211 Service Provider

APPLICATION

Welcome Interested Providers

Thank you for your interest in having your agency included in the 211 database. The application includes two basic areas:

- Agency Information:
  - This includes general information about your organization. This does not include information about specific services you provide.
- Program Information:
  - Programs are the services your agency offers. Please complete one program section for each program you are submitting for the 211 database.

Send the completed application by email to 211sbco@communify.sb.org

Please do not hesitate to contact the 211 Santa Barbara County Team if you have any questions or need assistance with this process.

We look forward to receiving your application.

Thank you,
211 Santa Barbara County Team

Reminder:

Please remember to read our 211 Santa Barbara County's Inclusion/Exclusion Policy before completing this application. This policy follows is posted on our 211SBCO.org, Click 211 Providers Policy.

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APPLICATION

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Agency Information

I have read the 211 Inclusion/ Exclusion Policy Yes■ No☐

Our organization provides services that are appropriate for the 211 database. Yes■ No☐

We have been in operation for at least six months. Yes■ No☐

General Agency Information

☐New Agency ☐Updating Agency Information

☐The agency has/will close, please remove us from the database, effective.

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: Agency Type

Agency Contact Information

Agency Website:

Agency Email: (for general questions from the public)

Agency Physical Address: ☐ Updating the Administration Office

Physical Address:

City: State: 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 below)*

Agency Mailing Address:

City: State: State Zip:

Administration Office Hours:

Mon: Tues: Wed:

Thur: Fri: Sat:

Sun:

What holidays does your agency close for?

Agency General Information

Phone #: Fax #: TDD/TTY#:

Agency Primary Contact for 211: *This person will receive the 211 annual update requests to confirm and/or update your agency's information. They will be contacted if there are questions about your agency's information to ensure the accuracy of referrals.*

Name: Title:

Phone: Email:

Agency Senior Executive:

Name: Title:

Phone: Email:

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Program Information

(Please submit one Program Information page per program) Number of programs this agency offers:

Agency Name: **Program Name:**

Is this program commonly known by another name or abbreviation?

☐New Program ☐Updating Program Information ☐Programming is no longer Available

As of what date should we remove this program?

Program website: **Program Email Contact:**

Program Description/ Primary Services: (Maximum of 100 words): *e.g., provides parenting classes to parents struggling with misbehavior of their children at home or school.*

Intake Procedure: ☐Walk-In ☐Call for appointment ☐Apply online

☐Referral Required from: Other:

Documentation Required at Intake:
(i.e., ID, SS Card, Proof of Income, etc.)

Program eligibility requirements:

No restrictions or eligibility criteria. Other (e.g., Must be a person with a disability, Age 62+, Teen ages 10-18)

Residency requirement:

☐No residency required

☐Must be a citizen of United States of America

☐Must be a California Resident

☐Must be a Santa Barbara County Resident

☐Must be a resident of a region: Choose an item.

☐Must be a resident of a specific city: Must be a resident of a specific zip code: Choose an item.

Fees: (check all that apply):

☐No Fee

☐Fees vary based on

☐Sliding Scale Fee

☐Set Program fee.

☐Per

Accepted Insurances:

☐Accepts Medi-Cal

☐Accepts Medi-Care

☐Accepts most Insurance

☐Membership Fee:

Per

Program Hours:

Mon: Tue: Wed:

Thu: Fri: Sat:

Sun: Hrs. Vary:

Languages- Services Available in: ☐English ☐Spanish ☐Mixteco ☐ASL

☐Other:

☐Hours of Interpreter Services Available:

Phone Numbers

Main Program phone #: TDD/TTY Phone Number:

Other Phone Number: Purpose of other phone
(i.e., after hours (8 am-5 pm)

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Sites

(Please include all sites and use another page if needed) Number of Sites:

Agency Name: **Program Name:**

Site A (Program is offered at this location)

Site Name: *(e.g., Santa Maria Office, Health Center, at A High School)*

Physical Address:

City: State: State Zip:

Is this the office?

A confidential Location? ☐Yes ■No Wheelchair accessible? ☐Yes ☐No

Mailing Address: ☐Use same as above (if mailing address is different, add below)

City: State: State Zip:

Sites B (Program is offered at this location)

Site Name: *(e.g., Santa Maria Office, Lompoc Health Center)*

Physical Address:

City: State: State Zip:

Is this the office?

A confidential Location? ☐Yes ☐No Wheelchair accessible? ☐Yes ☐No

Mailing Address: ☐Use same as above *(if the mailing address is different, add below)*

City: State: State Zip:

Sites C (Program is offered at this location)

Site Name: (e.g., Santa Maria Office, Lompoc Health Center)

Physical Address:

City: State: State Zip:

Is this the office?

A confidential Location? ☐Yes ☐No Wheelchair accessible? ☐Yes ☐No

Mailing Address: ☐Use the same as above (if the mailing address is different, add below)

City: State: State Zip:

Submit Application / Update via email or U.S.P.S.

211 SANTA BARBARA COUNTY
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211SBCO@CommUnify.sb.org I 211SBCO.org