Program Information

Please return form to:

2-1-1 Idaho CareLine
Idaho Department of Health & Welfare
P.O. Box 83720
Boise, Idaho 83720-0026
Fax (208) 334-5531

Hours of Operation:
8am - 6pm MST
Monday - Friday

E-mail: careline@dhw.idaho.gov
Website: www.idahocareline.org

Idaho CareLine • IDHW

2-1-1™

Get Connected. Get Answers.

Dial 2-1-1 or 1-800-926-2588

IDAHO DEPARTMENT OF HEALTH & WELFARE

Please type or print clearly.

NAME: What is the name of your program?_____

Acronyms: "Other Names"/Former Names:_____

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

☐ No ☐ Yes If yes, what is the name and address of that organization.

Name:_____

Address:_____

ADDRESS & TELEPHONE NUMBER: What is the physical address and telephone number of your program?

Street:_____

City:_____ State:_____ ZIP:_____

Telephone:_____ Fax:_____

E-mail:_____ Website:_____

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

PROGRAM or SERVICE DESCRIPTION: Please be as specific as possible. Callers are referred to your organization based on this description. Use an additional sheet of paper if needed.

_____

_____

_____

_____

_____

_____

_____

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

Is your organization or employees licensed or certified by a regulatory agency? ☐ Yes ☐ No

If so, the regulatory agency is: _____

License is valid through: _____

Please check **ONE** answer that indicates your program's organizational status.

☐ Non-profit ☐ Government ☐ Non-Profit Religious ☐ Military ☐ Volunteer ☐ For Profit

What is your Programs's funding source? Please check **ALL** which apply.

☐ County ☐ Donations ☐ Block Grant ☐ State Funds ☐ Federal Funds
☐ Tobacco Funds ☐ Foundation Funds ☐ Other _____

HOURS/DAYS: What are the days and hours of your organization's operation?

Hours/Days:_____

ELIGIBILITY: Can anyone received services from your program? ☐ Yes ☐ No If No, please explain _____

_____

_____

FEES: What are your fees?

- ☐ Sliding scale fee Details:_____
- ☐ Straight fee for services Details:_____
- ☐ No fee
- ☐ Other Considerations_____

Do you accept insurance? ☐ Yes ☐ No If Yes, ☐ Private Insurance ☐ Medicaid ☐ Medicare

Do you have a waiting list for your services? ☐ Yes ☐ No If Yes, how long _____

INTAKE: What is (are) your intake procedure(s)?

☐ Telephone ☐ Walk-in ☐ By appointment ☐ Referral required (please specify) _____

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

- ☐ English only ☐ Spanish ☐ American Sign Language
- ☐ Other: (specify) _____

AREA SERVED: What geographic area(s) does your program serve? (A specific city, county, region, statewide, or nationwide)

Please explain _____

_____

Does your organization collect or track information (data) on families and children served? ☐ Yes ☐ No ☐ Not sure

Does your organization track statistical data to measure outcomes of provided services?

☐ Yes ☐ No ☐ Not sure. If yes, what do you measure? _____

_____

Does your organization: Please check **ALL** which apply.

- ☐ Provide or increase services and resources for at-risk children, youth and families.
- ☐ Increase self-sufficiency and family stability.
- ☐ Increase awareness of teen abstinence programs to prevent and reduce the incidence of teen pregnancy.
- ☐ Encourage the development of family supports and the maintenance of two parent families.

Would you like 2-1-1 Idaho CareLine brochures to give to your clients? ☐ Yes, How many?_____ ☐ No

NOTE: The 2-1-1 Idaho CareLine has a database inclusion/exclusion policy and has the right the refuse or remove an agency at its discretion. Submission of your program to be included in the Idaho CareLine database assumes your permission is also given for your program to be included in any directory (printed or on-line) the Idaho Department of Health and Welfare or its community partners develop, unless otherwise noted.

I acknowledge the above information to be correct and accurately represent services provided by our agency/employees.

Signed:_____ Dated: _____