



INFORMATION ROCKLAND AGENCY PROFILE

Completion of this form is necessary to be considered for inclusion in Information Rockland's Health and Human Services database

Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing (PO Box) Address: _____

Agency Director Name/Title: _____ Phone: (Non-public?) _____

PUBLIC Phone Numbers: *Phone Types can include: Administrative, Help Line, Information only, Message/answering service, TDD/TTY, Toll-Free*

	Type	Main Number
	Type	FAX
	Type	24 Hr Emergency

	Type	Toll-Free
	Type	Other
	Type	Other

Other Agency Names: (AKA, Acronyms, former) _____

Agency Access

Public Transportation Accessible? Yes No Agency Days/Hours: _____

Languages spoken other than English: Creole Spanish Yiddish Sign Other(s) _____

Website: _____ Email: _____

Agency Description

Agency Overview *(Use descriptive keywords and phrases.)* _____

Agency Type (one): Community County Municipal State Federal Education Recreation/Historic Other _____

License(s)/Accreditation(s): _____

Contact Person for Agency Information Updates

Name (Please Print): _____ Date: _____

Signature: _____ Title: _____

Phone: _____ Email: _____

Make a copy for your files. Return this form to:

INFORMATION ROCKLAND

County of Rockland Department of Social Services ■ Building C, Sanatorium Road ■ Pomona, NY 10970

Email: InfoRock@co.rockland.ny.us ■ Telephone: (845) 364-2020 ■ Fax: (845) 364-2026 Website: www.informationrockland.com



INFORMATION ROCKLAND 364-2020 PROGRAM PROFILE

DUPLICATE this page as necessary.

Use **ONE** page for **EACH PROGRAM** you offer. Please **number** all sheets and staple together.

Program Name: _____ Agency: _____

Director Name/Title: _____ Phone: (Non public?) _____

If this program is available at **MORE THAN ONE SITE**, please provide the information in the shaded box below for **EACH LOCATION** where the program is offered. **Attach additional sheets as necessary.**

Program Location

Street Address: (Non-public?) _____

City: _____ State: _____ Zip: _____

Phone 1 _____ Type _____ Phone 2 _____ Type _____

Public Transportation Accessible? Yes No Days/Hours: _____

Languages spoken other than English: Creole Spanish Yiddish Sign Other(s) _____

Program Description

Overview: (Use descriptive phrases. Avoid superlatives like "best" or "unique.") _____

LIST Specific Services in Program: _____

Program Eligibility

Ages Served: All Infant Child Adolescent Adult Senior Specify: _____

Gender Served: F M \$\$ Income Requirement: _____

Population Served: (e.g. homeless, mentally ill) _____

Is this program for the entire Rockland County area? Yes No If no, indicate the specific geographic area served: _____

Other Eligibility Criteria: _____

Application Process and Fees

Procedure: all that apply

Appointment required Telephone Walk-in Referral required (from whom?): _____

Documents Required: all that apply Birth Certificate Photo ID Proof of Income Proof of Residence None

Other: (Please specify.) _____

Fees: all that apply Fee No fee Sliding fee scale Specify: _____ Wait List? (How long) _____

Payment: all that apply Cash Credit Card Medicaid Medicare Personal Check Private Insurance Voucher