Area Agency on Aging
FOR SOUTHWEST FLORIDA
Your Aging and Disability Resource Center

Please clearly fill out all items and sign on last page. If not applicable, please mark N/A.

After completion, please send by mail to: Area Agency on Aging for SWFL

15201 N. Cleveland Ave., Suite 1100 North Ft. Myers, FL 33903_

By fax to: 239-652-6916 By email to: Information@aaaswfl.org

For questions, call Carmen Torres, Director of Client Services, 239-652-6900 ext.58235

YOUR CONTACT INFORMATION (Person completing this form.)	
Name:	Title:
Telephone:	Email:

AGENCY INFORMATION	
Agency Legal Name:	
Also known as:	
Physical Address: Confidential? ☐	Mailing Address (if different): Confidential? ☐
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):
Office Hours:
Eligibility:
Intake Procedures:
Fees:
Payment Options Available: ☐Private Pay ☐Private Insurance ☐Medicare ☐Medicaid ☐Other: _____
Languages Spoken: ☐English ☐Spanish ☐Creole ☐Other: _____
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. Population served: ☐18+ ☐Specific Ages_____to_____ ☐Women Only ☐Men Only ☐Alzheimer's/Dementia ☐LGBTQ ☐Other _____
Do you offer discounted pricing or a sliding fee for seniors/disabled adults? ☐Yes ☐No Explain:
Would you be willing to offer any pro bono services on a short term basis? ☐Yes ☐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

Physical Address: Confidential? ☐	**Mailing Address:** Confidential? ☐
Line 1:	Line 1:
Line 2:	Line 2:
City, State, Zip:	City, State, Zip:
Location Overview	
Main Phone/Reception:	
Public Email:	
Website:	

Accessibility Features: ☐Fully Accessible ☐Limited Access ☐Designated Parking ☐Full Wheelchair Access ☐Elevators ☐No Access ☐Close to Public Transportation?
Office Hours:
Eligibility:
Intake Procedures:
Fees:
Payment Options Available: ☐Private Pay ☐Private Insurance ☐Medicare ☐Medicaid ☐Other: _____
Programs available at this location:
Service Area (City & County):
Services available at this location:

Any additional details or information about your agency?

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*****