



Please clearly fill out all items and sign on last page.  
 If not applicable, please mark N/A.  
 After completion, please return it to AAAPP Attn: Tracy Barrows  
 By mail: 9549 Koger Blvd, Suite 100, St. Petersburg, FL 33702  
 By fax: 727-234-4426  
 By email: adrc.helpline@aaapp.org  
 For questions, call Tracy Barrows at 727-570-9696 ext. 254

**YOUR CONTACT INFORMATION (Person completing this form.)**

Name:	Title:
Telephone:	Email:

**AGENCY INFORMATION**

Agency Legal Name:

Also known as:

Physical Address: Confidential? <input type="checkbox"/>	Mailing Address (if different): Confidential? <input type="checkbox"/>
Line 1:	Line1:
Line 2:	Line 2:
City, State, Zip:	City, State, Zip:

**PHONE & OTHER CONTACT INFORMATION**

Main Contact Name:	Title:	Phone:
Email:		
Director Name:	Title:	Phone:
Email:		
Fax:	Main/Toll Free Number:	
Website:	TDD/TTY:	

Agency Type (check one): For Profit Non-Profit United Way Member Faith-Based City  
County State Federal Other: \_\_\_\_\_  
 IRS Status: \_\_\_\_\_ Tax ID: \_\_\_\_\_ License #: \_\_\_\_\_ (Attach copy of license)

Funding Source: City County State Federal Fee for Service United Way  
Fund Raising Donations Private Other: \_\_\_\_\_

Has your organization been in business at least one year? Yes No Month/Year Incorporated:

Accessibility Features: Fully Accessible Limited Access Designated Parking  
Full Wheelchair Access Elevators No Access Close to public transportation?

Programs available at this location:

**AGENCY & SERVICES OVERVIEW**

Briefly describe services available at this location (attach additional sheets, if needed):

**AGING & DISABILITY RESOURCE CENTERS STATEWIDE INTEGRATED DATABASE APPLICATION**

Office Hours:
Eligibility:
Intake Procedures:
Fees:
Payment Options Available: <input type="checkbox"/> Private Pay <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____
Languages Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other: _____
<i>The information below is obtained solely to better match client needs with the appropriate service providers and will not affect your application to enlist in our database as a resource.</i>
Population served: <input type="checkbox"/> 18+ <input type="checkbox"/> Specific Ages _____ to _____ <input type="checkbox"/> Women Only <input type="checkbox"/> Men Only <input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> LGBTQ <input type="checkbox"/> Other _____
Do you offer discounted pricing or a sliding fee for seniors/disabled adults? <input type="checkbox"/> Yes <input type="checkbox"/> No   Explain:
Would you be willing to offer any pro bono services on a short term basis? <input type="checkbox"/> Yes <input type="checkbox"/> No   Explain:
Service Area (City & County):

**OTHER LOCATION(S) INFORMATION:**

DO NOT complete this section if you only have one location. Use additional sheets, if needed, for additional locations

<b>Physical Address:</b> Confidential? <input type="checkbox"/>	<b>Mailing Address:</b> Confidential? <input type="checkbox"/>
Line 1:	Line 1:
Line 2:	Line 2:
City, State, Zip:	City, State, Zip:
<b>Location Overview</b>	
Main Phone/Reception:	
Public Email:	
Website:	
Accessibility Features: <input type="checkbox"/> Fully Accessible <input type="checkbox"/> Limited Access <input type="checkbox"/> Designated Parking <input type="checkbox"/> Full Wheelchair Access <input type="checkbox"/> Elevators <input type="checkbox"/> No Access <input type="checkbox"/> Close to Public Transportation?	
Office Hours:	
Eligibility:	
Intake Procedures:	

AGING & DISABILITY RESOURCE CENTERS STATEWIDE INTEGRATED DATABASE APPLICATION

Fees:
Payment Options Available: <input type="checkbox"/> Private Pay <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____
Programs available at this location:
Service Area (City & County):
Services available at this location:

Any additional details or information about your agency?
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ACKNOWLEDGMENT

I, \_\_\_\_\_ attest that the information provided on behalf of our agency/organization is true and accurate. I also understand and agree that misrepresentation or omission of pertinent information regarding the agency and/or services provided will result in the deletion of the agency or organization from the database without notice. Furthermore, it is acknowledged and understood that participation in the statewide database does not constitute an endorsement of the agency by the Department of Elder Affairs or by the Aging & Disability Resource Centers in Florida.

Signature: \_\_\_\_\_  
Title: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*This form must be signed before information can be entered in Refer Database\*\*\***