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 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			
Organization or Program Name:			
Legal Status (Non-Profit, For-Profit, Public, Religious)			
Parent Company of Larger Agency Affiliation			
Street Address Is the street address confidential? Yes ☐ No ☐			
Mailing Address (if different)			
Phone No.		**Fax No.**	
Website		**Email**	

Service/Program Description **In Home Services? Yes ☐ No ☐ If yes, you must complete the Supplemental Questions Section on page 2**	
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):	
Days and Hours of Operation	
Service Hours	
Geographic Area(s) Served	
Fees	
Method of Payment	
Accept SSI	**Yes ☐ No ☐**
Languages other than English	
Transportation Provided	**Yes ☐ No ☐ If yes, describe:**
Is your office location wheelchair accessible?	**Yes ☐ No ☐**
Residential	**Yes ☐ No ☐**
	If yes, number of Beds:
	If yes, describe rates (e.g. Private/Semi Private):

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

Supplemental Questions Complete only if your agency provides in-home care services	
1. The staff that you send into clients' homes are	☐ **Employees of your company** ☐ **Independent contractors**
2. What are your minimum/maximum hours of service?	
3. Are your employees/volunteers covered by liability insurance?	☐ **Yes, please attach a copy of your current policy** ☐ **No**
4. Are your employees/volunteers covered by your Workman's Compensation Insurance Policy?	☐ **Yes, please attach a copy of your current policy** ☐ **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:**	☐ **Yes** ☐ **No**
6. Do you preform reference checks on all of your employees/volunteers?	☐ **Yes** ☐ **No**
7. Are you licensed with the California Home Care Services Bureau Licensing Agency?	☐ **Yes, please provide your licensing date**_____ ☐ **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.)	

Submitted By	
Name	
Telephone Number	
Email	

Agency Use Only	Date verified: Date Input: Date Sent to Other Agencies if Applicable:	By: By: By: