LifeStream
Life. On your terms.
A member of the INconnect Alliance.

Agency Survey – Resource Update

Return to I & A Department

Legal Agency Name: _____

Program Name: _____

Other Names (AKA, acronyms, former, etc): _____

Would you like informational brochures about LifeStream Services? ☐ Yes ☐ No

Please indicate specific programs of interest:

☐ Aging & Disability Resource Center ☐Transportation ☐ Nutrition and Wellness

☐ Community Services/Events ☐ E-Newsletter ☐ Other: Click here to enter text.

1. Location: (Please photocopy and complete a separate form for each additional program)

Address: _____ City: _____ State: _____ Zip: _____

Is the physical address confidential? ☐ Yes ☐ No

Is the mailing address different from the physical address? If yes, please indicate mailing address below:

Address: _____ City: _____ State: _____ Zip: _____

2. Agency Contact Information:

Telephone Number: _____ Fax Number: _____

Director Name/Title: _____ Phone: _____ Email: _____)_____

Other Contact Name/Title: _____ Phone: _____ Email: _____

TDD (Telecommunication Device for the Deaf) Number: Click here to enter text.

Organization Email Address: _____ Website: _____

3. Please check one answer that indicates your agency's organizational status.

☐ Federal ☐ State ☐ City ☐ County ☐ Non-profit religious ☐ Non-profit/Other ☐ For-Profit

4. Hours of operation:

Regular office hours: ____ am/pm to ____am/pm Days: ☐ Mon ☐Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
Please list special services that have limited hours/days or special intake hours if applicable:

_____

5. Service Description: Please describe the primary services offered to anyone meeting your eligibility requirments, including any disaster relief services. *Please be detailed in your description; attach additional pages or any pamphlets or flyers.*

_____

_____

_____

_____

***Continue on back**

6. Eligibility: Who is eligible for your services? Please include eligibility criteria and exclusion criteria.

Eligibility criteria: _____

_____

Exclusions: _____

_____

7. Fees for your services:

☐ No Fee ☐ Straight Fee; specify: _____ ☐ Sliding Fee Scale (specify range): _____

Payment types accepted: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Scholarships Available

8. Intake: What are your intake procedures?

☐Walk-in ☐Telephone ☐Appointment Only ☐ Web based referrals

Referral required? By whom: _____

Required Documentation:

☐ None Required ☐Picture ID/License ☐ Social Security Card ☐ Birth Certificate ☐ Proof of Residence

☐ Proof of Income ☐ Eviction Notice ☐ Proof of expenses ☐ Utility Cut-Off Notice

☐ Other (specify): _____

9. Languages: What languages are routinely spoken by your staff?

☐ English only ☐ English only/Translation Services Available ☐ Spanish ☐ American Sign Language

☐ Other: _____

10. Service Area: Check the area(s) you serve.

☐ Blackford ☐ Delaware ☐ Fayette ☐ Franklin ☐ Grant ☐ Henry

☐ Jay ☐Madison ☐Randolph ☐ Rush ☐ Union ☐ Wayne

If you restrict to certain cities or zip codes, please indicate them here:

Cities: _____

Zip Codes: _____

11. Directory: If your organization meets criteria to be included in our written products or publications, do you wish to be considered for inclusion? ☐ Yes ☐ No

12. Other: Please indicate any info you feel to be appropriate:

_____

_____

To the best of my knowledge all of the preceding information is true and accurate.

Signature: _____ Title: _____ Date: _____

☐ I am the contact person for future updates. ☐ For future updates, please contact: _____

Please mail completed form to LifeStream Services at 1701 Pilgrim Blvd. Yorktown, IN 47396 or fax to 765-759-0060.