_\_\_\_

a) Acronyms: Other Name/Former Name \_\_\_\_\_

Person in Charge: \_\_\_\_\_ Title \_\_\_\_\_

b) Are you part of a larger organization? i.e. CAP, District Health Department, Health and Welfare, United Way, etc.

Yes  No  If yes, what is the name and address of your parent or affiliate organization?

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

2. CONTACT INFORMATION: What is the physical / mailing address and telephone of your program, agency or business?

Street Address \_\_\_\_\_ P.O. Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Mobile \_\_\_\_\_ Fax \_\_\_\_\_

Toll Free \_\_\_\_\_ Other \_\_\_\_\_

Email \_\_\_\_\_

Website Address \_\_\_\_\_

a) Should the physical address be used for client referral to your program? Yes  No

Agency Name: \_\_\_\_\_ Tracking Number: \_\_\_\_\_ V initials: \_\_\_\_\_ Date: \_\_\_\_\_

**3. INFORMATION UPDATES:** Please list below the person to contact to update our records.

Name: \_\_\_\_\_

Title: \_\_\_\_\_

a) What is the easiest way for you to keep your information current in a database?

- Phone Call       Questionnaire (mail)       E-mail announcement and reply  
 Web-based (do it yourself)       Other: \_\_\_\_\_

**4. HOURS/DAYS OF OPERATION:** \_\_\_\_\_

**5. PROGRAM OR SERVICE DESCRIPTION:** Please be as specific as possible. Callers are referred to your agency based upon the description you provide. *Please use additional sheets, if needed.*

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

*In addition to this description, please attach a copy of your program brochure for our files.*

- a) Is your agency or are your employees licensed or certified by a regulatory agency?    Yes    No  
b) If so, the regulatory agency is \_\_\_\_\_  
c) License is valid through \_\_\_\_\_

**6. ORGANIZATIONAL TYPE:** Please check ONE that indicated your program's organizational type/status:

- Non-profit secular       Government       Non-profit Religious  
 Military       For Profit       Grassroots / Volunteer  
 Community Coalition       Other \_\_\_\_\_

**7. YOUR AGENCY'S SERVICE AREA:** What is your service area? Please check all that apply.

- Within Agency Only       Portion of the city       City-wide  
 Portion of the County       County-wide       Portion of the Region  
 Region-wide       Statewide       Portion of another State  
 Out of State       National       International

County: \_\_\_\_\_ Region: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**8. ETHNIC GROUPS SERVED:** Which ethnic groups do you predominately serve? Please signify percentages.

- American Indian \_\_\_\_%       Hispanic \_\_\_\_%       Asian \_\_\_\_%  
 Black or African American \_\_\_\_%       Caucasian \_\_\_\_%       Other \_\_\_\_%

Agency Name: \_\_\_\_\_ Tracking Number: \_\_\_\_\_ V initials: \_\_\_\_\_ Date: \_\_\_\_\_

9. **AGE GROUPS SERVED:** Please check all that apply or  All Ages
- Infants (0-3)       Young Children (4-8)       Children (9-12)       Youth (13-17)
- Young Adults (18-24)       Adults (25-54)       Young Seniors (55-64)       Seniors (65-over)

10. **ELIGIBILITY:** Who is eligible for your service? (Are your services limited to clients by gender, age, family status, military, economic status, ethnic origin, disease, or disability, etc?)

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11. **FEES:** What are your fees?

- Sliding scale fee      Details \_\_\_\_\_
- Straight fee for services      Details \_\_\_\_\_
- Other Considerations \_\_\_\_\_

a) Do you accept insurance?     Yes     No    If yes, \_\_\_ Private Insurance \_\_\_ Medicaid \_\_\_ Medicare

12. **INTAKE:** What is (are) your intake procedure(s)? Please check all that apply or  All Apply

- Telephone       Walk-in       By Appointment
- Referral Required (please specify) \_\_\_\_\_

13. **LANGUAGES:** What languages are routinely available and spoken by your staff or volunteers?

- English only       Spanish       American Sign Language
- Other(s) (specify) \_\_\_\_\_

14. **DATA COLLECTION:** Does your organization collect or track data on the population(s) you serve?

- Yes       No       Not sure

a) If yes, is the information available for inclusion in a statewide database?

- Yes       No

**Note: Privacy protection will be enforced (HIPAA)**

## 15. AGENCY KEYWORDS

Help us accurately assign keywords to your program by checking all that apply. Keep in mind that the general public will be using an on-line search tool and may not be familiar with your agency.

- Abuse: \_\_\_ Child \_\_\_ Adult
- Adoption Services (specify): \_\_\_\_\_
- Adult basic education
- Advocacy issues: \_\_\_\_\_
- After School Programs
- Aging / elderly / senior services
- Assistive technology / devices
- Baby items: \_\_\_\_\_
- Breastfeeding
- Career Counseling
- Child Care
- Child custody / support
- Child development
- Clothing
- Coalition building
- Communicable disease control
- Community development / organizing
- Conflict resolution / mediation
- Counseling (type): \_\_\_\_\_
- Crime victim program: \_\_\_\_\_
- Crisis hotline
- Dental care
- Disability (specify): \_\_\_\_\_  
\_\_\_ Youth \_\_\_ Adult
- Domestic violence
- Donation site (specify): \_\_\_\_\_
- Early childhood program (specify): \_\_\_\_\_
- Early intervention services
- Emergency services (specify):  
\_\_\_ shelter \_\_\_ family  
\_\_\_ women/children only
- Employment:  
\_\_\_ counseling \_\_\_ training  
\_\_\_ placement
- Financial assistance (cash distributed):  
\_\_\_ cash \_\_\_ counseling  
\_\_\_ rent/mortgage  
\_\_\_ medical expenses \_\_\_ utilities  
\_\_\_ gasoline
- Food / meals:  
\_\_\_ delivery \_\_\_ pick-up \_\_\_ served  
\_\_\_ food bank
- Foster care
- Health issues: (specify)  
\_\_\_ Audiology  
\_\_\_ Hearing  
\_\_\_ Cancer (specify): \_\_\_\_\_  
\_\_\_ Chronic pain  
\_\_\_ Diabetes  
\_\_\_ Disease/immunization information  
\_\_\_ Vision / blindness  
\_\_\_ Other (specify): \_\_\_\_\_
- Health Districts
- Health Insurance
- HIV / AIDS
- Home health
- Homelessness

- Hospital / medical facility
- Housing assistance:  
\_\_\_ emergency shelter \_\_\_ residential
- Immigration
- Information and referral:  
\_\_\_ comprehensive  
\_\_\_ specialized: \_\_\_\_\_
- Injury prevention
- Job Service / Training
- Law enforcement (specify): \_\_\_\_\_
- Legal assistance
- Library: \_\_\_ public \_\_\_ private
- Literacy: \_\_\_ child \_\_\_ adult
- Medicaid provider (specify): \_\_\_\_\_
- Medical expenses
- Medical services:  
\_\_\_ private office \_\_\_ clinic  
\_\_\_ hospital
- Mental Health Services:  
\_\_\_ private office \_\_\_ clinic  
\_\_\_ hospital
- Minority issues:  
\_\_\_ advocacy \_\_\_ education \_\_\_ other
- Offender / Ex-offender programs
- Parenting issues (specify):  
\_\_\_ education \_\_\_ advocacy \_\_\_ other
- Nutrition education:  
\_\_\_ child \_\_\_ adult
- Physical therapy
- Prenatal / pregnancy / family planning services (specify): \_\_\_\_\_
- Prescription assistance
- Respite care:  
\_\_\_ child \_\_\_ disabled adult  
\_\_\_ seniors/adult
- Seasonal program (specify) \_\_\_\_\_
- Social-emotional development
- Speech / language
- Substance abuse (drug, alcohol, tobacco abuse):  
\_\_\_ treatment  
\_\_\_ education / prevention
- Suicide issues:  
\_\_\_ hotline \_\_\_ edu./prevention  
\_\_\_ treatment
- Support groups (specify): \_\_\_\_\_
- Teen program (specify): \_\_\_\_\_
- Transportation:  
\_\_\_ bus tokens \_\_\_ van services  
\_\_\_ auto repair \_\_\_ gasoline vouchers
- Vocational rehabilitation
- Volunteer opportunities (coordination) (specify): \_\_\_\_\_

- WIC
- Women's health check
- Youth services (specify): \_\_\_\_\_
- (age range of clients): \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_

**16. AMERICA'S PROMISE**

If you are a youth-serving organization, please complete the following section. The categories below relate to America's Promise: The Alliance for Youth service designations for children and youth. The information gathered will be posted on your community's web-based Promise Station and Promise Checklist. Please check all that apply:

- Caring Adults (On-going relationships with care adults – **Mentor**)
- Safe Places (Safe places with structured activities during non-school hours – **Protect**)
- Healthy Start (Ensure a healthy start and a healthy future – **Nurture**)
- Marketable Skills (Marketable skills through effective education – **Teach**)
- Opportunities to Serve (Opportunities to give back through community service – **Serve**)

To learn more about America's Promise in your community, visit [www.americaspromise.org](http://www.americaspromise.org), [www.idahospromise.org](http://www.idahospromise.org) or call the Association of Idaho Cities at 1-866-432-4689.

**17. PRINTED MATERIALS:** The 211 Idaho CareLine has a 3 x 8 bilingual brochure / card outlining services (packs of 100).

Would you like to provide these to your clients?

- Yes                      How many? \_\_\_\_\_
- No

Are you interested in other CareLine printed materials?

**CERTIFICATION AND AUTHORIZATION**

*(This certification and authorization is only for 211 Idaho CareLine – if you decline to participate, you may still be posted on the Regional Resource Directory by filling in the information form following this page and sending it to RIVDA, P.O. Box 5079, Twin Falls, ID 83303-5079.)*

**Note:** The 211 Idaho CareLine has a database inclusion / exclusion policy and has the right to refuse or remove an agency at its discretion. Submission of your program for inclusion in the 211 Idaho CareLine database assumes your permission granted for your program(s) inclusion into any directory (printed or on-line) the Idaho Department of Health and Welfare or its community partners, unless otherwise noted. Cover pages 1-6.

It is the responsibility of your organization to update information on a regular basis (at least annually) to ensure accurate and timely referral. Thank you for assisting us in reaching Idahoans with needed information and resources!

I acknowledge that the above information is correct and accurately represents the services provided by our agency, organization or employees. I acknowledge that the information I provide will be combined with other data and analyzed at a local, county, regional, state and / or national-level as a decision-making tool. I consent to release the information gathered in this questionnaire for these purpose.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Print Name: \_\_\_\_\_

If completed by phone:

Interviewee's name: \_\_\_\_\_

Interviewer's name: \_\_\_\_\_

Interviewer's phone: \_\_\_\_\_

***Thank you!***