



HomeAid
Chicago

CARE PROVIDER INITIAL QUESTIONNAIRE

CONTACT INFORMATION

Name of Care Provider: _____

Address: _____

Phone: () _____ Fax: () _____

Contact Person: _____ Title: _____

SHELTER INFORMATION

Name of Shelter: _____

Address: _____

Phone: () _____ Fax: () _____

Contact Person: _____ Title: _____

Type of Shelter (*Please check all that apply of the following*):

- Emergency (1 to 5 nights)
- Short Term Transitional (1 to 6 months)
- Long Term Transitional (7 to 24 months)

Do you have 501(c)(3) exemption? _____
(*Please submit a copy of your organization's Letter of Determination*)

How long has the shelter been in operation (in years)? _____

Please describe the shelter's scope, mission, objectives and current programs and services:
(*Please be specific - attach additional pages if necessary*): _____

PROJECT INFORMATION

Financial: What is the total financial goal of the project? _____

What has been raised to date? _____

Renovation: Describe improvements needed and if the renovation will create additional beds?
(*Please be specific - attach additional pages if necessary*): _____

New Construction: Describe project. How many additional beds will be created?
(*Please be specific - attach additional pages if necessary*): _____

***Thank you for your interest in HomeAid Chicago.
Please complete and return this form to:***

HomeAid Chicago
1841 W. Army Trail Road, Addison, IL 60101
Or via fax to: 630/627-7580