



Indiana Family and Social Services Administration Eligibility Modernization Voluntary Community Assistance Network (V-CAN) Registration

Please complete this registration document to become a formal member of the Voluntary Community Assistance Network (V-CAN). We will use this information for internal purposes only and it will not be shared. Your information will help us better target our communications and materials for your organization.

Please note: This form is a fillable PDF and can be completed, saved and e-mailed or it can be printed and FAXed or mailed (see back page for contact information).

Organization Name: _____

Mailing Address: _____

City, ST Zip: _____

County: _____

Contact Name:* _____

Contact Phone: _____

Contact E-mail: _____

County(ies) with office: _____

Counties served: _____

* The Contact Name should be the person who should receive e-mails about official V-CAN communications and packages of V-CAN resources materials, if applicable. We encourage you to share the e-mails with others in your organization.

My organization would like to be a V-CAN member at the following level *(for more information on levels of membership, see the "Eligibility Modernization and V-CAN Overview" at <http://www.in.gov/fssa/2343.htm>).*

- Access Point – Receive supportive materials for new application tools (PC tent cards, Call Center tip cards, etc.)
- Referral – Receive client educational materials regarding changes to system (posters, postcards, etc.)
- Informational – Receive communication updates regarding changes to system (e-mails, newsletter links, etc.)

If you chose to be an **Access Point**, would you like your location publicized on the FSSA website for potential applicants? (Referral and Informational members' locations will **not** be publicized.)

Yes No

Do you have any publications, e-mail updates, or other communications in which it might be appropriate to include information on our project?

Yes No

If **yes**, would you accept updates from our project to include in your publication? Yes No

If **yes**, please briefly describe the type of and number of recipients of your publication:

Are you interested in becoming (or would you like information about becoming) a site for Community Work Experience Program (CWEP) participants? (In the CWEP, IMPACT job training participants are placed as volunteers in your organization to do part-time or full-time work, at no cost to your organization.)

Yes No

Type of organization (please choose the **one** response that best describes your organization):

- | | |
|--|---|
| <input type="checkbox"/> Advocacy Organization | <input type="checkbox"/> Health Department |
| <input type="checkbox"/> Area Agency on Aging | <input type="checkbox"/> Home Health Agency |
| <input type="checkbox"/> Child Care Provider | <input type="checkbox"/> Homeless Shelter |
| <input type="checkbox"/> Community Action Agency | <input type="checkbox"/> Housing Authority/Agency |
| <input type="checkbox"/> Community Center | <input type="checkbox"/> Information & Referral Agency |
| <input type="checkbox"/> Community Mental Health Center | <input type="checkbox"/> Religious Congregation |
| <input type="checkbox"/> Disability Agency | <input type="checkbox"/> United Way |
| <input type="checkbox"/> Domestic Violence Shelter/Rape Crisis Ctr | <input type="checkbox"/> Workforce Training Center/Provider |
| <input type="checkbox"/> Food Pantry/Food Bank | <input type="checkbox"/> YMCA/YWCA |
| <input type="checkbox"/> Health Center/Hospital | |
| <input type="checkbox"/> Other, please specify: _____ | |

Comments (if you serve more than one function, please explain here): _____

Check below all of the services you offer:

- | | |
|--|---|
| <input type="checkbox"/> Case management/service coordination | <input type="checkbox"/> Information and referral |
| <input type="checkbox"/> Child care | <input type="checkbox"/> Legal services |
| <input type="checkbox"/> Community-based services | <input type="checkbox"/> Medical services |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Mental health services |
| <input type="checkbox"/> Day shelter for the homeless | <input type="checkbox"/> Mentoring and/or tutoring |
| <input type="checkbox"/> Domestic violence/sexual assault counseling | <input type="checkbox"/> Overnight shelter |
| <input type="checkbox"/> Early intervention/prevention | <input type="checkbox"/> Substance abuse counseling/treatment |
| <input type="checkbox"/> Education | <input type="checkbox"/> Parenting education |
| <input type="checkbox"/> Emergency financial assistance | <input type="checkbox"/> Transitional housing |
| <input type="checkbox"/> Emergency food and/or clothing | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Foster care/adoption | <input type="checkbox"/> Vocational/job training |
| <input type="checkbox"/> Housing assistance | <input type="checkbox"/> None |
| <input type="checkbox"/> In-home/residential services | |
| <input type="checkbox"/> Other, please specify: _____ | |

Generally, what populations do you serve (check all that apply)?

- | | |
|---|---|
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Spanish-speaking individuals |
| <input type="checkbox"/> Low-income families | <input type="checkbox"/> Unemployed adults |
| <input type="checkbox"/> MR/DD population | <input type="checkbox"/> Infants/young children |
| <input type="checkbox"/> Older adults | <input type="checkbox"/> Victims of crime |
| <input type="checkbox"/> People with Disabilities | <input type="checkbox"/> Youth |
| <input type="checkbox"/> Other, please specify: _____ | |

Thank you for registering! You will receive confirmation of your registration as soon as it is processed.
If you have questions, please contact us at vcan@us.ibm.com.

Please e-mail, mail or FAX the completed form to the following:

E-mail: vcan@us.ibm.com

Indiana Eligibility Modernization
PO Box 40977
Indianapolis, IN 46240-0977

FAX: (317) 706-2660