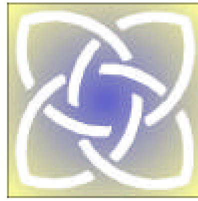

The Coordinating Council of Broward (CCB)
Organizational Profile for
PROVIDERS
of Health, Public Safety, Education, Economic and Human Services in Broward County

IMPORTANT -- PLEASE NOTE!

1. THIS PACKAGE INCLUDES BLANK FORMS TO BE FILLED OUT WITH INFORMATION ABOUT YOUR ORGANIZATION AND THE SERVICES YOU PROVIDE. IT INCLUDES A SET OF DETAILED DIRECTIONS INTENDED TO HELP YOU ACCURATELY PROVIDE THE REQUESTED INFORMATION. PLEASE TYPE OR LEGIBLY PRINT YOUR RESPONSES.
2. IF YOUR ORGANIZATION FILLED OUT THE PROFILE LAST YEAR, OR WAS PREVIOUSLY INCLUDED IN THE FIRST CALL FOR HELP INFORMATION AND REFERRAL DATABASE, YOU ALSO WILL FIND ATTACHED A PRINT-OUT OF THE INFORMATION CURRENTLY IN THE DATABASE. YOU MAY MAKE EDITS DIRECTLY ON THAT FORM, BUT BE SURE TO FILL IN ANY MISSING INFORMATION ON EXISTING PROGRAMS AND SERVICES. THIS WILL SAVE BOTH YOU AND FIRST CALL FOR HELP VALUABLE STAFF TIME. MAKE COPIES OF THE SECTIONS OF THIS FORM, AS NEEDED, TO INCLUDE ADDITIONAL SERVICE DELIVERY LOCATIONS, PROGRAMS OR SERVICES. BE SURE TO CROSS OUT ANY PROGRAMS OR SERVICES THAT HAVE BEEN DISCONTINUED.
3. TRAINING WILL BE PROVIDED IN DECEMBER, 2000 (SEE ATTACHED SCHEDULE). TRAINING IS DESIGNED FOR THE PERSON(S) WHO WILL BE FILLING OUT THE FORMS. A CD-ROM WITH RESULTS OF THE 2000 COMMUNITY RESOURCE INVENTORY AND DISKETTES WITH ELECTRONIC FORMS VERSIONS OF THE PROFILE WILL BE DEMONSTRATED AT THE TRAINING SESSIONS AND DISTRIBUTED IN JANUARY, 2001. THE SAME ELECTRONIC FORMS, AS WELL AS PRINTABLE FILES, ARE AVAILABLE ON-LINE AT HTTP://WWW.SFRPC.COM/CCB/CRI2001.HTM OR BY CALLING FIRST CALL FOR HELP.
4. PLEASE RETURN THE COMPLETED PROFILE TO THE ADDRESS BELOW BY NO LATER THAN JANUARY 22, 2001.

INFORMATION AND MARKETING MANAGER
FIRST CALL FOR HELP OF BROWARD, INC.
16 SE 13TH STREET
FORT LAUDERDALE, FLORIDA 33316
(954) 524-8371

Name of Organization ______________________________

Enclosed is my agency's completed organizational profile. I have reviewed all the information, and it is complete and accurate to the best of my knowledge. I understand that First Call For Help of Broward, Inc. and The CCB reserve the right to edit submitted material for clarity and to use the information for community information and/or referral purposes. I agree to accept faxed information from either agency.

Authorized Signature: ______________________________ **Date:** ____________

This box for FCFH internal use

Part I	Part II	Part III	Part IV	Part V	Tax/Key	QC

November 2000 (1.0)

Part I. Organization Identification

Thanks in advance for helping to improve the quality of life in Broward County!

The community assessment methodology adopted by The Coordinating Council of Broward (CCB) in mid-1997 identifies the need for a countywide resource inventory as an integral part of the community assessment process. It provides information to complement quality-of-life indicators and goals in the identification of critical issues and priorities for action by the CCB, the network of service funders and providers, and the community. **The assessment of how resources currently are allocated to health, public safety, education, economic and human services in Broward County is essential to the development of strategies to address priority needs identified by the periodic review of progress toward the County's goals.**

The creation of a consistent, comprehensive source for information about which services are provided, by whom, when and where in Broward County, subject to what eligibility criteria, ensures that funders and providers alike will be able to target scarce resources at high-priority needs. In addition, **by gathering this data through a single, coordinated survey, together with First Call For Help, and making the information available to meet the needs of a broad user base, there will be a substantial reduction in duplication of effort by providers and funders in filling out forms with this information.**

1. Name ______________________ Code FCHB# __________
2. Alternate Name (aka) ______________________
3. Main Administrative Address ______________________
   City ______________ State __________ ZIP __________
4. Phone ( ) __________ Fax ( ) __________ Days/Hours __________
5. E-Mail ______________ Web Site ______________
6. CEO/Executive Director ______________ Phone/Ext ( ) __________
7. Chief Financial Officer ______________ Phone/Ext ( ) __________
8. Profile Contact Person ______________ Phone/Ext ( ) __________
9. Agency Type (mark only one). Other ☐ ______________
   - ☐ Private, Non-Profit ☐ Unit of Federal Government ☐ Unit of State Government
   - ☐ Private, For Profit ☐ Unit of County Government ☐ Unit of City Government
   - ☐ Membership ☐ Joint Government / Non-Profit ☐ Faith-based Organization
10. Description of the Agency (limit 50 words) ______________________
11. Federal Identification Number ______________________
12. Accreditation by ______________________
    Level/Period ______________________
13. Broward County Certification Date ______________________

Part II. Service Delivery Locations (*Use as many sheets as needed.*)

Date ________________ **Page** ____ **of** ____

Organization Name ____ **Code** FCHB#__________

14. Location Code _______ **Location Name** ____
15. Address ____
City ____ ZIP _______________
16. Phone ( ) _________________ Fax ( ) ________________ TDD ( ) _________________
17. ADA compliance: Physical: ☐ Yes ☐ No Visual: ☐ Yes ☐ No Auditory: ☐ Yes ☐ No

14. Location Code _______ **Location Name** ____
15. Address ____
City ____ ZIP _______________
16. Phone ( ) _________________ Fax ( ) ________________ TDD ( ) _________________
17. ADA compliance: Physical: ☐ Yes ☐ No Visual: ☐ Yes ☐ No Auditory: ☐ Yes ☐ No

14. Location Code _______ **Location Name** ____
15. Address ____
City ____ ZIP _______________
16. Phone ( ) _________________ Fax ( ) ________________ TDD ( ) _________________
17. ADA compliance: Physical: ☐ Yes ☐ No Visual: ☐ Yes ☐ No Auditory: ☐ Yes ☐ No

14. Location Code _______ **Location Name** ____
15. Address ____
City ____ ZIP _______________
16. Phone ( ) _________________ Fax ( ) ________________ TDD ( ) _________________
17. ADA compliance: Physical: ☐ Yes ☐ No Visual: ☐ Yes ☐ No Auditory: ☐ Yes ☐ No

14. Location Code _______ **Location Name** ____
15. Address ____
City ____ ZIP _______________
16. Phone ( ) _________________ Fax ( ) ________________ TDD ( ) _________________
17. ADA compliance: Physical: ☐ Yes ☐ No Visual: ☐ Yes ☐ No Auditory: ☐ Yes ☐ No

14. Location Code _______ **Location Name** ____
15. Address ____
City ____ ZIP _______________
16. Phone ( ) _________________ Fax ( ) ________________ TDD ( ) _________________
17. ADA compliance: Physical: ☐ Yes ☐ No Visual: ☐ Yes ☐ No Auditory: ☐ Yes ☐ No

Part III. Program Information (*Use a separate Part III form for each program.*)

Date __________________ **Organization Code** FCHB#_______________ **Page** ____ **of** ____

18. Program Name ____ **Code** FCHB#____________

19. Program Description (limit 50 words) ____

____

____

____

____

20. Program Manager ____ Phone/Ext (   ) _______________

21. Funding sources, reference period(s) and amounts for this program.

Source of Funds (see attached Funding Source Code List)	Code	Contract Number	Reference Period	Amount ($)
Total				

22. Identify up to four indicators from the 2000 edition of *The Broward Benchmarks* that this program most impacts. **Please select only specific indicators identified with 3-digit numbers** (i.e. 1.3.2). If you need a copy of the report, please contact the CCB or visit www.sfrpc.com/ccb/tbb00.htm.

1. ____ 3. ____

2. ____ 4. ____

Part III. Program Information (*Use a separate Part III form for each program.*)

Date ________________ **Organization Code** FCHB#________________ **Page** ____ **of** ____

Program Name ____**Code** FCHB#____________

23. Identify the target population(s) for **this program** please mark (x) all that apply. Also, please note that age, sex, income, residential location, and other client characteristics will be identified as part of the eligibility question (Question #33). If you feel that the groups listed below do not properly identify an important target population for this program, please fill in one of the blanks and mark the corresponding box.

1. Persons in Need of Emergency Assistance

☐ Food ☐ Clothing ☐ Shelter ☐ Medical
☐ Transportation ☐ Financial ☐ ________________

2. Persons with Health Conditions

☐ AIDS / HIV ☐ Asthma ☐ Arthritis ☐ Alzheimer's Disease
☐ Brain Injuries ☐ Cancer ☐ Pre-natal Substance Exposed
☐ Diabetes ☐ Eating Disorders ☐ Heart Disease ☐ Dental
☐ Obesity ☐ Pregnancy / Birth ☐ STDs ☐ ____________________

3. Persons with Mental / Emotional Disturbances

☐ Attention Disorders ☐ Bipolar Disorder ☐ Conduct Disorders ☐ Personality Disorders
☐ Depression ☐ Schizophrenia ☐ Phobias ☐ Dual Diagnosis
☐ Suicidal Persons ☐ ________________

4. Persons with Disabilities

☐ Developmental ☐ Physical ☐ Visual ☐ Hearing
☐ Learning ☐ Communication ☐ ________________

5. Persons Needing Jobs / Learning Assistance

☐ Unemployed ☐ Dropouts ☐ Limited English ☐ Functionally Illiterate
☐ Job Training ☐ Academic Support ☐ ________________

6. Persons Receiving Family Support Services

☐ Adoption ☐ Foster Care ☐ Parenting ☐ Child Care
☐ __________________

7. Persons Involved in Abuse and Neglect

☐ Perpetrators ☐ Victims ☐ At-Risk ☐ ____________________

8. Substance Abusers

☐ Alcohol ☐ Drugs ☐ At-Risk ☐ ____________________

9. Persons Receiving Criminal Justice Services

☐ Adults ☐ Juveniles ☐ Ex-Offenders ☐ Diversion
☐ Sex Offenders ☐ Victims ☐ Gangs ☐ ____________________

10. Other Target Populations

☐ Orientation / Gender Identity ☐ Homeless ☐ Frail Elderly
☐ Refugees / Entrants / Asylees ☐ Bereaved ☐ ____________________

Part IV. Program Information by Location (*Use a separate Part IV form for each location*).

Date ________________ **Organization Code** FCHB# ________________ **Page** ____ **of** ____

Program Name ____ **Program Code** FCHB# __________

Location Name ____ **Location Code** ______

24. Program Manager ________________________________ Phone/Ext ( ) ____________

    E-mail ____ Fax ( ) ____________

25. Referrals Contact ________________________________ Phone/Ext ( ) ____________

26. Number of Full-Time Equivalent Program Staff: Paid __________ Volunteer __________

27. Do you provide transportation for clients to be able to obtain access to your services? ☐ Yes ☐ No

28. Do you provide childcare for clients to be able to obtain access to your services? ☐ Yes ☐ No

29. Please mark (x) which of the following languages (other than English) program staff speak.

    ☐ Spanish ☐ Haitian Creole ☐ American Sign Language

    ☐ ________________ ☐ ________________ ☐ ________________

30. What forms of payment do you accept? Please mark (x) all that apply. ☐ Medicare

    ☐ Insurance (HMO, POS, PPO, etc.) ☐ Medicaid ☐ Medicaid HMO

    ☐ Self-Pay/Full ☐ Self-Pay/Sliding Scale ☐ No Fee for Services

31. Fees (include range, criteria for sliding scale) ________________________________

    ____

32. Restrictions for acceptance of Medicaid or indigent ________________________________

33. Describe client eligibility for this program by answering each of the following six questions:

    (a) Sex: ☐ No restriction ☐ Male only ☐ Female only

    (b) Age: ☐ No restriction ☐ Restricted (specify exact ranges) ☐☐ years to ☐☐ years

    (c) Income: ☐ No restriction ♦ Below a given percentage of the federal poverty level - please mark (x) only one box: ☐ 100% ☐ 133% ☐ 150% ☐ 185% ☐ 200%

    ☐ Other income restriction (explain) ________________________________

    (d) Residence: ☐ No restriction ☐ Broward County ☐ A specific city ______________

    ☐ Other (specify) ____

    (e) Mark (x) below all restrictions that apply to client participation in this program. For all that apply, please use the space to give the specifics (agency, program, disability, diagnosis).

    ☐ Must be in the custody of a state/local agency ________________________

    ☐ Must be a participant in some other program ________________________

    ☐ Must be referred by another agency/program ________________________

    ☐ Must have a specific disability/diagnosis ________________________

    (f) Other eligibility requirements (specify) ________________________________

    ____

Part IV. Program Information by Location (*Use a separate Part IV form for each location*).

Date ________________ **Organization Code** FCHB#_______________ **Page** ____ **of** ____

Program Name ____ **Program Code** FCHB#__________

Location Name ____ **Location Code** ______

34. Intake procedure - Is an appointment required for intake? ☐ Yes ☐ No

    Document(s) required ____

    Other requirements: ____

    ____

35. Days and hours of program operation at this location. **Please check the box to the left of each day of the week during which program services are available, and use the box to the right to specify the normal hours of program operation.**

Days	Normal Hours of Business for this Program
☐ Monday	
☐ Tuesday	
☐ Wednesday	
☐ Thursday	
☐ Friday	
☐ Saturday	
☐ Sunday	

36. Where do you provide services for this program? Please mark (x) all that apply.

    ☐ At this location ☐ In the client's home ☐ At other locations (school, church, etc.)

37. How many clients does this **program** currently serve at this location in a year? __________________

    Are you required to accept all clients who are eligible for service? ☐ Yes ☐ No. If not, how many program clients could be served at this location at "full capacity" in a year? ____________

    Identify any specific capacity limit (i.e., # of beds, slots, cases). __________________________________

    Is there a waiting list? ☐ Always ☐ Occasionally ☐ Never ☐ Seasonal _______________

38. List the specific services provided by this program at this location and the number of clients that receive each. **Please see the detailed instructions on how to fill out this table. If you know the Taxonomy Service Code, fill it in. If not, leave the column blank.**

Service Name / Description	Taxonomy Service Code	P S	Clients Served

Part V. Community Assessment Activities

The CCB's Community Assessment Information Clearinghouse will create an information base to promote coordination and collaboration in the preparation of needs assessments for planning.

Date ____________ **Organization Code** FCHB#____________ **Page** ____ **of** ____

1. Does your organization conduct a formal needs assessment? ☐ Yes ☐ No
2. Do you use a needs assessment prepared by another organization? ☐ Yes ☐ No

   If yes, identify the organization. ____________
3. Have you collaborated with another agency to conduct a needs assessment? ☐ Yes ☐ No

   If yes, identify the organization and when. ____________

Stop!! If you do not conduct your own formal needs assessment, skip to Question 15.

4. How often do you conduct a needs assessment? ☐ Annually or more often

   ☐ Other (please specify) ____________
5. What is the date of the most recent needs assessment completed? ____________
6. Where can a copy of the most recent needs assessment be obtained? ____________

   ____________ Who is the contact? ____________
7. Is some or all of the most recent needs assessment available on-line? ☐ Yes ☐ No

   If yes, please provide the on-line address. ____________
8. Please answer the following questions about the most recent needs assessment you conducted.

   What was the purpose? ____________

   What was the target population and time period? ____________
9. Why do you conduct a needs assessment? Mark (x) all that apply. ☐ Required by law

   ☐ Required by one or more funding sources ☐ To develop an agency (strategic) plan

   ☐ Other (please specify) ____________
10. What methods do you utilize in conducting a needs assessment? Mark (x) all that apply.

    ☐ Issue scanning and visioning ☐ Asset mapping of community / neighborhood resources

    ☐ Secondary data compilation and analysis ☐ Key informant interviews

    ☐ Agency resource / service gap analysis ☐ Focus groups

    ☐ Program monitoring and evaluation ☐ Indicators / Benchmarks (including incidence rates)

    Survey(s) of ☐ Population ☐ Clients ☐ Providers ☐ Others

    ☐ Other (please specify) ____________
11. Is there a specific geographic area on which your needs assessment activities focus, or do you assess all of Broward County? ☐ All of Broward County

    ☐ Specific area (please specify) ____________
12. In conducting a needs assessment, do you use population estimates and projections? ☐ Yes ☐ No

    If yes, what is the source of the estimates and projections you use? Mark (x) all that apply.

    ☐ Self-generated ☐ U.S. Bureau of the Census ☐ State of Florida (EOG, UF/BEBR)

    ☐ Broward County ☐ Other (please specify) ____________

Part V. Community Assessment Activities

13. In conducting a needs assessment, do you develop a socio-economic profile of the population, including such characteristics as age, sex, marital status, race, ethnic origin, income, poverty level, household composition, etc.? ☐ Yes ☐ No
    If yes, what is the source of the socio-economic data you use? Mark (x) all that apply.
    ☐ Tabulations of client characteristics ☐ U.S. Bureau of the Census ☐ Broward County
    ☐ State of Florida / UF / BEBR ☐ State of Florida / Office of Vital Statistics
    ☐ Other (please specify) ____________________

14. In conducting a needs assessment, what is the geographic level at which you currently use population estimates and projections and the socio-economic characteristics of the population? Mark (x) all that apply.
    ☐ Broward County ☐ Municipalities ☐ ZIP Codes ☐ Traffic Analysis Zones (TAZs)
    ☐ Census Tracts ☐ Census Block Groups ☐ Census Blocks
    ☐ Other (please specify) ____________________

Note!! Begin again here if you skipped after Question 3. Otherwise, continue.

15. Do you plan to initiate or complete any of the following needs assessment activities during the next 12 months? If yes, please mark (x) the appropriate boxes, indicate the month/year when you will initiate, and give a brief description of what you plan to do.
    ☐ Issue scanning and visioning Month/Year: ______/_____
    Brief description ____________________
    ☐ Secondary data compilation and analysis Month/Year: ______/_____
    Brief description ____________________
    ☐ Indicators / Benchmarks (including incidence rates) Month/Year: ______/_____
    Brief description ____________________
    ☐ Agency resource / service gap analysis Month/Year: ______/_____
    Brief description ____________________
    ☐ Asset mapping of community / neighborhood resources Month/Year: ______/_____
    Brief description ____________________
    ☐ Key informant interviews Month/Year: ______/_____
    Brief description ____________________
    ☐ Focus groups Month/Year: ______/_____
    Brief description ____________________
    ☐ Program monitoring and evaluation Month/Year: ______/_____
    Brief description ____________________
    Survey(s) of ☐ Population ☐ Clients ☐ Providers ☐ Others ____________________
    Brief description ____________________
    ☐ Other (please specify) ____________________

    ____

16. Please identify the person to contact about needs assessment activities.
    Name ____________________ Phone/Ext (   ) ____________________

How can we serve you better?

Please take a moment to provide advice to The Coordinating Council of Broward on how to improve the Provider Organizational Profile. General comments on better ways to collect information for the Countywide Resource Inventory are welcome, but we also encourage you to make specific comments on each part of the form. Please return this page with your filled-out forms. Thanks for your help.

General comments on the Countywide Resource Inventory and the process for collecting information.
Comments and suggestions on specific parts of the Provider Organizational Profile.

Please feel free to use any additional sheets you may need.

INSTRUCTIONS FOR PROVIDER PROFILE

Please **type** or **print legibly** your responses on the form. Make any additional copies of specific parts of the form you may need to accommodate the information requested for the organization, its programs and its services. If necessary, attach additional sheets with any relevant information that cannot be included on the available forms. If you wish to fill in a computerized version of this form, call First Call For Help, (954) 524-8371, or visit http://www.sfrpc.com/ccb/publish.htm.

Part I. Organization Identification

1 **Name / Code** - The official name by which the organization is known and the code assigned by First Call For Help. If your received a print-out from First Call For Help, the organization code is listed (it begins with "FCHB"). The organization code should be included on all sheets of the profile. If you do not know the code or no code has been assigned, please leave blank.
2 **Alternate Name (aka)** - Include any aliases by which the organization is known.
3 **Main Administrative Address** - The Broward County address where the highest level of management and administration activities for the organization is located.
4 **Phone / Fax / Days/Hours -** Specify the corresponding contact numbers for the administration of the organization. Also indicate the days and hours that administration is available.
5 **E-Mail / Web Site** - Include an address for Internet e-mail contact with the organization or with one of its representatives. If the organization maintains a "home page" on the World Wide Web, provide the address (URL).
6 **CEO / Executive Director** - Name of the organization chief executive officer. If this person has a direct telephone number or extension, please include it.
7 **Chief Financial Officer** - Name of the person who is authorized to sign all financial statements. If this person has a direct telephone number or extension, please include it.
8 **Profile Contact Person** - Provide the name of a contact person for information related to this form, including funding, grants, programs and services. If this person has a direct telephone number or extension, please include it.
9 **Agency Type (mark only one)** - Select the category that best describes the type of organization. This will be used primarily for referrals.
10 **Description of the Agency** - A short description of the primary purpose and activities of the organization (50 words or less).
11 **Federal Identification Number** - Provide the organization's federal taxpayer ID number.
12 **Accreditation / Level / Period** - If national accreditation is applicable to the services the organization provides, give the name of the entity granting the accreditation, the level of the accreditation (if any), and the term of the current accreditation.
13 **Broward County Certification Date** - If the organization has been certified by the Broward County Department of Human Services, Program Development, Research and Evaluation Division, indicate the date of issue. If certification has been applied for, specify the expected date of issue. If you have questions, call the Division at (954) 357-6978.

Part II. Service Delivery Locations

General - This part of the profile should be used to identify all service delivery locations the organization maintains. Use as many copies as necessary to list the requested information for each service delivery location. Note that this form should be filled out even if the service delivery location is the same as the agency location identified in Part I. If there is a separate administrative unit, it should be included on this form. Be sure to include the date and page numbers, and the organization name and code on each page.

14 **Location Code / Name** - Identify the name of each service delivery location where you maintain a permanent point of service delivery, whether it is part of your organization or of a partner. In the blank to the left of the name, assign a unique, sequential 4-digit code with leading zeroes ("0001," "0002," "0003," and so on) for each location in the organization. Once established, these codes should be used in Part IV and retained over time for use in future profiles.
15 **Address / City / ZIP** - Full address of the location where services are delivered.

16 **Phone / Fax / TDD** - Main telephone, fax and TDD numbers that clients should use for this service location.

17 **ADA Compliance** - Mark "Yes" if the facility is ADA compliant for each of the referenced impairments: physical (e.g., ramps, accessible bathrooms), visual (e.g., materials available in large print, in Braille, or on disk or cassette) or auditory (e.g., availability of TDD, infrared listening devices).

Part III. Program Information

General - This part of the profile should be filled out **once for each program** the organization implements, without regard to the different locations at which program services are actually delivered. **Programs** generally identify the framework within which funds are made available for services by funding organizations or through self-funding. You may define programs in the way that is most suitable for the information you have available. **Use the organization's current budget cycle and/or fiscal year for all information about programs and services provided in Parts III and IV of this form**. If your organization's fiscal year goes from July to June, this form should be filled out with program and service information for the Jul/2000-Jun/2001 year. If your organization's fiscal year goes from October to September, this form should be filled out with information for the Oct/2000-Sep/2001 year. Where different programs are on different programming and/or funding cycles, give annual data for the current period. Use footnotes to identify programs that were or will be initiated or discontinued during the fiscal year. Be sure to include the date, organization code, and page numbers on each program sheet.

18 **Program Name / Code** Where applicable, identify programs by the name used in the contract signed with funder organizations.

19 **Program Description** - Provide a summary description of the program, its goals and objectives, target population, and any features that may help to understand its intent (limit of 50 words). This will be used primarily for information and referral purposes.

20 **Overall Program Manager / Telephone** - Name of the person responsible for program implementation. If this person has a direct telephone number or extension, please include it.

21 **Funding sources, contract number, reference period(s) and amounts for this program** - Program funding may come from contracts with one or more funders, or from non-contract sources, or both. All program funding should be listed in this table, and the amounts in the "Amount ($)" column should add up to total program funding. Use a separate line for each funding source. Consult the attached Funding Source Code List to properly identify the funders of your program. If appropriate, identify the entity that directly provided the resources to your organization, not the original source of the funds.

Contract Funding - For each contract funder, identify the "Source of Funds" (and the corresponding code), the "Contract Number" and the 12-month "Period." Specify the funding amounts expected for the contract year. If funding amounts are not pre-determined (as for some "entitlement" funding), use the projected amounts based on previous-year funding and current-year client loads.

Non-Contract Funding - For non-contract funds, list on separate lines any funds from paying clients, fund-raising activities and other self-funding. You will find generic categories for these sources of funds in the Funding Source Code List. Specify the fiscal year for each funding amount. If exact amounts are not known, use budgeted funding or use previous-year funding to project current-year (expected) funding. Use footnotes to identify programs that were initiated or discontinued during the fiscal year.

22 **Identify up to four indicators from the 2000 edition of *The Broward Benchmarks* that this program most impacts. Please select only specific indicators identified with 3-digit numbers (i.e. 1.3.2).** - Using the 2000 edition of *The Broward Benchmarks*, identify the four most important indicators that this program impacts. Please list them by number and name in the order of greatest importance, with the most important first. If you do not have a copy of *The Broward Benchmarks*, you may contact The Coordinating Council of Broward at (954) 467-1105, Ext. 10. If you have access to the Internet, you may view or download the report at http://www.sfrpc.com/ccb/tbb00.htm. The various chapters of the report are available in Portable Document Format (PDF), which requires the use of Adobe

Acrobat Reader, a free download if you do not already have it installed on your computer. A link to the Adobe site (http://www.adobe.com/prodindex/acrobat/readstep.html), and instructions for downloading, installing and using Acrobat Reader, are available at the same link. These files are all included on the CD-ROM distributed with results of the 1999-2000 Community Resource Inventory.

23 **Identify the target population(s) for this program - please mark (x) all that apply -** Please note that age, sex, income, residential location, and other client characteristics will be identified as part of the eligibility question (Question #33). If you feel that the groups listed do not properly identify an important target population for this program, please fill in one of the blanks and mark the corresponding box.

Part IV. Program Information by Location

General - This part of the profile should be filled out **once for each service delivery location for each program** the organization implements. In other words, for each program, you should provide one Part III and as many Parts IV as needed to describe the characteristics of program availability at each location. Since much of the requested program information may be the same from one location to another, feel free to fill in the information which is common to all locations on a blank Part IV form, make the necessary copies, and then fill in the information which is unique to each location (including the location name and code). Be sure to include the date, organization code, program name and code and page numbers on each sheet.

Program Name / Code Use the same program name used in Part III. The print-out provided by First Call For Help identifies the codes for programs at each location currently in their database use these if they are available and still applicable. If one or more of your programs and/or service delivery locations has changed or is not listed, please leave the code field blank.

Location Name / Code Use the same name and code identified in Part II.

24 **Program Manager / Telephone / Fax / E-mail** - Name of the person in charge of the program at this location. If this person has a direct telephone number or extension, fax and/or e-mail, please include them.

25 **Referrals Contact / Telephone** - Name of the person to be contacted by interested clients. If this person has a direct telephone number or extension, please include it.

26 **Number of Full-Time Equivalent Staff** - Specify the number of annual full-time equivalent (FTE) paid staff people maintained by this program. For example, a person working 20 hours a week would constitute 0.5 FTE, and four such staff people would be the equivalent of 2 FTEs. Three full-time staff people splitting time evenly between two programs would constitute 1.5 FTEs in each. Total staff for all programs should add up to the number of FTE employees in the organization. If there are volunteers on staff for this program, also estimate the total FTEs for volunteers. If you include volunteers and you have an estimate of the annual value of their services, be sure to include this as a separate "funding source" in Part III.

27 **Do you provide transportation for clients to be able to obtain access to your services?** - Mark "Yes" if you provide transportation to and/or from the service delivery location for some or all of the clients of this program.

28 **Do you provide childcare for clients to be able to obtain access to your services?** - Mark "Yes" if you provide childcare for clients of this program to enable those clients to have access to the services.

29 **Please mark (x) which of the following languages (other than English) program staff speak.** - Use the three blank spaces as needed to specify any other languages that program staff speak. If the program offers access to the AT&T Language Line to translate for clients, write "AT&T" in one of the blank spaces.

30 **What forms of payment do you accept? Please mark (x) all that apply.** - Specify the forms of payment accepted for at least some of the services provided by this program.

31 **Fees (include range, criteria for sliding scale) -** Specify the standard fees charged for basic services and the range and criteria for fees charged on a sliding scale. If the range and diversity of fees charged is large, focus on the fees required for an initial consultation or use of services.

PROVIDER: The directions below are designed to help you, where necessary, in filling out this Organizational Profile. Thanks for building a better Broward County!

32 **Restrictions for acceptance of Medicaid or indigent** - List any restrictions on the acceptance of Medicaid or indigent clients.

33 **Describe client eligibility for this program by answering each of the following six questions:**

(a) **Sex** - If participation in the program is restricted to clients of only one sex, please indicate which. Otherwise, choose "no restriction."

(b) **Age** - If the program is open to all ages, choose "No restriction." If participation in the program is restricted to clients of a specific age range, please specify that age range in detail, using the two sets of boxes put the beginning age in the first two-box set (i.e., 06) and the ending age in the second two-box set (i.e., 12). Where partial years apply, please round up to the next highest whole year. For example, newborns should be specified as "00" to "01".

(c) **Income** - If the program is open to clients at all income levels, choose "No restriction." If participation in the program is restricted to clients whose household income is lower than a specific threshold based on the federal poverty level, mark the appropriate box. If another income restriction applies, please mark the box and explain it in detail.

(d) **Residence** - If participation in the program is open to clients regardless of where they live (including outside of Broward County), choose "No restriction." If participation is available to clients who reside anywhere in Broward County, choose "Broward County." Choose "A specific city" to specify a city that the program is designed to serve. If clients must reside in some "other" area, use the space to clearly identify the area.

(e) **Mark (x) below all restrictions that apply to client participation in this program. For all that apply, please use the space to give the specifics (agency, program, disability, diagnosis).**

- Must be in the custody of a state/local agency - To participate in this program clients must be in the custody of a qualified agency. Please specify which agency(ies) qualify(ies).
- Must be a participant in some other program - To participate in this program clients also must participate in some other program. Please specify the program(s).
- Must be referred by another agency/program - To participate in this program clients must be referred by a qualified agency or program. Please specify which agency(ies) or program(s) qualify(ies).
- Must have a specific disability/diagnosis - To participate in this program clients must present one or more qualifying disabilities or must have been diagnosed with a qualifying condition. Please specify the qualifying disabilities or diagnosed conditions required.

(f) **Other eligibility requirements (specify)** - If there are other eligibility requirements that have not been addressed in (a) through (e), please identify them here.

34 **Intake procedure** - Specify whether an appointment is necessary or not, any documents that are required, and any other requirements that apply, such as the average length of time it takes to complete intake.

35 **Days and hours of program operation at this location. Please check the box to the left of each day of the week during which program services are available, and use the box to the right to specify the normal hours of program operation** - Specify the days of the week and the respective hours during which clients may have access to the services offered under this program at this location. If the schedule varies depending on the specific service offered, specify the full range of hours during which any services are available.

36 **Where do you provide services? Please mark (x) all that apply.** Indicate where program staff provides services to clients: at this location, in the client's home, or at other locations (school, church, etc.)

37 **How many clients does this program currently serve at this location in a year?** Given the funding and staffing levels identified elsewhere on this form, and the anticipated need for services, how many clients do you expect to serve during this program year?

Are you required to accept all clients who are eligible for service? If not, how many program clients could be served at this location at "full capacity" in a year? Considering any constraints of the facility and current funding and staffing levels, how many clients could you serve during this program year?

Identify any specific capacity limit (i.e., # of beds or slots). If this program is limited by a facility constraint such as the number of beds, cells or slots, please specify the number and type of constraint.
Is there a waiting list? Please mark (x) one of the 4 descriptions for the waiting list to receive service. If you are always at full capacity, but do not maintain a waiting list, please mark "Always." If there is a seasonal waiting list, please identify the period of the year when it applies.

38 **List the specific services provided by this program at this location. Please see the detailed instructions on how to fill out this table.**
Service Name / Description - Please list each of the program services you provide at this location.
Services Code (Taxonomy) - First Call For Help will use the AIRS Info Line Taxonomy of Human Services to classify the services provided. Please leave this (shaded) column blank.
P/S - In the space provided, please identify whether the service listed is a Primary (P) or a Secondary (S) service for your clients. **Primary services** are those entry-point services that a person can receive without already being involved with the organization in some way. **Secondary services**, in contrast, are available only to people who already are receiving another service from the organization. For example, suppose an agency provides a residential program for emotionally disturbed adolescents, and counseling is provided to the client and his/her family. The residential program for emotionally disturbed adolescents is the primary service, while counseling is the secondary service because the client must already be in the residential program to get the counseling service. Similarly, a job training program that offers day care for the children of participants while they are in class would have a primary service of job training, and child care would be the secondary service because it is restricted to training participants. **All programs must have at least one primary service.**
Clients Served - The total number of clients to be served for each service during the program year. Where appropriate, use the same measure of clients to be served that is specified in contract deliverables. If you do not have a precise number of clients programmed, use previous-year averages to project numbers based on current-year funding and client loads. If you have identified the number of program clients, but are unable to specify the number of clients for each individual service, we will assume that the number of clients for each service is equal to the number of program clients (i.e., all clients get each service).

Part V. Community Assessment Activities

General Many health, education and human service funders and providers prepare or use a needs assessment to support the development of funding requests and to guide strategic planning for service delivery. Please answer the following questions in light of where you typically obtain such information. If your organization conducts more than one needs assessment, provide information about the most important one and reference the other(s) with footnotes.

1 **Does your organization conduct a formal needs assessment?** Answer "Yes" if you prepare a document that could be shared, in whole or in part, with other organizations.

2 **Do you use a needs assessment prepared by another organization? If yes, identify the organization**. Answer "Yes" if you consult a formal needs assessment prepared by another organization to prepare your agency strategic plan and/or grant applications.

3 **Have you collaborated with another agency to conduct a needs assessment? If yes, identify the organization and when.** Answer "Yes" if you have partnered in producing a formal needs assessment conducted by another organization.

Stop!! If you do not conduct your own formal needs assessment, skip to Question 15.

4 **How often do you conduct a needs assessment?** If it is on a regular cycle, specify whether (1) "Annually or more often" or (2) some other frequency (specify under "Other"). If it is not on a regular cycle, indicate approximately how often, or state "occasionally" under "Other. "

5 **What is the date of the most recent needs assessment completed?** Enter the month/year of publication or of completion. If a needs assessment is underway at this time and will be completed within the next 3 months, indicate the projected completion date.

PROVIDER: The directions below are designed to help you, where necessary, in filling out this Organizational Profile. Thanks for building a better Broward County!

6 **Where can a copy of the most recent needs assessment be obtained? Please provide contact information.** Inform at which organization location a copy of the needs assessment can be obtained and any restrictions on access. Identify the name and telephone number for the person who can provide additional information about the most recent needs assessment.

7 **Is some or all of the most recent needs assessment available on-line? If yes, please provide the on-line address.** This applies whether the portion of the needs assessment available on-line is a summary, a downloadable copy of a report or a searchable database with some of the results.

8 **Please answer the following questions about the most recent needs assessment you conducted.**
What was the purpose? Please summarize the overall purpose of the most recent needs assessment.
What was the target population and time period? Please identify the target population and the period of reference of the most recent needs assessment conducted by your organization.

9 **Why do you conduct a needs assessment? Mark (x) all that apply.** If you prepare information to enable you to respond to grant applications, mark the option "Required by one or more funding sources. "

10 **What methods do you utilize in conducting a needs assessment? Mark (x) all that apply.** A typical needs assessment will make use of several of the methods listed. Be sure to mark all that apply to the needs assessment your organization conducts.
Issue scanning and visioning review of specialized literature as well as the news media to identify trends and emerging issues; development of a vision of where your organization and/or the population of Broward County should be in the future with regard to the services your organization provides.
Indicators / benchmarks (including incidence rates) identification of specific indicators of quality of life or performance for needs in the area of services your organization provides; this could include compilation of time series data for the chosen indicators and/or establishment of goals to be pursued.
Secondary data compilation and analysis use of data/information published or otherwise made available by other organizations to assess need; this could include published surveys or compilations of administrative records, population statistics, etc.
Asset mapping of community / neighborhood resources identification and compilation of the institutional capability, personal skills and other resources available in specific communities or neighborhoods to address health, education and human service needs.
Agency resource / service gap analysis compilation of information about the amount of services provided, along with the identification of any gaps or overlaps in service availability, both in terms of the kind of services and their accessibility due to location, time of day, or eligibility criteria.
Key informant interviews interviews with representatives of key organizations involved in funding, providing, monitoring or evaluating the delivery of services, as well as representatives of the communities served, to identify issues related to the performance of the service delivery system.
Focus groups small group discussions with representatives of key organizations involved in funding, providing, monitoring or evaluating the delivery of services, as well as representatives of the communities served, to identify issues related to the performance of the service delivery system.
Program monitoring and evaluation compilation of information about the implementation of current programs and their ultimate effectiveness in addressing program objectives.
Surveys of population, clients, providers, others direct surveys of the population at large, the specific clients of your organization, the providers of similar services, or others.
Other (please specify) if you use any other techniques for assessment of the needs of the population or your specific clients, identify and describe them here.

11 **Is there a specific geographic area on which your needs assessment activities focus, or do you assess all of Broward County?** If the needs assessment you conduct is focused on specific geographic sub-area(s) of Broward County, identify the area(s). If it is countywide, so indicate.

12 **In conducting a needs assessment, do you use population estimates and projections? If yes, what is the source of the estimates and projections you use? Mark (x) all that apply.** Overall estimates and projections of population are a common element of a needs assessment. Answer yes if you make use of such estimates or projections in the needs assessment. If you answer yes, identify the

source(s) of the numbers you currently use. Official population estimates and projections of the State of Florida are defined by the Joint Legislative Management Committee and the Executive Office of the Governor, through the Consensus Estimating Conferences, and are published by the Bureau of Economic and Business Research (BEBR) at the University of Florida.

13 **In conducting a needs assessment, do you develop a socio-economic profile of the population, including such characteristics as age, sex, marital status, race, ethnic origin, income, poverty level, household composition, etc.? If yes, what is the source of the socio-economic data you use? Mark (x) all that apply.** Answer yes if you must identify your target population based on some combination of socio-economic characteristics and/or include some type of description of the population based on its socio-economic characteristics. If you answer yes, identify the source(s) of the information you currently use.

14 **In conducting a needs assessment, what is the geographic level at which you currently use population estimates and projections and the socio-economic characteristics of the population? Mark (x) all that apply.** Answer this question in accordance with the actual data you currently use, considering the availability. Do not answer based on what you would like to be able to use. If different types of data are used at different geographic levels, mark all that apply.

15 **Do you plan to initiate or complete any of the following needs assessment activities during the next 12 months? If yes, please mark (x) the appropriate boxes, indicate the month/year when you will initiate the activity and give a brief description of what you plan to do.** Please identify and describe any needs assessment activities you expect to initiate during the next 12 months. If there are needs assessment activities currently in process, identify and describe those activities you expect to conclude in the next 12 months. Descriptions should clarify beginning or conclusion dates, target population and other relevant details.

16 **Please identify the person to contact about needs assessment activities.** Please include the name and telephone number of the person to be contacted by anyone who may be interested in finding out additional information about needs assessment activities at your organization.

Enclosures:

- List of existing information for the organization (from First Call For Help)

Funding Source Code List

CODE	FUNDING SOURCE
601	Area Agency on Aging of Broward County - AAA
503	Broward Alliance
501	Broward Community College - BCC
399	Broward County / General Funds
320	Broward County / Community Services Department CS
310	Broward County / CS / Cultural Affairs Division
309	Broward County / CS / Libraries Division
300	Broward County / Human Services Department HS
301	Broward County / HS / Substance Abuse and Health Care Services
302	Broward County / HS / Family Success Administration Division
303	Broward County / HS / Children's Services Administration Division
304	Broward County / HS / Community Development Division
305	Broward County / HS / Elderly and Veteran's Services Division
306	Broward County / HS / Fire Rescue Division
307	Broward County / HS / Program Development, Research and Evaluation Division
332	Broward County / HS / Housing Finance Division
340	Broward County / Planning and Environmental Protection Department - DPEP
380	Broward County / DPEP / Transportation Planning Division
350	Broward County / Office of Equal Opportunity - OEO
351	Broward County / OEO / Human Rights Division
391	Broward County / Licensing and Fees
390	Broward County / Other
502	Broward County Commission on Substance Abuse
511	Broward County Community Development Corporation
550	Broward County / Court Administrator
510	Broward County Housing Authority
509	Broward Employment and Training Administration - BETA
512	Broward Healthy Start Coalition
504	Broward Sheriff's Office - BSO
505	Broward Workforce Development Board
192	Carl Perkins Act
401	City of Coconut Creek
402	City of Cooper City
403	City of Coral Springs
404	City of Dania Beach
451	City of Dania Beach Housing Authority
406	City of Deerfield Beach
452	City of Deerfield Housing Authority
407	City of Fort Lauderdale
453	City of Fort Lauderdale Housing Authority
408	City of Hallandale
410	City of Hollywood
454	City of Hollywood Housing Authority
412	City of Lauderdale Lakes
413	City of Lauderhill
415	City of Lighthouse Point
416	City of Margate
417	City of Miramar
418	City of North Lauderdale

Funding Source Code List

CODE	FUNDING SOURCE
419	City of Oakland Park
420	City of Parkland
422	City of Pembroke Pines
423	City of Plantation
424	City of Pompano Beach
455	City of Pompano Beach Housing Authority
425	City of Sea Ranch Lakes
430	City of Southwest Ranches
426	City of Sunrise
427	City of Tamarac
428	City of Weston
429	City of Wilton Manors
299	Florida / General Revenues
200	Florida / Department of Agriculture and Consumer Services
210	Florida / Department of Children and Families FDCF
217	Florida / FDCF / Adult Payments
212	Florida / FDCF / Adult Services
211	Florida / FDCF / Alcohol, Drug Abuse and Mental Health
213	Florida / FDCF / Developmental Disabilities
218	Florida / FDCF / District Administration
214	Florida / FDCF / Economic Self-Sufficiency Services
216	Florida / FDCF / Family Safety (Child Welfare)
280	Florida / Department of Community Affairs FDCA
275	Florida / Department of Corrections
220	Florida / Department of Education FDOE
215	Florida / Department of Elder Affairs
285	Florida / Department of Environmental Protection FDEP
240	Florida / Department of Health / State Health Office FDOH
241	Florida / FDOH / Broward County Health Department
242	Florida / FDOH / Children's Medical Services
235	Florida / Department of Highway Safety and Motor Vehicles
250	Florida / Department of Juvenile Justice FDJJ
251	Florida / FDJJ / Detention Services
252	Florida / FDJJ / Prevention & Victim's Services
253	Florida / FDJJ / Probation & Community Corrections
254	Florida / FDJJ / Residential and Correctional Facilities
260	Florida / Agency for Workforce Innovation AWI (former FDLES)
261	Florida / FDLES / Blind Services Division
270	Florida / Department of Law Enforcement FDLE
265	Florida / Department of Revenue FDOR
266	Florida / FDOR / Child Support Enforcement
255	Florida / Department of State FDOS
230	Florida / Department of Transportation FDOT
245	Florida / Office of the Attorney General OAG
205	Florida / State Attorney's Office
297	Florida / Operation and Maintenance Trust Fund
298	Florida / Fees
290	Florida / Other
	Medicaid (see U.S. Department of Health and Human Services)
	Medicare (see U.S. Department of Health and Human Services)

Funding Source Code List

CODE	FUNDING SOURCE
506	Memorial Healthcare System (South Broward Hospital District)
460	Municipalities in Miami-Dade County
461	Municipalities in Palm Beach County
469	Municipalities in Other Counties
507	North Broward Hospital District
191	Ryan White Title I
508	School Board of Broward County
506	South Broward Hospital District (Memorial Healthcare System)
405	Town of Davie
409	Town of Hillsboro Beach
411	Town of Lauderdale-by-the-Sea
421	Town of Pembroke Park
100	US / Department of Agriculture
110	US / Department of Commerce
120	US / Department of Education
130	US / Department of Health and Human Services - DHHS
131	US / DHHS / Medicare
132	US / DHHS / Medicaid
160	US / Department of Housing and Urban Development - HUD
161	US / HUD / Community Development Block Grants - CDBG
162	US / HUD / HOME
163	US / HUD / HOPWA
140	US / Department of the Interior - DOI
170	US / Department of Justice - DOJ
155	US / Department of Labor - DOL
150	US / Department of Transportation - DOT
151	US / DOT / Federal Transportation Authority - FTA
180	US / Federal Emergency Management Agency - FEMA
181	US / FEMA / Emergency Food and Shelter Program Board
195	US / Federal Block Grants
196	US / Federal Grant Trust Funds
190	US / Other
414	Village of Lazy Lake

Funding Source Code List

CODE	EXAMPLES OF PRIVATE AND PASS-THROUGH FUNDING SOURCES
602	Catholic Charities
604	Jewish Federation of Broward County
650	Faith Community - Churches, Synagogues, Other Religious Organizations
800	Private Foundation / Corporate Giving (examples) • Community Chest • Sun-Sentinel • Junior League of Fort Lauderdale • Liberia Economic and Social Development, Inc. • National Collegiate Athletic Association - NCAA • Other
606	United Way of Broward County
810	Community Foundation of Broward, Inc.
607	Family Central, Inc.
608	Henderson Mental Health Center
513	The Coordinating Council of Broward - CCB
603	Greater Fort Lauderdale Chamber of Commerce
920	Agency-Generated Funding (examples) • Membership Dues • Endowments / Estate Giving • Fundraising • Merchandise Sales • Special Events • Miscellaneous Income • Other
950	Fees for Services