



## 2-1-1 Northeast Michigan 22 County Call Center

Community Resource Database New Organization Survey

INSTRUCTIONS: If your organization has  
multi locations, please duplicate and complete

one page for each.

ORGANIZATION'S LEGAL NAME: \_\_\_\_\_

Other Names, AKA's (acronyms): \_\_\_\_\_

Former Names: \_\_\_\_\_

SITE NAME (if applicable): \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

ORGANIZATION LOCATION (Nearest cross streets, identifiable landmarks, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

### CONTACT INFORMATION

Main #: ( ) \_\_\_\_\_ Client Contact # (if different): ( ) \_\_\_\_\_

FAX: ( ) \_\_\_\_\_ TTY/TDD: ( ) \_\_\_\_\_

Other #: ( ) \_\_\_\_\_ Please specify type: \_\_\_\_\_

URL/Website Address: \_\_\_\_\_

General E-Mail: \_\_\_\_\_

### ORGANIZATION TYPE

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Non-Profit 501c3 | <input type="checkbox"/> Private, Non-Profit –Religious | <input type="checkbox"/> For-Profit      |
| <input type="checkbox"/> Support Group    | <input type="checkbox"/> Coalition/Other Group          | <input type="checkbox"/> Public –City    |
| <input type="checkbox"/> Public –County   | <input type="checkbox"/> Public –State                  | <input type="checkbox"/> Public –Federal |

### AGENCY DIRECTOR/ADMINISTRATOR

Name: \_\_\_\_\_ Title: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

### RESOURCE CONTACT PERSON (if not the director)

Name: \_\_\_\_\_ Title: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

AREA SERVED: \_\_\_\_\_

### ADMINISTRATIVE/OFFICE HOURS:

M \_\_\_\_\_ TU \_\_\_\_\_ W \_\_\_\_\_ TH \_\_\_\_\_ F \_\_\_\_\_ SAT \_\_\_\_\_ SUN \_\_\_\_\_

### ACCESSIBILITY (check all that apply)

- |   |   |                                    |   |
|---|---|------------------------------------|---|
| <input type="checkbox"/> Full Wheelchair Access | <input type="checkbox"/> Limited Access       | <input type="checkbox"/> No Access | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Designated Parking     | <input type="checkbox"/> Ramps                | <input type="checkbox"/> Elevators | <input type="checkbox"/> No Stairs      |
| <input type="checkbox"/> Automated Doors        | <input type="checkbox"/> Accessible Restrooms |                                    |   |

ORGANIZATION DESCRIPTION/MISSION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YEAR OF INCORPORATION: \_\_\_\_\_

FEDERAL IDENTIFICATION NUMBER (EIN): \_\_\_\_\_

### Survey completed by:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Business Telephone Carrier \_\_\_\_\_ Home Carrier \_\_\_\_\_

**PROGRAM SURVEY FORM**

Organization Name: \_\_\_\_\_

**INSTRUCTIONS: Complete one program survey form for each service or program that your organization provides.** Please duplicate this form as needed.

PROGRAM/SERVICE NAME: \_\_\_\_\_

PROGRAM/SERVICE DESCRIPTION: \_\_\_\_\_

**PROGRAM LOCATION:**

Please check and list the site name(s) and/or address at which this program is offered.

Site 1: Main/Administrative Office: \_\_\_\_\_

Site 2: \_\_\_\_\_

Site 3: \_\_\_\_\_

Site 4: \_\_\_\_\_

**PROGRAM CONTACT INFORMATION**

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Program Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

TDD/TYY: ( ) \_\_\_\_\_ Other: \_\_\_\_\_

**PROGRAM/SERVICE DAYS AND HOURS:**

M \_\_\_\_\_ TU \_\_\_\_\_ W \_\_\_\_\_ TH \_\_\_\_\_ F \_\_\_\_\_ SAT \_\_\_\_\_ SUN \_\_\_\_\_

Check here if this service is not available year round on a consistent basis\*. Please Explain: \_\_\_\_\_

**APPLICATION/INTAKE PROCESS**

Walk-in \_\_\_\_\_ Call \_\_\_\_\_ Appointment required \_\_\_\_\_ Referrals from: \_\_\_\_\_

Other, please describe: \_\_\_\_\_

DOCUMENTATION REQUESTED (Picture ID, proof of income, etc.): \_\_\_\_\_

FEES AND PAYMENT METHODS: \_\_\_\_\_

ELIGIBILITY REQUIREMENTS/TARGET POPULATION (Income, age, gender, etc.): \_\_\_\_\_

LANGUAGES/TRANSLATION SERVICES: (other than English): \_\_\_\_\_

**Survey completed by:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

THANK YOU, FOR PROVIDING YOUR ORGANIZATIONAL AND SERVICE INFORMATION.  
PLEASE RETURN ALL FORMS TO:

**Mary A. Leininger---leininger@nemichigan.org**  
**2-1-1 Northeast Michigan**  
**4520 East Ashman, Suite U**  
**Midland, MI 48642**  
**PH: (989) 636-0608 FAX: (989) 636-2103**