SC ACCESS
AGING AND DISABILITY INFORMATION

Data Collection Form

If you have any questions regarding the data collection forms or about *SC Access* in general, please contact Rene Beard or Ron Ralph at the Lieutenant Governor's Office on Aging through 1-800-868-9095, or scaccess@aging.sc.gov.

Please return the completed form to SC Access at the Lt. Governor's Office on Aging, 1301 Gervais St., Suite 350, Columbia, SC 29201 or fax to *SC Access* at (803) 734-9887.

Form Completed By:_____ Date:_____

Section I: Agency / Business / Corporation Information ***(Please attach a general description or a brochure to this section.)***

Name: *(As used on legal documents)*

Aliases: *(Include acronyms and former names)*

Legal Status: *(Check all that apply)*
☐ Nonprofit ☐ Government ☐ For Profit ☐ Faith-Based

Affiliations: *(Parent organization, major funding partners, etc.)*

Physical Site Address:
Street 1:
Street 2:
City, State & Zip:

Mailing Address: *(If different from above)*
Street 1:
Street 2:
City, State & Zip:

Phone Numbers:
Main:
Fax:
TDD / TTY:
(For persons who are unable to use a traditional phone)
Hotline or Toll-Free:
Emergency / After Hours:
Other:

Email: *(For public to request general information)*

Web Address:

Business / Office Hours: *(Hours and days; Are services provided at other times?)*

Geographic Area Served: *(Include SC counties served and any limitations such as particular cities or zip codes.)*

Public Transportation: *(Office accessible by local bus; agency transports clients; etc.)*

Facility / ADA Access: *(Special parking; existence and location of ramps, automatic doors, elevators, etc.)*

Director's Information:
Title: ☐ None ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Director's Name and Position:

Contact's Information:
Contact Person's Name and Position:
Contact's Phone: *(If different from main phone)*

Languages Spoken: *(Staff can function as official interpreter for Spanish, American Sign Language, etc.; contract with interpreter service; other accommodations)*

Section 2: Program Information ***(Complete this section if services are provided through a location(s) other than the agency office; OR through contact with a particular department/division within the agency. Duplicate this section as needed.)***

Program / Branch / Department Name and Description:

Contact Information:

Title: ☐ None ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Contact's Name:
Contact's Position:

Physical Site Address:

Street 1:
Street 2:
City, State & Zip:

Mailing Address: *(If different from above)*

Street 1:
Street 2:
City, State & Zip:

Phone Numbers:

Main:
Fax:
TDD / TTY:
(For persons who are unable to use a traditional phone)
Hotline or Toll-Free:
Emergency / After Hours:
Other:

Program Email: *(To request information or to apply for services)*

Office Hours: *(Hours and days; Are services provided at other times?)*

Public Transportation: *(Office accessible by local bus; agency transports clients; etc.)*

Facility / ADA Access: *(Special parking; existence and location of ramps, automatic doors, elevators, etc.)*

List Services Provided through This Program Location or Department:

Section 3: Service Information ***(Please complete one form for each type of service you offer and describe it in as much detail as possible. Copies of any printed materials regarding your agency and its services would be helpful. Duplicate this section as needed.)***

Service Name and Description #1: (*Please be as detailed as possible.)*

Intake Procedure: *(Include required referrals, method of contact, etc.)*

Materials Required for Intake: *(Check all that apply)*

- ☐ None / Not Applicable
- ☐ Immunization Records
- ☐ Health Insurance Card(s)
- ☐ Medicare Card
- ☐ Picture ID
- ☐ Social Security Card
- ☐ Other: _____
- ☐ Birth Record
- ☐ Income Tax Return
- ☐ Insurance Records
- ☐ Medical History
- ☐ Proof of Income
- ☐ TB Test
- ☐ Current Physical
- ☐ Immigration (INS) Form
- ☐ Medicaid Card
- ☐ Medication List
- ☐ School Records
- ☐ Utility Bills

Eligibility Requirements:

Helpful Tips for Accessing This Service:

Target Population / Conditions: *(Is service provided only to persons in certain groups or with certain physical or mental conditions?)*

Ages Served: ☐ All Ages ☐ Children/Teens ☐ Adults ☐ Senior Adults

Gender Served: ☐Male ☐ Female ☐ Both

Driver's License: ☐Required ☐ Not Required

Types of Fees: *(Check all that apply)*
☐ Free (No Charge) ☐ Donations ☐ Standard Fee ☐ Sliding Scale

Fee Amounts: *(Details of above, such as general fee ranges; qualifications for sliding scale; etc.)*

Insurance Accepted: *(Check all that apply)*

☐ None / Not Applicable ☐ Long Term Care Insurance ☐ Health Insurance
☐ Veterans Administration ☐ Medicaid ☐ Private Pay
☐ Medicare ☐ Other (Explain in Payment Notes)

Payment Notes: *(Other insurance from above; acceptance of checks, credit cards, etc.; billing)*

Capacity Limitations: *(Number of beds / units in the facility; variables such as availability of funds or staff; seasonal restrictions; etc.)*

Waiting List: ☐ Yes ☐ No ☐ Check with Agency

Languages Spoken: *(If different from agency)*

Grievance Process: *(If a consumer has a concern or complaint about this service or your agency, whom should they contact and what steps should they take to resolve the situation?)*

Service Information: *(Only if different from those already provided)*

Contact Name and/or Position:
Phone:
Fax:
Email:

Hours Services Are Available: *(If different from office hours)*

Licensing / Accreditation: *(Check all that apply)*

☐ None / Not Applicable ☐ DSS ☐ CARF
☐ JCAHO ☐ Consumer Affairs ☐ LSS
☐ DHEC Date Expires:

Update Contact: *(Person best suited to ensuring the accuracy of this information)*

Name:
Position Title:
Email:
Phone:
Fax:

Service Name and Description #2: (*Please be as detailed as possible.)*

Intake Procedure: *(Include required referrals, method of contact, etc.)*

Materials Required for Intake: *(Check all that apply)*

☐ None / Not Applicable	☐ Birth Record	☐ Current Physical
☐ Immunization Records	☐ Income Tax Return	☐ Immigration (INS) Form
☐ Health Insurance Card(s)	☐ Insurance Records	☐ Medicaid Card
☐ Medicare Card	☐ Medical History	☐ Medication List
☐ Picture ID	☐ Proof of Income	☐ School Records
☐ Social Security Card	☐ TB Test	☐ Utility Bills
☐ Other: _____		

Eligibility Requirements:

Helpful Tips for Accessing This Service:

Target Population / Conditions: *(Is service provided only to persons in certain groups or with certain physical or mental conditions?)*

Ages Served: ☐ All Ages ☐ Children/Teens ☐ Adults ☐ Senior Adults

Gender Served: ☐Male ☐ Female ☐ Both

Driver's License: ☐Required ☐ Not Required

Types of Fees: *(Check all that apply)*
☐ Free (No Charge) ☐ Donations ☐ Standard Fee ☐ Sliding Scale

Fee Amounts: *(Details of above, such as general fee ranges; qualifications for sliding scale; etc.)*

Insurance Accepted: *(Check all that apply)*

☐None / Not Applicable	☐ Long Term Care Insurance	☐ Health Insurance
☐ Veterans Administration	☐ Medicaid	☐ Private Pay
☐ Medicare	☐Other (Explain in Payment Notes)	

Payment Notes: *(Other insurance from above; acceptance of checks, credit cards, etc.; billing)*

Capacity Limitations: *(Number of beds / units in the facility; variables such as availability of funds or staff; seasonal restrictions; etc.)*

Waiting List: ☐ Yes ☐ No ☐ Check with Agency

Languages Spoken: *(If different from agency)*

Grievance Process: *(If a consumer has a concern or complaint about this service or your agency, whom should they contact and what steps should they take to resolve the situation?)*

Service Information: *(Only if different from those already provided)*
Contact Name and/or Position:
Phone:
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Update Contact: *(Person best suited to ensuring the accuracy of this information)*
Name:
Position Title:
Email:
Phone:
Fax: