

**2-1-1 Texas - Rio Grande Area Information Center
RGAIC Database Organization Application**

Please type or print clearly so we can record your information easily. You must also fill out Part B (Program Information) for each service and site your organization offers. We reserve the right to edit your information.

PART A: ORGANIZATIONAL INFORMATION:

1. Organization's Name: _____ Year Established: _____
2. Organization Type: ___ Non-profit (501c3) ___ Other Non-profit ___ Governmental ___ For Profit
3. Contact Person: _____
(A person in authority we can call to clarify or request additional information.)
4. Physical Address of Organization's Administrative Offices: (Check here ___ if physical location is confidential and provide P. O. Box mailing address.)

Street: _____ Suite No.: _____

City: _____ State _____ Zip Code _____

P. O. Box: _____ City: _____ State: _____ Zip Code: _____

5. Is this location accessible to the disabled? ___ Yes ___ No Wheelchair accessible: ___ Yes ___ No
6. Person in charge of the entire organization (Executive Director, President, Administrator, etc.)

Name: _____ Title: _____

7. Telephone numbers and Internet access for organization:

Main telephone number: () _____ Toll free telephone number: _____

TDD (for deaf and hearing impaired individuals): _____

Fax: () _____ E-mail: _____ Web Site:: _____

8. Days/Hours of Operation: _____

I hereby authorize the RGAIC to utilize my organization's information for inclusion in its Community Resources Database, and all printed and electronic materials that it publishes and/or sells to others.

Signature of Authorized Person

Official Title

Date

PART B: PROGRAM INFORMATION:

Make copies of this section of the form before completing. You will need to fill out more than one PART B, IF:

- ✓ Your organization has multiple services, with different eligibility requirements, target groups, service areas, etc.
- ✓ Your organization has services at more than one location (one form for each location).

Please type or print clearly.

Date Part B completed: _____

1. Organization Name: _____
This is the only organizational information to be put on this form. All else is for your programs and services.

2. Program Name: _____
If there is no official name for program, please use a descriptive service name such as day care or social services, etc.

3. Person in charge of program: _____

4. Physical address of program: (If physical address of location is confidential, please provide P. O. Box mailing address.)

Street: _____ Suite No.: _____ City: _____ State: _____ Zip: _____

P. O. Box: _____ City: _____ State: _____ Zip Code: _____

5. Is this location accessible to the disabled? ___ Yes ___ No Wheelchair accessible: ___ Yes ___ No

6. Telephone numbers and Internet access for organization:

Main telephone number: () _____ Toll free number: _____ Intake number: _____

TDD: _____ Fax: () _____ E-mail: _____ Website: _____

7. Days and hours program is open for business: _____

8. Is this program licensed: ___ Yes ___ No
 If YES, what is the name of the licensing agency: _____

9. Populations Served: ___ All ___ Female ___ Male ___ Infants ___ Children ___ Teens ___ Adults

10. Ages Served: _____ to _____

11. Fees: ___ None ___ Sliding scale ___ Based on: _____
 Other: _____

12. Other eligibility restrictions: _____

13. Accepts: ___ Medicaid ___ Medicare ___ Private Insurance/HMO/PPO ___ Credit cards ___ Checks

14. Intake: (Check all that apply): ___ Appointment required ___ Walk-ins accepted ___ Call for information

Other (explain): _____

15. Documentation required: _____

16. Languages Spoken by Staff (other than English): _____

17. Service Area(s): (List cities, counties, school districts, etc. Also specify zip codes served if only PART of a city is served.) _____

18. Transportation: ___ No fee ___ Fee (\$ ___) ___ Only for client
Bus route(s): _____

19. Funding Sources: Circle all that apply). : ___ United Way ___ Private Grants ___ Special Events
___ Membership Dues ___ Individual fees ___ Governmental (City ___, County ___,
Federal ___)

20. Will your agency be assisting with disaster response or services for disaster relief. Yes ___ No ___
Please be sure to add all disaster services your agency will provide in the description below.

21. BRIEF DESCRIPTION OF SERVICES PROVIDED AT THIS LOCATION: _____

RGAIK Use Only:

Date Received: _____

Information Verified by: _____

Data input into database on: _____

Data input into database by: _____

Data input verified by: _____ Date: _____