[MS 0787.004.020.001]

Do not fill in. COMMUNITY CONTACT SERVICES use only.

AC# _____ ALPHA _____

For our information only, this is not included in the data printout.

DATE FORM COMPLETED 02/20/74

NAME AND PHONE # OF PERSON COMPLETING FORM David M. Cueny 238-1121

This information found in the first five lines of the data printout.

FULL NAME OF AGENCY, GROUP, ORGANIZATION OR INDIVIDUAL: COMMUNITY CONTACT SERVICES

STREET ADDRESS: 1194 Broadway

CITY: San Diego STATE: CA ZIP CODE: 92101

MAILING ADDRESS: P.O. Box 2671

CITY: San Diego STATE: CA ZIP CODE: 92112

NEW INFORMATION Does not appear in the printout.

IF THE ORGANIZATION LISTED ABOVE IS PART OF SOME OTHER ORGANIZATION (I.E., IS A PROJECT, PROGRAM, DEPARTMENT, DIVISION, ETC.,) PLEASE WRITE THE NAME OF THE "PARENT" ORGANIZATION BELOW.

United Way of San Diego County

Found listed in two places in the printout: PHONE NO. and ADDITIONAL PHONE(S): (in the ADDITIONAL INFORMATION section)

TELEPHONE NUMBERS MAIN (714) 238 - 1121 (Area Code)

OTHERS: Please identify what these numbers are for in this space.

(714) 238 - 1111	GuideLine - problem-solving, crisis intervention, I&R
(714) 238 - 0992	GuideLine - office business
(714) 238 - 1120	ReSource
( ) -	

NEW INFORMATION Does not appear in the printout.

Does the organization have ramps, elevators, etc., to accomodate clients in wheelchairs?

___ YES X NO (If yes, what?) we are on the street floor, entrance to sidewalk

Are there any physical obstacles, such as steps, which would deter or hinder persons with any walking disabilities?

___ YES X NO (If yes, what?)

Found after title PERSON IN CHARGE: in data print out.

NAME OF PERSON IN CHARGE (Director, chief, head, etc.) David M. Cueny

NEW INFORMATION not in data print out.

HIS/HER TITLE Facilitator

Found under titles OPERATION HOURS - - - DAYS and ADDITIONAL HOURS/DAYS: (in the ADDITIONAL INFORMATION section)

OFFICE HOURS/DAYS HOURS: From- 8:00 To- 4:30 DAYS: From- MO To- FR

OTHER HOURS/DAYS **Please state what these hours/days are for here→

HOURS: From- To- DAYS: From- To-

HOURS: From- To- DAYS: From- To-

HOURS: From- To- DAYS: From- To-

HOURS: From- To- DAYS: From- To-

IF THERE IS ANY OTHER INFORMATION ABOUT YOUR HOURS/DAYS OF OPERATION WE SHOULD KNOW ABOUT, TELL US HERE.

PLEASE CHECK THE HOLIDAYS YOU ARE CLOSED.

- ___ no holidays
- X New Years Day
- ___ Lincoln's Birthday
- X Washington's Birthday
- ___ Good Friday
- X May, Memorial Day
- X July 4, Independence Day
- X Labor Day
- ___ Calif. Admission Day
- ___ Columbus Day
- ___ Veterans Day
- ___ Election days
- X Christmas
- X other, please specify: Thanksgiving

Found after title ORGANIZATION TYPE: in data print out.

ARE YOU? (Please check)

(A) ___ an individual

(B) ___ a public (governmental) organization

(C) ___ a private, non-profit, religious or sectarian organization

(D) ___ a private, non-profit, non-sectarian organization

(E) ___ a private, proprietary (profit-making) organization

(F) X other (please explain below)

part of a private, non-profit, non-sectarian organization

REFERRALS IN: I. What are the three largest sources of referrals to your organization? (Include self and family referrals.)

1. Public Welfare Dept., SD Co 2. telephone directory (self) 3. Probation Dept., SD Co

II. List three organizations who do not or who infrequently refer clients to you, but whose clients could benefit from your services.

1. private practitioners 2. schools 3. Volunteer Bureau

REFERRALS OUT: I. List three organizations to which you most frequently refer clients.

1. Public Welfare Dept., SD Co 2. Free clinics/County Health Dept. Clinics 3. Family Services Assn.

II. List services which do not exist (or which you don't know about) or which you cannot obtain for clients, but which would be of benefit to the persons you serve.

1. financial aid 2. transportation 3. housing

NEW INFORMATION
not in data print out.

* *

REPORTING: X We keep all information on our clients strictly confidential.

____ We can and will furnish reports to other agencies on request.

____ We can and will furnish reports only under the following conditions:

____

____

If this information does not apply to minors (under 18 years of age), please record differences.

NEW INFORMATION
not in data print out.

* *

LICENSES, PERMITS, PERMISSION, ETC. - What we're trying to find out here is what is required of various agencies in order for them to provide services.

IF ANY LICENSES AND/OR PERMITS ARE REQUIRED:

Name of license or permit	Issued by	Required by

IF NOT: By what authority do you operate? OR Did you have to obtain permission or ? in order to operate? (E.G., non-profit incorporation, tax-exempt status, zoning special-use permit, zoning re-classification, etc.)

At present, we are a part of an organization with a tax-exempt, non-profit status. As such, we also have this status.

NEW INFORMATION
not in data print out.

List any languages besides English which are spoken by persons in the organization. Do not include languages which are spoken by persons who are not available to clients or other helping agencies.

Spanish, French

Found after title
LANGUAGES BESIDES ENGLISH:
in data print out.
(in ADDITIONAL INFORMATION section)

* *

WRITE A DESCRIPTION OR STATEMENT OF THE GENERAL GOAL(S) OF THE ORGANIZATION. (Think of a sentence which begins "We exist in order to. . ." Begin writing your statement with the word To.

To enhance the level of functioning of community individuals, groups and agencies through the innovative use of communication tools and technology and through the process of gathering, processing, storing and disseminating information.

Found after title
FUNCTION:
in data print out.
(in ADDITIONAL INFORMATION section)

Found after title VOLUNTEER PROGRAM INFORMATION in the data print out.

IF YOUR ORGANIZATION HAS A VOLUNTEER PROGRAM, PLEASE COMPLETE THIS PAGE. IF NOT, SKIP IT AND GO ON.

(Fill in or check, as appropriate.)

16 is the minimum age the organization will accept a volunteer.

X Yes, we will accept a volunteer over the age of 60.

X Yes, we will accept a volunteer assigned by a court.

X Yes, we will accept a volunteer who is serving in the military.

____ Yes, a potential volunteer should have his/her own car.

SEX LIMITATIONS FOR A VOLUNTEER: ____ Males only ____ Females only OR X no limitation

X Yes, we are active with the Volunteer Bureau of San Diego. (or other city, if applies)

X Yes, we have a memo of understanding with the RSVP Program.

X Yes, we have a volunteer training program.

NAME OF VOLUNTEER COORDINATOR Maria Erickson/Brian Dugan (GuideLine/ReSource)

WE USE VOLUNTEERS FROM- 8:00 TO- 4:30 (Hours) FROM- MO TO- FR (Days)

WHAT DO YOUR VOLUNTEERS DO? (Use the space below. Describe in your own way.)

clerical work
operate Travelers' Switchboard
applied research/information-gathering
crisis intervention counseling/problem-solving

ANYTHING WE DIDN'T ASK ABOUT YOUR VOLUNTEER PROGRAM THAT WE SHOULD KNOW?

The selection process for volunteers is relatively stringent.

EW INFORMATION or found in printout.

BUDGET INFORMATION

The total budget amount (FY 1973-4) for this organization is $ 98,096

Breakdown of the above figure:

Source of funds	Amount	This figure represents - contract, allocation grant, fee income, etc. ? ? ?	Length or term of this income (no. of months)	Start/Stop Dates Mo-Yr/Mo-Yr	If earma please specify what for
United Way	47,515	allocation	12	7-73/6-74	
Revenue Sharing	10,620	contract	7	12-73/6-74	
public	28,000	income from sales of directory	N/A	N/A	production and publicatio of directory

In-kind service or equipment agreements

Source	Amount	Type of service/equipment	Length or term (no. of months)	Start/Stop Dates Mo-Yr/Mo-Yr
United Way	XXX	office space, use of computer	12	7-73/6-74
Management Planning Program, Human Resources Agency, San Diego County	11,961	programmer/ analyst	9	1-74/9-74

NEW INFORMATION
not in data print out.

****OPTIONAL
The space on this page is to give you an opportunity to make any statement you like about the organization being described. This section will be called "Agency Statement" and will be recorded verbatim. Space is limited, so please try to restrict yourself to ± 100 words.

Community resources are people, time, energy, skills, ideas, services, things, money, space and information. In every community, these resources are available, but often there is little or no connection between the source and the need. In San Diego County this is particularly apparent as many persons do not receive even those services which are available to them, generally because of a lack of knowledge of those services.

In addition, planners, service providers, the makers of public policy and others are actively seeking information to aid them in their work. At the present time, the means for obtaining active, sustained consumer input for planning and other purposes are inadequate.

Community Contact Services consists of four interrelated components:

1. GuideLine
2. ReSource
3. Contact Communications
4. Community Development Consultation Service

All of these are involved in activities centered around data-gathering, information dissemination and communications. The clients of CCS may be individuals, groups or organizations concerned with human care services - both those seeking services and the planners and providers of services.

ON THIS PAGE, PLEASE DESCRIBE IN DETAIL THE SERVICES YOU OFFER TO INDIVIDUALS, TO GROUPS OR TO OTHER ORGANIZATIONS. PLEASE NUMBER EACH ONE FOR LATER REFERENCE. (We ask you to describe in detail so that we can be sure of identifying exactly what you do.) ATTACH OTHER SHEETS IF YOU NEED THEM.

This information, adapted to our Service Identification System, is found after the title: TYPES OF SERVICE AVAILABLE? and after the title SERVICES: or ADDITIONAL SERVICES: (in the ADDITIONAL INFORMATION section) of the data printout.

PLEASE double-check your data printout to be sure that the information is correct.

Your Service Numbers	The Name You Use For This Service	Detailed Description of Service	Average number of persons served per month
1	GuideLine	Provides basic counseling services related to crisis intervention, problem-identification, problem-solving and referrals. Provides community resource information and referrals to individuals, groups and agencies. Operates a telephone "hot-line". Operates a walk-in service. Operates a Travelers' Switchboard. Keeps records on each contact made, the type of request, the type of service provided by GuideLine, the course of action (including referral, if any), and the results, if available. Informs individuals, groups and agencies of courses of action to assist them in achieving their objectives. Provides training in information and referral to community groups. Interprets the GuideLine services to the community.	650
2	ReSource	Collects and prepares data for data-processing. Implements the data-processing system design in conjunction with electronic data-processing personnel. Provides data and information to those requesting it, including, but not limited to, the other components of Community Contact Services. Provides training in information-gathering and compiling, development of resource files and other related training.	25*

3	Contact Communications	Prepares and distributes resource directories of various types to individuals, groups and agencies requesting them. Prepares and distributes information to the public about Community Contact Services.	N/A** see below
4	Community Development Consultation Service	Assists with people-mobilization and coalition-building. Provides assistance with proposal-writing. Provides consultation assistance upon requests from individuals, groups and agencies with regard to the following: funding; resource procurement and development; information-gathering, use and dissemination; social change and community organization; various community processes; public education; organizational development and style; voluntary action; and other areas according to requests and available expertise.	30***

* The ReSource client count represents organizations, not individuals.

** At the present time, Contact Communications produces printed materials only. No client count per se is kept.

*** The average given here is somewhat misleading. During certain times of the year, such as prior to United Way funding processes, many more individuals and groups are assisted. At other times, few requests for this service are received.

SPECIFIC SERVICE INFORMATION — Page 5-1

These packets are used to provide more information on each of the services you have identified on Page 8.

- If information in this packet refers to more than one service, list your service numbers for those to which it applies.
- If the same information applies to all of your services, just say so and complete only one packet.

SERVICES TO WHICH THE FOLLOWING INFORMATION APPLIES:

(List your service numbers.) 1 GuideLine

Found after title CONTACT: (in ADDITIONAL INFORMATION section)

What is the title or name (whichever is appropriate) of the person to whom one would refer or inquire regarding intake? (If more than one, list more than one.)

any GuideLine counselor

Found after title INTAKE PROCEDURE: (in ADDITIONAL INFORMATION section)

Write a brief description of the intake procedure.

Phone, walk in and/or write.

Found after title FEE STRUCTURE: in the printout.

What is the fee structure for this service or these services?

X NO FEES CHARGED ____ VARIABLE FEES, SLIDING SCALE ____ FIXED FEE SCHEDULE

NEW INFORMATION not found in printout.

What happens to a prospective client for this service if he/she has no money?

The client is served.

If you have a listing of the exact fees charged, please include this with the questionnaire when you return it.

OR Make a statement about your fee schedule below.

N/A

found after title INSURANCE INFORMATION: in the printout.

If any types of insurance are accepted for this service, please respond below.

(1)____will take Medi-Cal only (5)____will take Medi-Cal & CHAMPUS

(2)____will take Medicare only (6)____will take Medicare & CHAMPUS

(3)____will take CHAMPUS only (7)____will take Medi-Cal, Medicare & CHAMPUS

(4)____will take Medi-Cal & Medicare (*)____Other, please specify

_____

NEW INFORMATION not found in printout.

Is this service __X__directly provided by your staff?

____purchased from another organization?

May persons be required to use your services? (E.G., mandatory referral from a court.)

____YES __X__NO

Is a client for this service required to be a client for services from or benefits from some other organization or program? (E.G., Medicare, Social Security Administration, Department of Public Welfare.)

____YES __X__NO

If YES, explain below.

ON THE NEXT PAGE and the page which follows it are questions dealing with limitations to the service(s) you are offering. Later, we will ask other questions dealing with the target population for whom the service(s) is intended. KEEP IN MIND, the two pages which follow deal with limitations or restrictions.

found after title SERVICE LIMITATIONS: and specific titles used on this form.

SERVICE LIMITATIONS OR RESTRICTIONS TO SERVICE PROVISION
(Check or fill in, as appropriate.)

SEX: ____Males only ____Females only OR __X__no limitations as to sex

AGE: Will serve persons from age _____ through age _____. OR __X__ age not a limiting factor

ETHNIC: Is the service generally limited to a particular ethnic group? (If not, skip this question.)

(B)____Yes, for Blacks.

(T)____Yes, for Hispanos

(A)____Yes, for Asian-Americans.

(P)____Yes, for Pilipino-Americans.

(N)____Yes, for American Indians.

(W)____Yes, for Whites excluding Hispanos.

(*)____Yes, but your groupings don't make sense for this service.
(If you checked the above choice, please help us make sense of our groupings by naming the group here _____.)

MILITARY: Is the service generally limited to those with some military connection?
(If not, skip this question.)

(N)____Yes, Navy. (C)____Yes, Coast Guard.

(A)____Yes, Army. (D)____Yes, for dependents only.

(F)____Yes, Air Force. (V)____Yes, for veterans only.

(M)____Yes, Marines. (*)____Yes, but the connection cannot be specified according to your classifications.
(If you checked the above choice, please specify here _____.)

NEW INFORMATION not found in printout.

EDUCATION: Are there any educational requirements for service in this program?
(If not, skip this question.)

Yes, a minimum of _____ years. Yes, a maximum of _____ years.

____Yes, a degree. (Specify)_____

____Yes, other. (Specify)_____

MARITAL STATUS: __X__not a factor

____never married ____married ____separated ____divorced ____widowed

HEALTH: Are there specific health conditions which would disqualify a person for this service?
If YES, please state. If NO, skip this question.

NO

This information has not been asked in this way before. Related information found in section titled GEOGRAPHIC AREA(S) SERVED; in the printout.

GEOGRAPHY: Must applicants for this service come from a specific geographic area? If so, please describe the area. (E.G., name of city, boundaries, etc.)

If there are length-of-residence requirements, please respond.

Where:______________________________ How long (in months):______

If there is a requirement for legal residence, please respond.

Where:______________________________

What is needed to establish this residence?

____

* *

Found after title ADDITIONAL LIMITATIONS; (in ADDITIONAL INFORMATION section)

If there are any additional limitations or restrictions to this service, please list here.

* *

NEW INFORMATION not found in printout.

If there are sometimes exceptions made to the ongoing requirements for service, please list the types of exceptions which are made.

* *

ON THE NEXT PAGE we will be trying to identify the problems or conditions affecting people in our community. By relating this information directly to the services which are designed to impact the problems or conditions, we hope to identify our community's problem-solving system.

Please check the statement which best describes this service. (OR, if none of them seem to apply, write your own.)

____(A) provision of minimum essentials for living

____(B) guidance and/or promotion of normal personal and social development

____(C) restoration of physical and/or social functioning - rehabilitation

____(D) prevention of damage - social protection - prevention of physical dysfunction

____(E) enrichment or enhancement of quality of life and living - development to fullest potential

____(F) social and/or health planning - community development

__X__(G) (Write your own.) problem-solving counseling & information

All NEW INFORMATION not found in printout.

PROBLEM IDENTIFICATION

1. Considering the response you made to the last question on the preceding page, what is condition affecting individuals, groups or the community which you are trying to impact through this service? (e.g., jail recidivism, substance abuse, sickle-cell anemia, marital discord, etc.)

   Lack of knowledge about resources.

   Secondarily, lack of knowledge about analyzing and solving problems.

2. What is the extent or severity of this condition? (If you have available figures to substantiate this, they would be most helpful. If not, don't worry. If we can't find this out from you, we will try to find out for you.)

   The problem is relatively severe. A pilot study conducted in the Kearny Mesa area showed that information needs were the number two needs cited. A recent study of senior citizens showed that the major problem confronting seniors was not emotional dependency, but a lack of access to current information and information systems.

3. As far as this service is concerned, where (geographically) does this condition exist? (Describe the geographical area in your own words.)

   Primary service area, San Diego County. The problem exists everywhere, so cases accepted regardless of geography.

4. Aside from the problem you have described above, what are some of the typical problems of clients who are receiving this service? Include those which you do not deal with.

   Financial aid, housing and transportation.

* *

ON THE NEXT THREE PAGES we are asking you to describe the Target Population, the persons for whom this service was designed. REMEMBER, this is not the group to whom the service is restricted, but for whom it is intended.

All of the information being collected in this section is NEW INFORMATION, and will not be found in the data print out.

TARGET POPULATION

(Check appropriate items.)

Sex: X (Ø) not an identifying factor

____(M) males

____(F) females

Ethnic Background: X (Ø) not a limiting factor

____(B) Blacks

____(T) Hispanos

____(A) Asian-Americans

____(P) Pilipino-Americans

____(N) American Indians

____(W) Whites, excluding Hispanos

____(*) Other, please specify _____

Age: X (Ø) not a limiting factor

____(A) under 3

____(B) 3 - 4

____(C) 5

____(D) 6

____(E) 7 - 9

____(F) 10 - 13

____(G) 14

____(H) 15

____(J) 16

____(K) 17

____(L) 18

____(M) 19

____(N) 20

____(P) 21

____(R) 22 - 24

____(S) 25 - 34

____(T) 35 - 44

____(U) 45 - 54

____(V) 55 - 59

____(W) 60 - 64

____(X) 65 - 74

____(Y) 75 and over

Employment: X (Ø) not a limiting factor

____(A) employed ____(B) underemployed ____(C) unemployed

Skill level: X (Ø) not a limiting factor

____(A) unskilled ____(B) semi-skilled ____(C) skilled

All of the information being collected in this section is NEW INFORMATION, and will not be found in the data print out.

Education: X (Ø) not a limiting factor

A. (for persons aged 3-34 years) If must be presently enrolled,

____(A) in nursery school

____(B) in kindergarten

____(C) in elementary school

____(D) in high school

____(E) in college

B. (for persons age 24 or less, not currently enrolled) If must have completed

____(A) grades 1-4

____(B) grades 5-7

____(C) grade 8

____(D) grades 9-11

____(E) grade 12 or more

C. (for persons age 25 and over) If must have completed

____(A) grades 1-4

____(B) grades 5-7

____(C) grade 8

____(D) grades 9-11

____(E) grade 12 or more

D. Degrees/Certificates, if required

____(A) high school

____(B) AA

____(C) BA/BS

____(D) Trade school

____(E) Other, please specify _____

Income levels - please indicate the percentage of your client population which falls into the categories in each table.

A. Poverty level - Manpower Administration guidelines

	Family size	Income
8 %	(A) 1	$2,200
2 %	(B) 2	2,900
15 %	(C) 3	3,600
15 %	(D) 4	4,300
4 %	(E) 5	5,000
3 %	(F) 6	5,700
3 %	(G) 7	6,400

B. (General) Overall income levels

7 % (A) less than $1,000

3 % (B) 1,000-2,999

30 % (C) 3,000-4,999

12 % (D) 5,000-6,999

12 % (E) 7,000-8,999

10 % (F) 9,000-9,999

13 % (G) 10,000-11,999

5 % (H) 12,000-14,999

4 % (J) 15,000-19,999

2 % (K) 20,000-24,999

2 % (L) 25,000 or more

All of the information being collected in this section is NEW INFORMATION and will not be found in the printout.

Special Characteristics: __X__ (Ø) not a limiting factor

____(A) Physically handicapped

____(B) Mentally handicapped

____(C) Drug misusers or abusers

____(D) Alcoholics

____(E) Ex-offenders

____(F) Single parents with dependent children

____(G) Youths with disciplinary problems

____(H) Out-of-school youth

____(J) Other - please specify____________________

All NEW INFORMATION not found in printout.

SERVICE BUDGET

Of the total budget amount quoted on Page 6, how much is used to fund this service?

$ 23,938

What are the sources of these funds? (Just list the names.)

United Way, Revenue Sharing

* *

GEOGRAPHICAL DISTRIBUTION OF CLIENTS - Please indicate the percentage of your client population which falls into the listed categories.

What percentage of your clients come from a radius of:

__15__ % (A) 2 miles or less

__15__ % (B) 2-5 miles

__45__ % (C) 5-10 miles

__30__ % (D) more than 10 miles

* *

SERVICE AREA BY CENSUS TRACTS - We need to know which census tracts are included in the area in which this service is offered. We are offering you some alternatives for this response since so few of us know census tracts (even the ones where we live). Please indicate which alternative you chose.

__X__ There are no geographical restrictions; our service area is unlimited.

_____ We serve the entire county, so we didn't use any map.

_____ We used MAP A.

_____ We used one of the smaller maps (or two, or more.)

Which one or ones?____________________

OR

If you do have a service area, but none of the above alternatives help to describe it, please describe below. For example: the name of a school district, the name of a city, the names of the streets on the boundaries, a catchment area, etc., will do fine. Use the space below.

SPECIFIC SERVICE INFORMATION

These packets are used to provide more information on each of the services you have identified on Page 8.

-If information in this packet refers to more than one service, list your service numbers for those to which it applies.

-If the same information applies to all of your services, just say so and complete only one packet.

SERVICES TO WHICH THE FOLLOWING INFORMATION APPLIES:

(List your service numbers.) 2 ReSource

****

Found after title CONTACT: (in ADDITIONAL INFORMATION section)

What is the title or name (whichever is appropriate) of the person to whom one would refer or inquire regarding intake? (If more than one, list more than one.)

Brian Dugan

****

Found after title INTAKE PROCEDURE: (in ADDITIONAL INFORMATION section)

Write a brief description of the intake procedure.

Phone, walk in or write.

****

Found after title FEE STRUCTURE: in the printout.

What is the fee structure for this service or these services?

____NO FEES CHARGED X VARIABLE FEES, SLIDING SCALE ____FIXED FEE SCHEDULE

****

NEW INFORMATION not found in printout.

What happens to a prospective client for this service if he/she has no money?

Insofar as finances will allow, service is provided.

If you have a listing of the exact fees charged, please include this with the questionnaire when you return it.

OR Make a statement about your fee schedule below.

A charge is made for lengthy data printouts. This varies according to length and complexity.

Found after title INSURANCE INFORMATION: in the printout.

If any types of insurance are accepted for this service, please respond below.

(1)____will take Medi-Cal only (5)____will take Medi-Cal & CHAMPUS

(2)____will take Medicare only (6)____will take Medicare & CHAMPUS N/A

(3)____will take CHAMPUS only (7)____will take Medi-Cal, Medicare & CHAMPUS

(4)____will take Medi-Cal & Medicare (*)____Other, please specify

****

NEW INFORMATION not found in printout.

Is this service X directly provided by your staff?

____purchased from another organization?

May persons be required to use your services? (E.G., mandatory referral from a court.)

____YES X NO

Is a client for this service required to be a client for services from or benefits from some other organization or program? (E.G., Medicare, Social Security Administration, Department of Public Welfare.)

____YES X NO

If YES, explain below.

****

ON THE NEXT PAGE and the page which follows it are questions dealing with limitations to the service(s) you are offering. Later, we will ask other questions dealing with the target population for whom the service(s) is intended. KEEP IN MIND, the two pages which follow deal with limitations or restrictions.

Found after title SERVICE LIMITATIONS: and specific titles used on this form.

SERVICE LIMITATIONS OR RESTRICTIONS TO SERVICE PROVISION
(Check or fill in, as appropriate.)

SEX: ____Males only ____Females only OR X no limitations as to sex

AGE: Will serve persons from age _____ through age _____. OR X age not a limiting factor

ETHNIC: Is the service generally limited to a particular ethnic group? (If not, skip this question.)

(B)____Yes, for Blacks.

(T)____Yes, for Hispanos

(A)____Yes, for Asian-Americans.

(P)____Yes, for Pilipino-Americans.

(N)____Yes, for American Indians.

(W)____Yes, for Whites excluding Hispanos.

(*)____Yes, but your groupings don't make sense for this service.
(If you checked the above choice, please help us make sense of our groupings by naming the group here _____.)

MILITARY: Is the service generally limited to those with some military connection? (If not, skip this question.)

(N)____Yes, Navy.

(A)____Yes, Army.

(F)____Yes, Air Force.

(M)____Yes, Marines.

(C)____Yes, Coast Guard.

(D)____Yes, for dependents only.

(V)____Yes, for veterans only.

(*)____Yes, but the connection cannot be specified according to your classifications.
(If you checked the above choice, please specify here _____.)

NEW INFORMATION not found in printout.

EDUCATION: Are there any educational requirements for service in this program? (If not, skip this question.)

Yes, a minimum of _____ years. Yes, a maximum of _____ years.

____Yes, a degree. (Specify)_____

____Yes, other. (Specify)_____

MARITAL STATUS: X not a factor

____never married ____married ____separated ____divorced ____widowed

HEALTH: Are there specific health conditions which would disqualify a person for this service? If YES, please state. If NO, skip this question.

No

This information has not been asked in this way before. Related information found in section titled GEOGRAPHIC AREA(S) SERVED: in the printout.

GEOGRAPHY: Must applicants for this service come from a specific geographic area? If so, please describe the area. (E.G., name of city, boundaries, etc.)

No

If there are length-of-residence requirements, please respond.

Where:_____ How long (in months):_____

If there is a requirement for legal residence, please respond.

Where:_____

What is needed to establish this residence?

_____

Found after title ADDITIONAL LIMITATIONS: (in ADDITIONAL INFORMATION section)

If there are any additional limitations or restrictions to this service, please list here.

N/A

NEW INFORMATION not found in printout.

If there are sometimes exceptions made to the ongoing requirements for service, please list the types of exceptions which are made.

N/A

ON THE NEXT PAGE we will be trying to identify the problems or conditions affecting people in our community. By relating this information directly to the services which are designed to impact the problems or conditions, we hope to identify our community's problem-solving system.

Please check the statement which best describes this service. (OR, if none of them seem to apply, write your own.)

____(A) provision of minimum essentials for living

____(B) guidance and/or promotion of normal personal and social development

____(C) restoration of physical and/or social functioning - rehabilitation

____(D) prevention of damage - social protection - prevention of physical dysfunction

____(E) enrichment or enhancement of quality of life and living - development to fullest potential

X (F) social and/or health planning - community development

____(G) (Write your own.)

All
NEW INFORMATION
not found in printout.

PROBLEM IDENTIFICATION

1. Considering the response you made to the last question on the preceding page, what is condition affecting individuals, groups or the community which you are trying to impact through this service? (e.g., jail recidivism, substance abuse, sickle-cell anemia, marital discord, etc.)

 1. (Organizations only) lack of information about resources.
 2. Inadequate knowledge about how to deal with information and informational problems.

2. What is the extent or severity of this condition? (If you have available figures to substantiate this, they would be most helpful. If not, don't worry. If we can't find this our from you, we will try to find out for you.)

 Varies with organization requesting service.

3. As far as this service is concerned, where (geographically) does this condition exist? (Describe the geographical area in your own words.)

 San Diego County

4. Aside from the problem you have described above, what are some of the typical problems of clients who are receiving this service? Include those which you do not deal with.

 N/A

* *

ON THE NEXT THREE PAGES we are asking you to describe the Target Population, the persons for whom this service was designed. REMEMBER, this is not the group to whom the service is restricted, but for whom it is intended.

All of the information being collected in this section is
NEW INFORMATION,
and will not be found in the data print out.

TARGET POPULATION

(Check appropriate items.)

Sex: _X_(Ø) not an identifying factor

____(M) males

____(F) females

Ethnic Background: _X_(Ø) not a limiting factor

____(B) Blacks	____(N) American Indians
____(T) Hispanos	____(W) Whites, excluding Hispanos
____(A) Asian-Americans	____(*) Other, please specify ________
____(P) Pilipino-Americans	

Age: _X_(Ø) not a limiting factor

____(A) under 3	____(M) 19
____(B) 3 - 4	____(N) 20
____(C) 5	____(P) 21
____(D) 6	____(R) 22 - 24
____(E) 7 - 9	____(S) 25 - 34
____(F) 10 - 13	____(T) 35 - 44
____(G) 14	____(U) 45 - 54
____(H) 15	____(V) 55 - 59
____(J) 16	____(W) 60 - 64
____(K) 17	____(X) 65 - 74
____(L) 18	____(Y) 75 and over

Employment: _X_(Ø) not a limiting factor

____(A) employed ____(B) underemployed ____(C) unemployed

Skill level: _X_(Ø) not a limiting factor

____(A) unskilled ____(B) semi-skilled ____(C) skilled

All of the information being collected in this section is NEW INFORMATION, and will not be found in the data print out.

Education: __X__ (Ø) not a limiting factor

A. (for persons aged 3-34 years) If must be presently enrolled,

____(A) in nursery school

____(B) in kindergarten

____(C) in elementary school

____(D) in high school

____(E) in college

B. (for persons age 24 or less, not currently enrolled) If must have completed

____(A) grades 1-4

____(B) grades 5-7

____(C) grade 8

____(D) grades 9-11

____(E) grade 12 or more

C. (for persons age 25 and over) If must have completed

____(A) grades 1-4

____(B) grades 5-7

____(C) grade 8

____(D) grades 9-11

____(E) grade 12 or more

D. Degrees/Certificates, if required

____(A) high school

____(B) AA

____(C) BA/BS

____(D) Trade school

____(E) Other, please specify _____

Income levels - please indicate the percentage of your client population which falls into the categories in each table.

A. Poverty level - Manpower Administration guidelines

N/A

	Family size	Income
____%(A)	1	$2,200
____%(B)	2	2,900
____%(C)	3	3,600
____%(D)	4	4,300
____%(E)	5	5,000
____%(F)	6	5,700
____%(G)	7	6,400

B. (General) Overall income levels

____% (A) less than $1,000

____% (B) 1,000-2,999

____% (C) 3,000-4,999

____% (D) 5,000-6,999

____% (E) 7,000-8,999

____% (F) 9,000-9,999

____% (G) 10,000-11,999

____% (H) 12,000-14,999

____% (J) 15,000-19,999

____% (K) 20,000-24,999

____% (L) 25,000 or more

All of the information being collected in this section is NEW INFORMATION and will not be found in the printout.

Special Characteristics: ____(Ø) not a limiting factor

____(A) Physically handicapped

____(B) Mentally handicapped

____(C) Drug misusers or abusers

____(D) Alcoholics

____(E) Ex-offenders

____(F) Single parents with dependent children

____(G) Youths with disciplinary problems

____(H) Out-of-school youth

__X__ (J) Other - please specify organizations

All
NEW INFORMATION
not found in printout.

SERVICE BUDGET

Of the total budget amount quoted on Page 6, how much is used to fund this service?

$ 21,379

What are the sources of these funds? (Just list the names.)

United Way, Revenue Sharing, Management Planning Program

* *

GEOGRAPHICAL DISTRIBUTION OF CLIENTS - Please indicate the percentage of your client population which falls into the listed categories.

What percentage of your clients come from a radius of:

25 % (A) 2 miles or less

25 % (B) 2-5 miles

25 % (C) 5-10 miles

25 % (D) more than 10 miles

* *

SERVICE AREA BY CENSUS TRACTS - We need to know which census tracts are included in the area in which this service is offered. We are offering you some alternatives for this response since so few of us know census tracts (even the ones where we live). Please indicate which alternative you chose.

X There are no geographical restrictions; our service area is unlimited.

____ We serve the entire county, so we didn't use any map.

____ We used MAP A.

____ We used one of the smaller maps (or two, or more.)

Which one or ones? ________________

OR

If you do have a service area, but none of the above alternatives help to describe it, please describe below. For example: the name of a school district, the name of a city, the names of the streets on the boundaries, a catchment area, etc., will do fine. Use the space below.

SPECIFIC SERVICE INFORMATION

These packets are used to provide more information on each of the services you have identified on Page 6.

- If information in this packet refers to more than one service, list your service numbers for those to which it applies.

- If the same information applies to all of your services, just say so and complete only one packet.

SERVICES TO WHICH THE FOLLOWING INFORMATION APPLIES:

(List your service numbers.) 3 Contact Communications

* *

Found after title
CONTACT:
(in ADDITIONAL INFORMATION section)

What is the title or name (whichever is appropriate) of the person to whom one would refer or inquire regarding intake? (If more than one, list more than one.)

David Cueny

* *

Found after title
INTAKE PROCEDURE:
(in ADDITIONAL INFORMATION section)

Write a brief description of the intake procedure.

Phone, walk in or write.

* *

Found after title
FEE STRUCTURE:
in the printout.

What is the fee structure for this service or these services?

____ NO FEES CHARGED X VARIABLE FEES, SLIDING SCALE ____ FIXED FEE SCHEDULE

* *

NEW INFORMATION
not found in printout.

What happens to a prospective client for this service if he/she has no money?

Insofar as finances will allow, service is provided.

If you have a listing of the exact fees charged, please include this with the questionnaire when you return it.

OR Make a statement about your fee schedule below.

Fees for services vary according to the form the information dissemination takes - lecture, workshop, seminar, pamphlet, computer printout, publication, etc. The general directory of resource information, for example, costs $7.50 per year for two issues of approximately 550 pages each.

Found after title INSURANCE INFORMATION: in the printout.

If any types of insurance are accepted for this service, please respond below.

(1)____will take Medi-Cal only (5)____will take Medi-Cal & CHAMPUS

(2)____will take Medicare only (6)____will take Medicare & CHAMPUS N/A

(3)____will take CHAMPUS only (7)____will take Medi-Cal, Medicare & CHAMPUS

(4)____will take Medi-Cal & Medicare (*)____Other, please specify

____

* *

NEW INFORMATION not found in printout.

Is this service _X_ directly provided by your staff?

____purchased from another organization?

May persons be required to use your services? (E.G., mandatory referral from a court.)

____YES _X_ NO

Is a client for this service required to be a client for services from or benefits from some other organization or program? (E.G., Medicare, Social Security Administration, Department of Public Welfare.)

____YES _X_ NO
If YES, explain below.

* *

ON THE NEXT PAGE and the page which follows it are questions dealing with limitations to the service(s) you are offering. Later, we will ask other questions dealing with the target population for whom the service(s) is intended. KEEP IN MIND, the two pages which follow deal with limitations or restrictions.

Found after title SERVICE LIMITATIONS: and specific titles used on this form.

SERVICE LIMITATIONS OR RESTRICTIONS TO SERVICE PROVISION
(Check or fill in, as appropriate.)

SEX: ____Males only ____Females only OR _X_ no limitations as to sex

AGE: Will serve persons from age ____ through age ____. OR _X_ age not a limiting factor

ETHNIC: Is the service generally limited to a particular ethnic group? (If not, skip this question.)

(B)____Yes, for Blacks.

(T)____Yes, for Hispanos

(A)____Yes, for Asian-Americans.

(P)____Yes, for Pilipino-Americans.

(N)____Yes, for American Indians.

(W)____Yes, for Whites excluding Hispanos.

(*)____Yes, but your groupings don't make sense for this service.
(If you checked the above choice, please help us make sense of our groupings by naming the group here
________________________________.)

MILITARY: Is the service generally limited to those with some military connection?
(If not, skip this question.)

(N)____Yes, Navy. (C)____Yes, Coast Guard.

(A)____Yes, Army. (D)____Yes, for dependents only.

(F)____Yes, Air Force. (V)____Yes, for veterans only.

(M)____Yes, Marines. (*)____Yes, but the connection cannot be specified according to your classifications. (If you checked the above choice, please specify here
________________________________.)

* *

NEW INFORMATION not found in printout.

EDUCATION: Are there any educational requirements for service in this program?
(If not, skip this question.)

Yes, a minimum of ____ years. Yes, a maximum of ____ years.

____Yes, a degree. (Specify)________________

____Yes, other. (Specify)________________

MARITAL STATUS: _X_ not a factor

____never married ____married ____separated ____divorced ____widowed

HEALTH: Are there specific health conditions which would disqualify a person for this service?
If YES, please state. If NO, skip this question.

No

This information has not been asked in this way before. Related information found in section titled GEOGRAPHIC AREA(S) SERVED: in the printout.

GEOGRAPHY: Must applicants for this service come from a specific geographic area? If so, please describe the area. (E.G., name of city, boundaries, etc.)

No

If there are length-of-residence requirements, please respond.

Where:________________________________ How long (in months):_______

If there is a requirement for legal residence, please respond.

Where:________________________________

What is needed to establish this residence?

____

* *

Found after title ADDITIONAL LIMITATIONS: (in ADDITIONAL INFORMATION section)

If there are any additional limitations or restrictions to this service, please list here.

N/A

* *

NEW INFORMATION not found in printout.

If there are sometimes exceptions made to the ongoing requirements for service, please list the types of exceptions which are made.

N/A

* *

ON THE NEXT PAGE we will be trying to identify the problems or conditions affecting people in our community. By relating this information directly to the services which are designed to impact the problems or conditions, we hope to identify our community's problem-solving system.

Please check the statement which best describes this service. (OR, if none of them seem to apply, write your own.)

____(A) provision of minimum essentials for living

____(B) guidance and/or promotion of normal personal and social development

____(C) restoration of physical and/or social functioning - rehabilitation

____(D) prevention of damage - social protection - prevention of physical dysfunction

____(E) enrichment or enhancement of quality of life and living - development to fullest potential

____(F) social and/or health planning - community development

_X_(G) (Write your own.)

Dissemination or provision of information.

All NEW INFORMATION not found in printout.

PROBLEM IDENTIFICATION

1. Considering the response you made to the last question on the preceding page, what is condition affecting individuals, groups or the community which you are trying to impact through this service? (e.g., jail recidivism, substance abuse, sickle-cell anemia, marital discord, etc.)

   Lack of information about resources and processes in our community.

2. What is the extent or severity of this condition? (If you have available figures to substantiate this, they would be most helpful. If not, don't worry. If we can't find this our from you, we will try to find out for you.)

   Generally severe, especially among certain populations in the county.

3. As far as this service is concerned, where (geographically) does this condition exist? (Describe the geographical area in your own words.)

   San Diego County

4. Aside from the problem you have described above, what are some of the typical problems of clients who are receiving this service? Include those which you do not deal with.

   Lack of money.

* *

ON THE NEXT THREE PAGES we are asking you to describe the Target Population, the persons for whom this service was designed. REMEMBER, this is not the group to whom the service is restricted, but for whom it is intended.

All of the information being collected in this section is NEW INFORMATION, and will not be found in the data print out.

TARGET POPULATION

(Check appropriate items.)

Sex: X (Ø) not an identifying factor

____(M) males

____(F) females

Ethnic Background: X (Ø) not a limiting factor

____(B) Blacks

____(T) Hispanos

____(A) Asian-Americans

____(P) Pilipino-Americans

____(N) American Indians

____(W) Whites, excluding Hispanos

____(*) Other, please specify _____

Age: X (Ø) not a limiting factor

____(A) under 3

____(B) 3 - 4

____(C) 5

____(D) 6

____(E) 7 - 9

____(F) 10 - 13

____(G) 14

____(H) 15

____(J) 16

____(K) 17

____(L) 18

____(M) 19

____(N) 20

____(P) 21

____(R) 22 - 24

____(S) 25 - 34

____(T) 35 - 44

____(U) 45 - 54

____(V) 55 - 59

____(W) 60 - 64

____(X) 65 - 74

____(Y) 75 and over

Employment: X (Ø) not a limiting factor

____(A) employed ____(B) underemployed ____(C) unemployed

Skill level: X (Ø) not a limiting factor

____(A) unskilled ____(B) semi-skilled ____(C) skilled

All of the information being collected in this section is NEW INFORMATION, and will not be found in the data print out.

Education: X (Ø) not a limiting factor

A. (for persons aged 3-34 years) if must be presently enrolled,

____(A) in nursery school

____(B) in kindergarten

____(C) in elementary school

____(D) in high school

____(E) in college

B. (for persons age 24 or less, not currently enrolled) if must have completed

____(A) grades 1-4

____(B) grades 5-7

____(C) grade 8

____(D) grades 9-11

____(E) grade 12 or more

C. (for persons age 25 and over) if must have completed

____(A) grades 1-4

____(B) grades 5-7

____(C) grade 8

____(D) grades 9-11

____(E) grade 12 or more

D. Degrees/Certificates, if required

____(A) high school

____(B) AA

____(C) BA/BS

____(D) Trade school

____(E) Other, please specify _____

Income levels - please indicate the percentage of your client population which falls into the categories in each table.

A. Poverty level - Manpower Administration guidelines

	Family size	Income
4 %(A)	1	$2,200
4 %(B)	2	2,900
5 %(C)	3	3,600
5 %(D)	4	4,300
5 %(E)	5	5,000
4 %(F)	6	5,700
3 %(G)	7	6,400

B. (General) Overall income levels

1 % (A) less than $1,000

7 % (B) 1,000-2,999

10 % (C) 3,000-4,999

15 % (D) 5,000-6,999

15 % (E) 7,000-8,999

10 % (F) 9,000-9,999

10 % (G) 10,000-11,999

10 % (H) 12,000-14,999

10 % (J) 15,000-19,999

6 % (K) 20,000-24,999

6 % (L) 25,000 or more

All of the information being collected in this section is NEW INFORMATION and will not be found in the printout.

Special Characteristics: _X_ (B) not a limiting factor

____ (A) Physically handicapped

____ (B) Mentally handicapped

____ (C) Drug misusers or abusers

____ (D) Alcoholics

____ (E) Ex-offenders

____ (F) Single parents with dependent children

____ (G) Youths with disciplinary problems

____ (H) Out-of-school youth

____ (J) Other - please specify____________________

SAN DIEGO STATE UNIVERSITY 1897

All NEW INFORMATION not found in printout.

SERVICE BUDGET

Of the total budget amount quoted on Page 6, how much is used to fund this service?

$ 32,773

What are the sources of these funds? (Just list the names.)

United Way, Revenue Sharing, subscriptions (the public)

* *

GEOGRAPHICAL DISTRIBUTION OF CLIENTS - Please indicate the percentage of your client population which falls into the listed categories.

What percentage of your clients come from a radius of:

10 % (A) 2 miles or less

25 % (B) 2-5 miles

30 % (C) 5-10 miles

35 % (D) more than 10 miles

* *

SERVICE AREA BY CENSUS TRACTS - We need to know which census tracts are included in the area in which this service is offered. We are offering you some alternatives for this response since so few of us know census tracts (even the ones where we live). Please indicate which alternative you chose.

_X_ There are no geographical restrictions; our service area is unlimited.

____ We serve the entire county, so we didn't use any map.

____ We used MAP A.

____ We used one of the smaller maps (or two, or more.)

Which one or ones?____________________

OR

If you do have a service area, but none of the above alternatives help to describe it, please describe below. For example: the name of a school district, the name of a city, the names of the streets on the boundaries, a catchment area, etc., will do fine. Use the space below.

SPECIFIC SERVICE INFORMATION

These packets are used to provide more information on each of the services you have identified on Page 8.

- If information in this packet refers to more than one service, list your service numbers for those to which it applies.
- If the same information applies to all of your services, just say so and complete only one packet.

SERVICES TO WHICH THE FOLLOWING INFORMATION APPLIES:

(List your service numbers.) 4 Community Development Consultation Service

Found after title CONTACT: (in ADDITIONAL INFORMATION section)

What is the title or name (whichever is appropriate) of the person to whom one would refer or inquire regarding intake? (If more than one, list more than one.)

David Cueny

Found after title INTAKE PROCEDURE: (in ADDITIONAL INFORMATION section)

Write a brief description of the intake procedure.

Phone, walk in or write.

Found after title FEE STRUCTURE: in the printout.

What is the fee structure for this service or these services?

_X_ NO FEES CHARGED ____ VARIABLE FEES, SLIDING SCALE ____ FIXED FEE SCHEDULE

NEW INFORMATION not found in printout.

What happens to a prospective client for this service if he/she has no money?

N/A

If you have a listing of the exact fees charged, please include this with the questionnaire when you return it.

OR Make a statement about your fee schedule below.

N/A

Found after title INSURANCE INFORMATION: in the printout.

If any types of insurance are accepted for this service, please respond below.

(1)____ will take Medi-Cal only (5)____ will take Medi-Cal & CHAMPUS

(2)____ will take Medicare only (6)____ will take Medicare & CHAMPUS N/A

(3)____ will take CHAMPUS only (7)____ will take Medi-Cal, Medicare & CHAMPUS

(4)____ will take Medi-Cal & Medicare (*)____ Other, please specify

NEW INFORMATION not found in printout.

Is this service _X_ directly provided by your staff?

____ purchased from another organization?

May persons be required to use your services? (E.G., mandatory referral from a court.)

____ YES _X_ NO

Is a client for this service required to be a client for services from or benefits from some other organization or program? (E.G., Medicare, Social Security Administration, Department of Public Welfare.)

____ YES _X_ NO

If YES, explain below.

ON THE NEXT PAGE and the page which follows it are questions dealing with limitations to the service(s) you are offering. Later, we will ask other questions dealing with the target population for whom the service(s) is intended. KEEP IN MIND, the two pages which follow deal with limitations or restrictions.

SERVICE LIMITATIONS OR RESTRICTIONS TO SERVICE PROVISION
(Check or fill in, as appropriate.)

Found after title SERVICE LIMITATIONS: and specific titles used on this form.

SEX: ____Males only ____Females only OR _X_ no limitations as to sex

AGE: Will serve persons from age ______ through age ______. OR _X_ age not a limiting factor

ETHNIC: Is the service generally limited to a particular ethnic group? (If not, skip this question.)

(B)____Yes, for Blacks.

(T)____Yes, for Hispanos

(A)____Yes, for Asian-Americans.

(P)____Yes, for Pilipino-Americans.

(N)____Yes, for American Indians.

(W)____Yes, for Whites excluding Hispanos.

(*)____Yes, but your groupings don't make sense for this service.
(If you checked the above choice, please help us make sense of our groupings by naming the group here
____________________.)

MILITARY: Is the service generally limited to those with some military connection?
(If not, skip this question.)

(N)____Yes, Navy. (C)____Yes, Coast Guard.

(A)____Yes, Army. (D)____Yes, for dependents only.

(F)____Yes, Air Force. (V)____Yes, for veterans only.

(M)____Yes, Marines. (*)____Yes, but the connection cannot be specified according to your classifications. (If you checked the above choice, please specify here
____________________.)

* *

NEW INFORMATION not found in printout.

EDUCATION: Are there any educational requirements for service in this program?
(If not, skip this question.)

Yes, a minimum of ______ years. Yes, a maximum of ______ years.

____Yes, a degree. (Specify)____________________

____Yes, other. (Specify)____________________

MARITAL STATUS: _X_ not a factor

____never married ____married ____separated ____divorced ____widowed

HEALTH: Are there specific health conditions which would disqualify a person for this service?
If YES, please state. If NO, skip this question.

This information has not been asked in this way before. Related information found in section titled GEOGRAPHIC AREA(S) SERVED: in the printout.

GEOGRAPHY: Must applicants for this service come from a specific geographic area?
If so, please describe the area. (E.G., name of city, boundaries, etc.)

No

If there are length-of-residence requirements, please respond.

Where:____________________ How long (in months):______

If there is a requirement for legal residence, please respond.

Where:____________________

What is needed to establish this residence?

____

* *

Found after title ADDITIONAL LIMITATIONS: (in ADDITIONAL INFORMATION section)

If there are any additional limitations or restrictions to this service, please list here.

The availability of staff and time are the only limiting factors.

* *

NEW INFORMATION not found in printout.

If there are sometimes exceptions made to the ongoing requirements for service, please list the types of exceptions which are made.

N/A

* *

ON THE NEXT PAGE we will be trying to identify the problems or conditions affecting people in our community. By relating this information directly to the services which are designed to impact the problems or conditions, we hope to identify our community's problem-solving system.

Please check the statement which best describes this service. (OR, if none of them seem to apply, write your own.)

____(A) provision of minimum essentials for living

____(B) guidance and/or promotion of normal personal and social development

____(C) restoration of physical and/or social functioning - rehabilitation

____(D) prevention of damage - social protection - prevention of physical dysfunction

____(E) enrichment or enhancement of quality of life and living - development to fullest potential

_X_(F) social and/or health planning - community development

____(G) (Write your own.)

All
NEW INFORMATION
not found in printout.

PROBLEM IDENTIFICATION

1. Considering the response you made to the last question on the preceding page, what is condition affecting individuals, groups or the community which you are trying to impact through this service? (e.g., jail recidivism, substance abuse, sickle-cell anemia, marital discord, etc.)

   1. Inadequate planning skills and resources.
   2. Minimal access to communications and information.

2. What is the extent or severity of this condition? (If you have available figures to substantiate this, they would be most helpful. If not, don't worry, If we can't find this our from you, we will try to find out for you.)

   Varies greatly according to the group requesting the service.

3. As far as this service is concerned, where (geographically) does this condition exist? (Describe the geographical area in your own words.)

   San Diego County

4. Aside from the problem you have described above, what are some of the typical problems of clients who are receiving this service? Include those which you do not deal with.

   Lack of, or inadequate, financial support. Lack of staff.

* *

ON THE NEXT THREE PAGES we are asking you to describe the Target Population, the persons for whom this service was designed. REMEMBER, this is not the group to whom the service is restricted, but for whom it is intended.

All of the information being collected in this section is NEW INFORMATION, and will not be found in the data print out.

TARGET POPULATION

(Check appropriate items.)

Sex: _X_ (Ø) not an identifying factor

____ (M) males

____ (F) females

Ethnic Background: _X_ (Ø) not a limiting factor

____ (B) Blacks	____ (N) American Indians
____ (T) Hispanos	____ (W) Whites, excluding Hispanos
____ (A) Asian-Americans	____ (*) Other, please specify
____ (P) Pilipino-Americans	________________

Age: _X_ (Ø) not a limiting factor

____ (A) under 3	____ (M) 19
____ (B) 3 - 4	____ (N) 20
____ (C) 5	____ (P) 21
____ (D) 6	____ (R) 22 - 24
____ (E) 7 - 9	____ (S) 25 - 34
____ (F) 10 - 13	____ (T) 35 - 44
____ (G) 14	____ (U) 45 - 54
____ (H) 15	____ (V) 55 - 59
____ (J) 16	____ (W) 60 - 64
____ (K) 17	____ (X) 65 - 74
____ (L) 18	____ (Y) 75 and over

Employment: _X_ (Ø) not a limiting factor

____ (A) employed ____ (B) underemployed ____ (C) unemployed

Skill level: _X_ (Ø) not a limiting factor

____ (A) unskilled ____ (B) semi-skilled ____ (C) skilled

All of the information being collected in this section is NEW INFORMATION, and will not be found in the data print out.

Education: X (%) not a limiting factor

A. (for persons aged 3-34 years) If must be presently enrolled,

____(A) in nursery school

____(B) in kindergarten

____(C) in elementary school

____(D) in high school

____(E) in college

B. (for persons age 24 or less, not currently enrolled) If must have completed

____(A) grades 1-4

____(B) grades 5-7

____(C) grade 8

____(D) grades 9-11

____(E) grade 12 or more

C. (for persons age 25 and over) If must have completed

____(A) grades 1-4

____(B) grades 5-7

____(C) grade 8

____(D) grades 9-11

____(E) grade 12 or more

D. Degrees/Certificates, if required

____(A) high school

____(B) AA

____(C) BA/BS

____(D) Trade school

____(E) Other, please specify _____

Income levels - please indicate the percentage of your client population which falls into the categories in each table.

A. Poverty level - Manpower Administration guidelines

	Family size	Income	N/A
____%	(A) 1	$2,200	
____%	(B) 2	2,900	
____%	(C) 3	3,600	
____%	(D) 4	4,300	
____%	(E) 5	5,000	
____%	(F) 6	5,700	
____%	(G) 7	6,400	

B. (General) Overall income levels

____% (A) less than $1,000

____% (B) 1,000-2,999

____% (C) 3,000-4,999

____% (D) 5,000-6,999

____% (E) 7,000-8,999

____% (F) 9,000-9,999

____% (G) 10,000-11,999

____% (H) 12,000-14,999

____% (J) 15,000-19,999

____% (K) 20,000-24,999

____% (L) 25,000 or more

All of the information being collected in this section is NEW INFORMATION and will not be found in the printout.

Special Characteristics: X (%) not a limiting factor

____(A) Physically handicapped

____(B) Mentally handicapped

____(C) Drug misusers or abusers

____(D) Alcoholics

____(E) Ex-offenders

____(F) Single parents with dependent children

____(G) Youths with disciplinary problems

____(H) Out-of-school youth

____(J) Other - please specify _____

SERVICE BUDGET

Of the total budget amount quoted on Page 6, how much is used to fund this service?

$ 6566

What are the sources of these funds? (Just list the names.)

United Way, Revenue Sharing

All
NEW INFORMATION
not found in printout.

* *

GEOGRAPHICAL DISTRIBUTION OF CLIENTS - Please indicate the percentage of your client population which falls into the listed categories.

What percentage of your clients come from a radius of:

30 % (A) 2 miles or less

30 % (B) 2-5 miles

30 % (C) 5-10 miles

10 % (D) more than 10 miles

* *

SERVICE AREA BY CENSUS TRACTS - We need to know which census tracts are included in the area in which this service is offered. We are offering you some alternatives for this response since so few of us know census tracts (even the ones where we live). Please indicate which alternative you chose.

X There are no geographical restrictions; our service area is unlimited.

____ We serve the entire county, so we didn't use any map.

____ We used MAP A.

____ We used one of the smaller maps (or two, or more.)

Which one or ones? ____

OR

If you do have a service area, but none of the above alternatives help to describe it, please describe below. For example: the name of a school district, the name of a city, the names of the streets on the boundaries, a catchment area, etc., will do fine. Use the space below.

SUPPLEMENT TO THE QUESTIONNAIRE

Due to additional information needs, we have a few more questions for you to answer. By doing so, however, you will have eliminated the need to fill out surveys from two other organizations as we are doing this for them.

EVERYONE: Please answer the questions in this section.

HEALTH SERVICES PROVIDERS: Please answer the questions in the section headed by the cover letter from Comprehensive Health Planning Association.

THOSE PROVIDING SERVICES TO THE DEVELOPMENTALLY DISABLED (services of any kind to developmentally disabled persons): Please answer the questions in the section headed by the cover letter from Area 13 Planning Board.

NAME & ADDRESS OF STATE ORGANIZATION (if any) ____

NAME & ADDRESS OF NATIONAL ORGANIZATION (if any) ____

(Here we're asking a familiar question in a different way.) Do you have as part of your services bilingual availability?

X YES ____ NO

If YES, number of staff available 3

number of volunteers 0

Do you provide transportation? ____ YES X NO

Please give directions to your agency via public transportation (bus) from Horton Plaza (if San Diego) or another central location in your area. If not San Diego, name the central area.

We are located in the building on the northwest corner of Twelfth & Broadway. It is possible to walk east on Broadway (eight blocks) or to take busses:

0, 2, 9, 11 bus to Twelfth & Broadway
7 bus to Eleventh & Broadway.