

COMPANY NAME:

Street: _____
City: _____ State: _____ Zipcode: _____
Phone: _____ Fax: _____ Toll-Free: _____
Web site: _____ Email Address: _____

Mailing Address:

Company Name (If different from above): _____
Street: _____
City: _____ State: _____ Zipcode: _____
County: _____

Service Area:

Center's Information:

Type of Ownership:
Private: [] Individual [] Partnership [] Association [] Corporation
Government: [] City [] County [] Public Trust Association
Other: _____

Parent Company or Sponsor: The Office of Elder Americans _____
Tax Status: [] For Profit [] Not-for-Profit
Model Type: [] Social [] Medical

Key Executives:

Executive Director: _____
Program Director: _____
Activities Director: _____
Other #1 _____
Other #2 _____

Number of full-time staff: _____ Number of part-time staff: _____ Number of Volunteers: _____
Staff Composition: (Please check all that apply - if available on referral not on staff, please put a "R" next to number):

- [] RNs [] LPNs [] CNAs [] Drivers
[] Aides [] Physicians [] Activities Directors [] Cooks
[] Nutritionist [] Social Worker [] Case Manager
Other Staff: _____

Services Offered:

- [] AIDS Day Care [] Nursing Services [] Pharmacology Assistance [] Respite Care
[] Caregivers' Support Group [] Nutritional [] Phone Reassurance [] Speech Therapy
[] Formal Exercise [] Occupation Therapy [] Physical Therapy [] Social Service Counseling
[] Hospice [] Pastoral Counseling [] Podiatry Services [] Stress Management
[] Insurance Counseling [] Personal Care (bath) [] Psychotherapy [] Substance Abuse Council
[] Intergenerational Program [] Pet Therapy [] Reminiscent Therapy [] Weight Control Group
Other Services: _____

Activities Offered:

- [] Arts & Crafts [] Cooking [] Informal Exercise [] Religious Programs
[] Adult Education [] Current Events [] Lectures [] Social games, movies, etc.
[] Bingo [] Field Outings [] Music [] Swimming
[] Choral Group/Sing-Alongs [] Gardening [] Plays
Other Activities: _____

Program Operation:

Program Capacity: _____ Regular Program: _____ Alzheimers'/Dementia: _____
Hours of Operation: (Sample: 7:00am to 4:00pm)
Monday _____ Tuesday _____ Wednesday _____
Thursday _____ Friday _____ Saturday _____
Sunday _____ Evening Hours: _____

Provide Transportation:

- [] Center's Van [] County's Van
[] Town's Van [] Public Transportation
Transportation Other: _____

Cost for transportation: _____ Average Client Ages: _____

Staff to Client Ratio:

Incontinence accepted: [] Full [] Partial
Average Length of time a client is enrolled in your program? _____

Fee Structure:

Hourly: _____ Daily: _____ Weekly: _____ Monthly: _____ Other: _____

Charges fees on a sliding scale: []

Prepayment Required: []

Type of Payment Accepted:

- [] Medicare [] Medicaid [] Private Pay [] Private Insurance
[] Medicare Supplemental/Medigap [] Veteran's Insurance [] Long-Term Care Insurance
Other: _____

Adult Day Care Centers

Marketing Efforts: (Note: This question's response **will not** be published in the directory, it is for our use only..)

Do you advertise? Yes No

If yes, please check media used:

Television - Public Television - Non-Public Local Cable Channel Radio Newspaper

How often do you advertise? Weekly Monthly Less than once a month

Do you send out press releases? Yes No

Do you have a web site? Yes No Please list: www. _____

Please list any fund raising marketing activities (If you need more space, please attach another sheet of paper.

Example: Putting the Mayor on a roof for a week-end, having a craft fair, hosting a dance, bake sale, etc.

Budget Benchmarking: (Note: This information **will not** be published in the directory. It will be used for benchmarking only, not associated with your organization's name.)

Please estimate your average annual operating budget:

under \$100,000 \$100,000 to \$199,999 \$200,00 to \$499,999 \$500,000 to \$999,999 \$1,000,000+

What do you estimate it costs you overall per client per day? \$ _____

Please estimate percent of total operating budget by funding sources:

Medicaid % _____ Private Insurance % _____ State Grant % _____

Federal Grant % _____ Private Donations % _____ City/Town Grant % _____

Fund Raising/Marketing % _____ Other source (type): _____ % _____

Please tell us what you believe are the biggest hurdles you face during your working day as you try to operate an efficient adult day care program: _____

Please list all satellite programs (include address, phone & contact person):

Center's Name: _____

Address: _____

City: _____ State _____ Zipcode: _____

Telephone: _____

Contact Person: _____

Center's Name: _____

Address: _____

City: _____ State _____ Zipcode: _____

Telephone: _____

Contact Person: _____

Center's Name: _____

Address: _____

City: _____ State _____ Zipcode: _____

Telephone: _____

Contact Person: _____

Center's Name: _____

Address: _____

City: _____ State _____ Zipcode: _____

Telephone: _____

Contact Person: _____

Form completed by:	
Name: _____	Title: _____
Phone: _____	