

WEST CENTRAL FLORIDA AREA AGENCY ON AGING, INC.

5905 Breckenridge Parkway, Suite F

Tampa, FL 33610

www.AgingFlorida.com

Phone: (813) 740-3888 Fax: (813) 623-1342 In FL: (800) 336-2226

HUMAN SERVICES AGENCY REFERRAL PROFILE

ORGANIZATION:

Name of Organization: _____

Other Names (acronyms): _____

Name of Program: _____

Name of Service: _____

Service Inception Date: _____

Area Covered/Territory: _____

Date Organization was Established: _____

CONTACT:

Physical Address: _____

Mailing Address: _____

Contact Phone Number: *(For referrals)* _____

Fax Number: _____ TDD Number: _____

Director Name: _____ Number: _____

Other Contact Name: _____ Number: _____

E-mail Address: _____ Website: _____

Territory Covered: _____

BRANCHES: *(If you provide this limited information we may contact them further)*

Names: _____

Addresses: _____

Phone numbers: _____

Territory/Service areas Covered: _____

(Counties, etc...)

HOURS OF OPERATION:

Regular Office Hours: _____ a.m./p.m. to _____ a.m./p.m. Days: Mon Tues Wed Thurs Fri Sat Sun

ELIGIBILITY:

Who is eligible for services? This helps us make appropriate referrals to you. _____

SERVICE

DESCRIPTION: _____

HUMAN SERVICES AGENCY REFERRAL PROFILE

PROGRAM/SERVICE DETAILS:

Do you provide in-home services? _____ Yes _____ No
Is transportation provided (if applicable)? _____ Yes _____ No
Are you Insured: _____ Yes _____ No
Abuse Background Checks on Employees? _____ Yes _____ No
Level I Criminal History _____ Yes _____ No Level II Criminal History _____ Yes _____ No

Licensed as: _____

License Number: _____ License Expiration Date: _____

Please list areas of specialization/expertise, especially those that relate to older adults/caregivers: _____

Special Degrees/Certifications (if applicable): _____

INTAKE:

Intake Procedures: _____

FEES:

- No Fee:
- Sliding Fee Scale; please specify: _____
- Straight Fee; please specify: _____
- Discount for Seniors, please specify: _____
- If Insurance accepted, please specify: _____

LANGUAGES:

REQUIRED DOCUMENTATION: _____

PUBLIC TRANSPORTATION: _____

ACCESSIBILITY: _____

ORGANIZATIONAL STATUS:

- Federal
- Non-Profit Religious
- State
- County
- Non-Profit, Other
- For Profit
- Other

Additional Comments: _____

Statement of Certification: I attest to the fact that all information provided in this form is true, and accurately reflects the service delivery of this agency/organization.

Signature and Title

Date