

Agency Legal Name \_\_\_\_\_

Agency Acronyms or AKA's \_\_\_\_\_

### Physical Address

Check here if physical address is CONFIDENTIAL

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

County \_\_\_\_\_ ZIP Code \_\_\_\_\_

### Mailing Address (if different)

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

County \_\_\_\_\_ ZIP Code \_\_\_\_\_

### Phone Numbers

Number \_\_\_\_\_ Contact Person/Title \_\_\_\_\_

Toll Free \_\_\_\_\_ Fax \_\_\_\_\_

### Organization's Info

Agency E-Mail \_\_\_\_\_ Agency Website \_\_\_\_\_

Hours/Days of Operation \_\_\_\_\_

Area Served (Counties) \_\_\_\_\_

Organizational Status (Check all that apply)

- |   |  |                                  |                                 |
|---|--|----------------------------------|---------------------------------|
| <input type="checkbox"/> Non Profit -Church Affiliated      | <input type="checkbox"/> For Profit            | <input type="checkbox"/> Federal | <input type="checkbox"/> County |
| <input type="checkbox"/> Non Profit -Church Dependent       | <input type="checkbox"/> Coalition/Other Group | <input type="checkbox"/> State   | <input type="checkbox"/> City   |
| <input type="checkbox"/> Non Profit -Other (please specify) | <input type="checkbox"/> Proprietary           |                                  |                                 |

Affiliation (Is agency affiliated with a larger organization?)  No  Yes

If yes, name of organization \_\_\_\_\_

### Facility License Information

License (specify) \_\_\_\_\_

Unlicensed (specify) \_\_\_\_\_

Certificates/ Accreditations (specify) \_\_\_\_\_

Funding (Check all that apply)

- |                                  |                                     |                                     |   |  |
|----------------------------------|-------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Federal | <input type="checkbox"/> City       | <input type="checkbox"/> Donations  | <input type="checkbox"/> Independent Fund Raising | <input type="checkbox"/> Dept of Human Services      |
| <input type="checkbox"/> State   | <input type="checkbox"/> HUD        | <input type="checkbox"/> Fees       | <input type="checkbox"/> Corporation/Business     | <input type="checkbox"/> Non Profit, Other (specify) |
| <input type="checkbox"/> County  | <input type="checkbox"/> United Way | <input type="checkbox"/> Foundation | <input type="checkbox"/> Church/Religious         | _____  |

Fees: Please indicate the fee structure for each program/service. (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> No Fee                                 | <input type="checkbox"/> Sliding Scale based on _____ |
| <input type="checkbox"/> Donations Accepted                     | _____   |
| <input type="checkbox"/> Fee for Service (same for each client) | <input type="checkbox"/> Varying Fees (explain) _____ |
|   | _____   |

**Transportation** (Check all that apply)

- No Transportation Provided
- Public Transportation Available (on bus line, bus pass, etc.)
- Agency Provides Transportation
- Agency will arrange for Transportation

**Handicapped Accessibility** (What accommodations does your facility provide to people with disabilities?)

- Not applicable
- Access without Special Facilities
- Limited Access
- Hearing Impaired/Deaf
- No access
- Full Wheelchair Access
- Vision Impaired/Blind

**Special Language Services**  Spanish  Other (specify) \_\_\_\_\_

**Available Services** (Check all that apply ... specifics can be detailed in the program description section)

- Children (12 & under)
- Adolescent (13-18)
- Adults (over 18)
- Male Only
- Female Only
- Co-Ed
- Intervention
- Assessment
- Prevention
- Outreach
- Aftercare
- Relapse Prevention
- Intensive Outpatient
- Outpatient
- Individual/Group Counseling
- Medical Detox
- Social Setting Detox
- Support Groups
- Residential
- Long Term Residential
- Halfway House
- DUI School
- Drug Testing
- ADAT
- Emergency Relief/Shelter
- Co-Occurring Disorders
- Mental Health
- Women with Children

**Insurance** (Do you accept/require private insurance or equivalent third party payors?)

- No Insurance
- Self Pay Only
- TennCare
- Medicare
- Cigna
- Aetna
- Not applicable
- Insurance Accepted (please indicate what plans are accepted and specific plans excluded if any):

**Eligibility:** Are your services limited to clients by criteria such as ethnic origin, disability, economic or marital status, age, military, etc.? Please specify: \_\_\_\_\_

**Agency Description:** Please attach a general agency description and/or administrative overview

**Program Description(s):** Please attach a description of each program/service your agency provides. Include any admissions procedures, policies, criteria, hours, etc., not covered previously. Also include number of beds if applicable. Please also include a copy of your agency's brochure or other literature. **Callers are referred to your agency based on this description so please be as thorough as possible.**

**Satellites:** If your agency has satellite locations that offer some or all of your programs and/or services, please attach a list of these locations, including program name, address, site contact person, phone number, and hours/days of operation.

**Thank you very much for your time and effort. If you have any questions or comments, please give us a call. Please return this survey by mail, fax or e-mail to:**

TAADAS  
 1800 Church St., Ste. 100  
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 1-800-889-9789 ♦ 615-780-5901 ♦ (Fax) 615-780-5905