Types of clients served by the organization filling out this form (mark all that apply)				
Children/Youth (0-18)	Adults (18-64)	Elderly (65+)	Disabled	Other

The Coordinating Council of Broward (CCB)

Organizational Profile for

PROVIDERS

of Health, Education 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 separate set of detailed directions intended to help you accurately provide the requested information. Please type or legibly print your responses.
2. Attached to this package you will find a print-out of the information currently in the information and referral database at First Call For Help. You are encouraged to use this information, if it is accurate, to complete the forms. This will save both you and First Call For Help valuable staff time.
3. Training will be provided during the second week of July, 1998 (see attached schedule). Training is designed for the person(s) who will be filling out the forms. Computer disks will be available at the training sessions for those who would prefer to use them for completion of the forms.
4. Once completed, please return this profile to the address below by no later than July 29, 1998.

Information and Marketing Manager
First Call For Help of Broward, Inc.
16 SE 13th Street
Fort Lauderdale, Florida 33316
(954) 524-8371

Thanks for building a better Broward County!

Part I. Organization Identification

1. Name _____ Code _____
2. Alternate Name (aka) _____
3. Main Administrative Address _____

   City _____ State _____ ZIP _____
4. Phone ( ) _____ Fax ( ) _____ Days/Hours _____
5. E-Mail _____ WWW Site http:// _____
6. CEO/Executive Director _____ Phone/Ext ( ) _____
7. Chief Financial Officer _____ Phone/Ext ( ) _____
8. 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 _____

    _____

    _____
11. Federal Identification Number _____
12. Non-Profit Status (501(c)(3), etc.) _____
13. Accreditation/Level/Period _____
14. Broward County Certification Date _____
15. If **not** Broward County certified, please indicate whether copies of the documents specified below are available and the date of reference for the most recent update. Do not attach any copies to this form.

Document	Available			Date of Reference
Articles of Incorporation	Yes	No	NA	
List of Members of the Board of Directors	Yes	No	NA	
Mission Statement	Yes	No	NA	
Organizational Chart	Yes	No	NA	
Most Recent Operating Budget	Yes	No	NA	
Audited Financial Statements (2 years)	Yes	No	NA	
Certificate/Letter of Insurance	Yes	No	NA	
License(s) _____	Yes	No	NA	

Where may copies of the documents be reviewed? _____

_____

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

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

16. Organization Name ____ **Code** __________________

17. Location Code _______ Location Name ____
18. Address ____
City _______________________________________ ZIP __________ Fax ( ) __________________
19. Phone ( ) ________________ On-Call ( ) __________________ TDD ( ) _________________
20. Manager at Location _____________________________________ Phone/Ext ( ) _______________
21. ADA compliance: Physical: Yes No Visual: Yes No Auditory: Yes No

17. Location Code _______ Location Name ____
18. Address ____
City _______________________________________ ZIP __________ Fax ( ) __________________
19. Phone ( ) ________________ On-Call ( ) __________________ TDD ( ) _________________
20. Manager at Location _____________________________________ Phone/Ext ( ) _______________
21. ADA compliance: Physical: Yes No Visual: Yes No Auditory: Yes No

17. Location Code _______ Location Name ____
18. Address ____
City _______________________________________ ZIP __________ Fax ( ) __________________
19. Phone ( ) ________________ On-Call ( ) __________________ TDD ( ) _________________
20. Manager at Location _____________________________________ Phone/Ext ( ) _______________
21. ADA compliance: Physical: Yes No Visual: Yes No Auditory: Yes No

17. Location Code _______ Location Name ____
18. Address ____
City _______________________________________ ZIP __________ Fax ( ) __________________
19. Phone ( ) ________________ On-Call ( ) __________________ TDD ( ) _________________
20. Manager at Location _____________________________________ Phone/Ext ( ) _______________
21. ADA compliance: Physical: Yes No Visual: Yes No Auditory: Yes No

17. Location Code _______ Location Name ____
18. Address ____
City _______________________________________ ZIP __________ Fax ( ) __________________
19. Phone ( ) ________________ On-Call ( ) __________________ TDD ( ) _________________
20. Manager at Location _____________________________________ Phone/Ext ( ) _______________
21. ADA compliance: Physical: Yes No Visual: Yes No Auditory: Yes No

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

Date _____ **Organization Code** _____ **Page** ____ **of** ____

22. Program Name _____

23. Program Description _____

_____

_____

_____

_____

24. Program Manager _____ Phone/Ext ( ) _____

25. From what sections of Broward County do most of the clients served by this program come? Please mark (x) all that apply. All of Broward County (skip boxes below)

North West (North of Commercial Boulevard, West of University Drive)	**North Central** (North of Commercial Boulevard, West of I-95, East of University Drive)	**North East** (North of Commercial Boulevard, East of I-95)
Central West (South of Commercial Blvd, North of State Road 84, West of University)	**Central Central** (South of Commercial Blvd, North of SR 84, West of I-95, East of University)	**Central East** (South of Commercial Blvd, North of State Road 84, East of I-95)
South West (South of State Road 84, West of University Drive)	**South Central** (South of State Road 84, West of I-95, East of University Drive)	**South East** (South of State Road 84, East of I-95)

26. Fiscal Year (mm/yy mm/yy) _____

27. Funding sources and amounts for this program during the fiscal year.

Name of Funder	Code	Amount ($)
Total		

28. Identify up to six specific indicators from *The Broward Benchmarks* that this program most impacts.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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

Date _____ **Organization Code** _____ **Page** ____ **of** ____

22. Program Name _____ **Code** _____

29. Location Name _____ **Code** _____

30. Referrals Contact _____ Phone/Ext ( ) _____

31. Number of Full-Time Equivalent Staff: Professional _____ Clerical _____ Total _____

32. Geographic Service Area _____

_____

33. Do you provide transportation for clients? Yes No Not Applicable

34. Do you provide childcare for clients? Yes No Not Applicable

35. Please mark (x) which of the following languages (other than English) program clients speak. Also indicate if administrative or professional staff speak these languages.

Speakers	Spanish	Haitian Creole	Am. Sign Language	Other _____	Other _____	Other _____
Clients						
Clerical						
Professional						

36. What forms of payment do you accept? Please mark (x) all that apply. Medicare Self-Pay
Full Pay, i.e. Insurance, HMO, POS, PPO Medicaid Medicaid HMO
Sliding Scale No Fee for Services

37. Fees (include range, criteria for sliding scale) _____

_____

_____

38. Restrictions for acceptance of Medicaid or indigent _____

39. Program eligibility _____

_____

_____

_____

40. Intake procedure _____

_____

_____

41. Identify the days and hours of program availability at this location. _____

_____

_____

_____

42. Do you provide services off-site from this location? Please mark (x) all that apply.
At this location In the client s home At other locations (school, church, etc.)

Part IV. Resource Information by Program, Service and Service Location *(use as many sheets as needed)*

Date _____ **Page** ____ **of** ____

43. Organization/Code _____ **44. Fiscal Year (mm/yy mm/yy)** _____

45. Program/Service Name	Program Code	Location Code	46. Service Code (Taxonomy)	P S	47. Unit of Service		Clients Served	Capacity Code
					Specification	Number		

Part IV. Resource Information by Program, Service and Service Location *(Example)*

Date _____ **Page** ____ **of** ____

43. Organization/Code _____ **44. Fiscal Year (mm/yy mm/yy)** Jul/98 Jun/99

45. Program/Service Name	Program Code	Location Code	46. Service Code (Taxonomy)	P S	47. Unit of Service		Clients Served	Capacity Code
					Specification	Number		
Program - Overnight Shelter					*Unduplicated*	*Clients*	**420**	
• Community Shelters		001		P	Overnight Stay	9,125	150	NO
• Sack Lunches/Dinners		001		S	Meal	9,125	150	NO
• Community Shelters		002		P	Overnight Stay	7,300	120	NO
• Sack Lunches/Dinners		002		S	Meal	7,300	120	NO
• Community Shelters		003		P	Overnight Stay	9,125	150	WL/30
• Sack Lunches/Dinners		003		S	Meal	9,125	150	WL/30
Program - Counseling					*Unduplicated*	*Clients*	**120**	
• Intake		002		S	Assessment	120	120	NO
• Individual Counseling		002		S	1-hour Session	120	30	NO
• Group Counseling		002		S	90-minute Session	60	120	NO
• Case Management		002		S	15-minute Session	720	120	NO
Program - Employment Training					*Unduplicated*	*Clients*	**100**	
• Assessment		001		S	Assessment	50	50	NO
• Training		001		S	Day	100	50	NO
• Assessment		003		S	Assessment	50	50	NO
• Training		003		S	Day	100	50	NO

Part V. Community Assessment Activities

The CCB's Community Assessment Information Clearinghouse will create an information base to promote coordination and collaboration among funders and providers of health, education and human services in Broward County. Many of the public and private organizations engaged in funding and providing these services in the county develop activities designed to support the preparation of needs assessments for planning in their specific areas of interest. The information requested below about these activities will be compiled on a regular basis and made available both in a printed report and through on-line access. The timely sharing of information about efforts recently completed, those currently underway and those planned will create opportunities for improved coordination.

Date _____ **Organization Code** _____ **Page** ____ **of** ____

1. Does your organization conduct any type of needs assessment? Yes No
2. If no, do you use a needs assessment prepared by another organization? Yes No

   If yes, identify the organization. _____
3. If you conduct a needs assessment, how often do you do it? Annually or more often

   Other (please specify) _____
4. What is the reference date for the most recent needs assessment completed? _____
5. Where can a copy of the most recent needs assessment be viewed? Who is the contact? _____

   _____
6. Is some or all of the most recent needs assessment available on-line? Yes No

   If yes, please provide the on-line address. _____
7. Provide a summary description of the most recent needs assessment you conducted. _____

   _____
8. 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) _____
9. 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

   Survey(s) of Population Clients Providers Others

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

   Other (please specify) _____
10. 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) _____
11. In conducting a needs assessment, do you use population estimates and projections? Yes No
12. 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

14. 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) _____

15. 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) _____

16. 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 or complete the activity and give a brief description of what you plan to do.
    Issue scanning and visioning _____

    _____

    Secondary data compilation and analysis _____

    _____

    Indicators / Benchmarks (including incidence rates) _____

    _____

    Agency resource / service gap analysis _____

    _____

    Asset mapping of community / neighborhood resources _____

    _____

    Survey(s) of Population Clients Providers Others _____

    _____

    Key informant interviews _____

    _____

    Focus groups _____

    _____

    Program monitoring and evaluation _____

    _____

    Other (please specify) _____

    _____

17. Please identify the person to contact about needs assessment activities.

    Name _____ Phone/Ext ( ) _____

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

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 (in Word or WordPerfect for Windows), contact First Call For Help, (954) 524-8371.

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. 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/WWW 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 **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.

11 **Federal Identification Number** - Provide the organization's federal taxpayer ID number.

12 **Non-Profit Status** - If the organization has been granted formal non-profit status, identify the specific status that applies and any date of expiration.

13 **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.

14 **Broward County Certification Date** - If the organization has been certified by the Broward County Department of Human Services, Grants Management Research and Development Division, indicate the date of issue. If certification has been applied for, specify the expected date of issue. Then proceed to Part II. Otherwise, respond "No" and answer question 15 below. If you have questions, call the Division at (954) 357-6978.

15 **If <u>not</u> Broward County certified, please indicate whether copies of the documents specified below are available and the date of the most recent update. Do not attach any copies to this form.** Some of these may not be applicable for example, state agencies do not have Articles of Incorporation, and some organizations may not have a Board of Directors in that case, mark the NA box.

- ❑ **Articles of Incorporation** If a corporation, the Articles of Incorporation.
- ❑ **List of Members of the Board of Directors** - A list of all officers and members of the organization's Board of Directors, and any organizations they represent.
- ❑ **Mission Statement** - A formal statement of the organization mission and goals.
- ❑ **Organizational Chart** - A description of all of the departments/divisions of the organization and the institutional relationships among them.

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

- **Most Recent Operating Budget** - The most recent annual operating budget for the organization, spelling out revenues by source and expenditures by standard categories.
- **Audited Financial Statements (2 years)** - The two most recent audited financial statements.
- **Certificate/Letter of Insurance** - A copy of the organization's current Certificate or Letter of Insurance.
- **License(s)** - Any institutional license(s) required for operation, as well as a list of any professional or occupational licenses required by staff.

Where may copies of the documents be reviewed? Identify the address where these documents may be reviewed, if appropriate.

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 on each page.

16 **Organization Name** and **Code** - Identify your organization by a short name and by the code registered in Part I.

17 **Location Code** and **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 3-digit code with leading zeroes ("001," "002," "003," and so on) for each location in the organization. Once established, these codes should be retained over time to ensure consistent identification of each service delivery location.

18 **Address/City/ZIP/Fax** - Full address of the location where services are delivered. Include the fax number at this location.

19 **Phone/On-Call/TDD** - Main telephone, emergency/on-call and TDD numbers that clients should use for this service location.

20 **Manager at the Location** - Name of the person on-site responsible for the service delivery location. If this person has a direct telephone number or extension, please include it. If the organization has only one location, the manager may be the agency head.

21 **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-A. 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 same 12-month period, usually 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/98-Jun/99 year. If your organization s fiscal year goes from October to September, this form should be filled out with information for the Oct/98-Sep/99 year. Where different programs are on different programming and/or funding cycles, adjust and pro-rate all programs to the same annual period, if possible. If you cannot pro-rate, 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.

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

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

23 **Program Description** - Provide a summary description of the program, its goals and objectives, and any features that may help to understand its intent. This will be used primarily for referrals.

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

25 **From what sections of Broward County do most of the clients served by this program come?** - Mark the sections of the county that account for at least 90% of the Broward County clients for this program.

26 **Fiscal Year** Identify the 12-month period to which the information refers. The same period should be used for all annual program funding and service information provided on this form.

27 **Funding sources and amounts** - Specify the funding amounts received during the 12-month fiscal year from each funding source (use a separate line for each source). If appropriate, identify the entity that directly provided the resources to your organization, not the ultimate origin of the funds. Sources should include any funds from paying clients, fund-raising activities and other self-funding. Use footnotes to identify programs that were initiated or discontinued during the fiscal year. Identify funding source codes (see attached list) in the column provided. Please note that **funding information for each program should add up to 100% of all agency funding for the program in the fiscal year, and total funding for all programs should add up to organization funding.**

28 **Identify the specific indicators from *The Broward Benchmarks* that this program most impacts** - Using the February 1998 edition of *The Broward Benchmarks*, identify the six 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) 462-4850, Ext. 210. If you have access to the Internet, you may view or download the report at http://www.sfrpc.com/ccb/tbb98.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.

Part III-B. 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-A and as many Parts III-B 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 III-B 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.

22 **Program Name / Code** Use the same program name used in Part III-A. 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.

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

30 **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.

31 **Number of Full-Time Equivalent Staff** - Specify the number of annual full-time equivalent (FTE) 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. Include both professional and clerical staff. Total staff for all programs should add up to the number of FTE employees in the organization.

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 **Geographic Service Area** - Specify the boundaries of the geographic area from which clients for this program will be accepted. This could be all of Broward County or some sub-area within the county. It also could include areas outside of Broward County.

33 **Do you provide transportation for clients?** - Mark "Yes" if you provide transportation to and/or from the service delivery location for some or all of the clients of this program.

34 **Do you provide childcare for clients?** - Mark "Yes" if you provide childcare for clients of this program as a part of services.

35 **Please mark (x) which of the following languages (other than English) program clients speak. Also indicate if administrative or professional staff speak these languages.** - Use the three blank columns as needed to specify any other languages that a significant number of clients speak. Indicate that professional and/or clerical staff speak these languages only if that language ability can be applied to translating for clients. If the program offers access to the AT&T Language Line to translate for clients, write AT&T in each applicable box for professional/clerical staff.

36 **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.

37 **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.

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

39 **Program eligibility -** Describe all conditions on client eligibility for the services you provide through this program, including age ranges, gender, income, level of severity and any others that are critical.

40 **Intake procedure** - Specify the days and time periods when intake is available at this location, any documents required, and any other requirements.

41 **Days/Hours of program availability at this location** - 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 services are available.

42 **Do you provide services off-site from this location? Please mark (x) all that apply.** Indicate <u>where</u> your staff provides services to clients from this location: at this service delivery location, in the client s home, or at other locations (school, church, etc.)

<u>Part IV. Resource Information by Program, Service and Service Location</u>

General - This part of the profile requires programs to be broken down by individual service and service delivery location. It is designed to be reproduced as needed to accommodate any number of services and service locations. Each line of this form should correspond to a single program/service, for a single location (see example). Be sure to include the date and number the pages.

43 **Organization/Code** - Use the same code specified in Parts II and III.

44 **Fiscal Year** - Use the same 12-month period specified in Part III.

45 **Program/Service Name, Program Code, Location Code** - Please list each of the programs and each of the related services you provide. Where the services for a program are delivered at different locations, specify each location on a separate line (see example). Use the same names and codes (if available) for programs specified in Part III of this profile. If you do not have program codes, leave this column blank. Also, use the same code for service delivery locations used in Part II.

46 **Services Code (Taxonomy) -** First Call For Help will use the AIRS Info Line Taxonomy to classify the services provided. <u>Please leave this (shaded) column blank.</u>

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 only available 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.

47 **Unit of Service** and **Number of Units** Specify in detail the unit of service used to measure the volume of service, as well as the number of units of service provided during the fiscal year. Where appropriate, the unit of service should be the one used by the funder to specify contract deliverables.

48 **Clients Served** - The total number of clients to be served for each service during the fiscal year. Where appropriate, use the same measure of clients to be served that is specified in contract deliverables. Use footnotes to specify the types of duplication that could occur in your estimates, such as repeat visits for the same service by the same client in the program period or different services provided to the same client. Also, on the line for the program, identify the total number of unduplicated clients served by the program at all locations.

49 **Capacity Code** - Choose from one of the 3 following descriptions for the capacity to provide service:
AV - Additional clients could be served with current staff and facilities.
NO - No additional clients could be served with current staff and facilities, but there is no formal waiting list.
WL/nnn - There is a waiting list of identified clients in need of service, which current staff and facilities do not enable the organization to serve. If known, specify the average number of days waiting for 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, either provide information about the most important one or fill out two separate forms.

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

2 **If no, do you use a needs assessment prepared by another organization? If yes, identify the organization**. If you answered No to Question 1, answer Question 2 and then stop.

3 **If you conduct a needs assessment, how often do you do it?** 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.

4 **What is the reference date for 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.

5 **Where can a copy of the most recent needs assessment be viewed? Please provide contact information.** Inform at which organization location or other entity (i.e., library) the needs assessment can be viewed, any restrictions on access. Identify the name and telephone number for the person who can provide additional information about viewing the most recent needs assessment.

6 **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.

7 **Provide a summary description of the most recent needs assessment you conducted.** Please describe the target population, the period of reference, and the overall purpose of the most recent needs assessment conducted by your organization.

8 **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.

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9 **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.

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.

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.

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.

10 **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.

11 **In conducting a needs assessment, do you use population estimates and projections?** 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.

12 **If yes, what is the source of the estimates and projections you use? Mark (x) all that apply.** If you answered yes to Question 11, 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.?** 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.

14 **If yes, what is the source of the socio-economic data you use? Mark (x) all that apply.** If you answered yes to Question 13, identify the source(s) of the information you currently use.

15 **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?**

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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.

16 **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 or complete 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.

17 **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)
- Alphabetical list of funding sources with codes.

Sections of Broward County	ZIP Codes
North East (North of Commercial Boulevard, East of I-95)	33060, 33062, 33064 (part), 33308 (part), 33309 (part), 33334 (part), 33441
Central East (South of Commercial Boulevard, North of State Road 84, East of I-95)	33301, 33304, 33305, 33306, 33308 (part), 33309 (part), 33311 (part), 33312 (part), 33315 (part), 33316 (part), 33334 (part),
South East (South of State Road 84, East of I-95)	33004 (part), 33009 (part), 33019, 33020 (part), 33315 (part), 33316 (part)
North Central (North of Commercial Boulevard, West of I-95, East of University Drive)	33063, 33064 (part), 33065 (part), 33066, 33067, 33068, 33069, 33071 (part), 33073, 33309 (part), 33319 (part), 33321 (part), 33442
Central Central (South of Commercial Blvd, North of SR 84, West of I-95, East of University Drive)	33309 (part), 33311 (part), 33312 (part), 33313, 33315 (part), 33317 (part), 33319 (part),
South Central (South of State Road 84, West of I-95, East of University Drive)	33004 (part), 33009 (part), 33020 (part), 33021, 33023, 33024 (part), 33312 (part), 33314, 33315 (part), 33317 (part),
North West (North of Commercial Boulevard, West of University Drive)	33065 (part), 33071 (part), 33076, 33321 (part)
Central West (South of Commercial Blvd, North of State Road 84, West of University Drive)	33322 (part), 33323, 33324 (part), 33325 (part), 33326 (part), 33351
South West (South of State Road 84, West of University Drive)	33024 (part), 33025, 33026, 33027, 33028, 33029, 33328 (part), 33330, 33331, 33332, 33324 (part), 33325 (part), 33326 (part), 33327

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.