

Organization Information Sheet

Date

Organization Name

Name of Primary Point of Contact

Primary Contact email/phone number

Address

City

State

ZIP Code

Business Type

Total Number of Program Areas/Departments

Total Number of Employees/Staff

Would you like all staff trained?

(Yes-Ideally, No-Only a specific program/department,
Possibly-need more information)

What is your timeline for beginning?

Have your staff previously completed any
ACES, trauma-informed care, mental health,
etc... training?

Will this project be part of an identified or
proposed grant funded project? (yes, no)