

**Office on Aging and Aging and Disability Resource Connection of Orange County  
Information and Assistance  
APPLICATION FOR INCLUSION IN RESOURCE DATABASE**

Application is: New ☐ Update ☐

Complete all sections as applicable. Return your completed application to: Office on Aging Information and Assistance 1300 S. Grand Ave., Bldg. B, Santa Ana, CA 92705 or email to [AreaAgencyonAging@occr.ocgov.com](mailto:AreaAgencyonAging@occr.ocgov.com) or fax to 714 -567-5021.

Would you like us to share your information with other agencies providing similar information and assistance, such as 211, Alzheimer's Association Orange County, Council on Aging Orange County, Dayle McIntosh Center? Yes ☐ No ☐

Agency Information			
<b>Organization or Program Name:</b>			
<b>Legal Status (Non-Profit, For-Profit, Public, Religious)</b>			
<b>Parent Company of Larger Agency Affiliation</b>			
<b>Street Address</b>			
<b>Is the street address confidential? Yes <input type="checkbox"/> No <input type="checkbox"/></b>			
<b>Mailing Address (if different)</b>			
<b>Phone No.</b>		<b>Fax No.</b>	
<b>Website</b>		<b>Email</b>	

Service/Program Description	
<b>In Home Services? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, you must complete the Supplemental Questions Section on page 2</b>	
<b>Detailed Description (if operating more than one program, and all information for each is the same, list all program names below. However, if operating multiple programs with varying descriptions, submit a separate application for each program):</b>	
<b>Days and Hours of Operation</b>	
<b>Service Hours</b>	
<b>Geographic Area(s) Served</b>	
<b>Fees</b>	
<b>Method of Payment</b>	
<b>Accept SSI</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Languages other than English</b>	
<b>Transportation Provided</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe:
<b>Is your office location wheelchair accessible?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Residential</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	<b>If yes, number of Beds:</b>
	<b>If yes, describe rates (e.g. Private/Semi Private):</b>

Application/Eligibility	
<b>Application Process</b> (Include documents required, such as driver license, social security card, proof of resident status, etc.)	
<b>Eligibility Requirements/ Exclusions</b>	

Supplemental Questions Complete only if your agency provides in-home care services	
1. The staff that you send into clients' homes are	<input type="checkbox"/> Employees of your company <input type="checkbox"/> Independent contractors
2. What are your minimum/maximum hours of service?	
3. Are your employees/volunteers covered by liability insurance?	<input type="checkbox"/> Yes, please attach a copy of your current policy <input type="checkbox"/> No
4. Are your employees/volunteers covered by your Workman's Compensation Insurance Policy?	<input type="checkbox"/> Yes, please attach a copy of your current policy <input type="checkbox"/> No
5. Do you perform criminal background checks on all employees/volunteers?  If yes, provide the following information on the agency that conducts your background checks. Name: Address: Phone Number:	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you preform reference checks on all of your employees/volunteers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you licensed with the California Home Care Services Bureau Licensing Agency?	<input type="checkbox"/> Yes, please provide your licensing date _____ <input type="checkbox"/> No, please provide your licensing status: _____
Please submit the following required documents:	
1. Current business license.	
2. If you answered yes to question 3 above, please provide a copy of your Liability Insurance Policy.	
3. If you answered yes to question 4 above, please provide a copy of your Workman's Compensation Insurance Policy.	
4. If you answered yes to question 7 above, please provide a copy of your State of California Home Care Services Bureau License.	
5. If you employ caregivers, please include a rate sheet. If you do not have a printed rate sheet, please use the space below to describe your rate information (i.e. hourly/live in rates, etc.)	

<b>Submitted By</b>	
<b>Name</b>	
<b>Telephone Number</b>	
<b>Email</b>	

<b>Agency Use Only</b>	Date verified: Date Input: Date Sent to Other Agencies if Applicable:	By: By: By:
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