



## EBC Agency Partner Application

Thank you for your interest in joining the EBC - Eastside Baby Corner Agency Partner network. The EBC model is built upon strong relationships with our Partner Agencies. Through the collaboration of our amazing donors, volunteers and partners like yourself, EBC makes a positive difference in the lives of children and their families.

At our EBC – Central (Issaquah) and EBC – Northshore (Kenmore) branches we provide items for unborn babies through age 12 (children’s clothing up to size 14), and at our EBC – West Sound branch (Bremerton) we provide items for unborn babies through age 5 (children’s clothing up to size 7). All three of our branches provide items for expectant and new moms.

Apply to become an EBC Agency Partner by completing the application below. We will review all applications for completeness, alignment with our established criteria, and availability of slots in the network. The application review process takes place every quarter and takes couple of months before the agency is notified about the partnership.

For questions on completing the application or the application process, please email us at [ProviderReply@babycorner.org](mailto:ProviderReply@babycorner.org) or call our Partner Services Coordinator, Ruchi Charekar, at 425-865-0234, ext. 704.

1. **Complete the *Agency Partner Application* (below).** For more clarity on the terminology please see below definitions:
  - **Agency Partner:** a collective name for reporting organizations, its programs and program providers.
  - **Program:** the name of the division of the reporting Agency Partner that manages services to meet a social need(s).
  - **Provider:** the person who interacts with end user recipients and places orders with EBC on behalf of the Agency Partner’s program/site.
  - **Site:** location where a program operates
2. **Attach a copy of your 501(c)(3) tax-exempt determination letter or a letter on your agency or designated religious organization letterhead.**

Please attach your current non-discrimination policy, client confidentiality policy/agreement and most recent demographics of the children/families you serve.
3. **Submit completely filled out application with other requested attachments via email to [ProviderReply@babycorner.org](mailto:ProviderReply@babycorner.org).**



**A. Agency Information- GENERAL**  
Please provide information of the reporting “Parent Organization”

<b>Agency [Legal] Name:</b>	
<b>Tax ID (e.g. IRS EIN)</b> Please attach copy of the first page of most recent filed 990.	<b>Wa. State UBI: EIN:</b>
<b>Tax- Exempt Organization Type:</b>	<input type="checkbox"/> 501(c)(3) nonprofit: <input type="checkbox"/> Human or other service <input type="checkbox"/> Hospital/medical clinic <input type="checkbox"/> Church/faith based org <input type="checkbox"/> School <input type="checkbox"/> School District <input type="checkbox"/> Government/Quasi Government
<b>Physical Address:</b>	
<b>Mailing Address if <u>different</u> than physical address:</b>	
<b>How did you learn about EBC?</b>	
<b>Why would you like to partner with EBC?</b>	
<b>Does the agency have a written client nondiscrimination policy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please <b>attach</b> a copy.
<b>Does the agency have a written confidentiality policy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please <b>attach</b> a copy.
<b>Website:</b>	
<b>Agency Description:</b>	
<b>Mission Statement:</b>  NOTE: A concise statement to define the purpose the agency is aiming to achieve, describe the community served and often states the values which this agency defines its standards.	



<b>A. 1.1. Agency Information- CONTACTS</b>	
<b>Executive Director/CEO (Name)</b>	
Title:	
Contact number:	
Email address:	
<b>CFO or assigned person who handles finances (Name)</b>	
Title:	
Contact number:	
Email address:	
<b>Development or Communications person or assigned person to receive a biannual report of EBC goods distributed (Name)</b>	
Title:	
Contact number:	
Email address:	



## B. Program Information- GENERAL

Please tell us about the Program(s) within your agency providing services for kids 0-12, pregnant women and nursing mothers and would be receiving products through EBC. Please fill in details for the program site/s that will be requesting products through EBC. The Program information will help EBC analyze capacity needs to ensure we can fully support your Program. For multiple programs, please attach additional page.

### General Information

<b>Program Name:</b>	
<b>Primary Program Classification:</b>	<input type="checkbox"/> Case Management <input type="checkbox"/> Child Welfare Services Disability Services <input type="checkbox"/> Early Learning Emergency Assistance <input type="checkbox"/> Employment/education <input type="checkbox"/> Food Bank <input type="checkbox"/> Housing <input type="checkbox"/> Maternal and Infant Health Medical Services <input type="checkbox"/> Schools <input type="checkbox"/> Specialized Services <input type="checkbox"/> Other: _____
<b>Program(s) Description:</b>	
<p>NOTE: Describe the program(s), its purpose and how children in need are served on a <b>weekly</b> basis.</p> <p><b>Tell us about the individuals that your program serves.</b></p> <p>NOTE: Age range, income range, ethnicity, special needs, geography etc. Also, describe briefly the program's client intake process to include how client eligibility is determined.</p>	
<b>Tell us about program's client intake process to include how client eligibility is determined.</b>	



<p><b>Is your agency willing to provide individual demographic data with client consent?</b></p> <p>NOTE: Demographic information will be required for the ordering process. This will be stored in a secure application and will be used in aggregate for reporting purposes.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Is EBC going to primary source of providing stuff? Supplemental, emergency or other!</b></p>	<input type="checkbox"/> Primary <input type="checkbox"/> Supplemental <input type="checkbox"/> Emergency <input type="checkbox"/> Other
<p><b>List top 5 items you anticipate ordering from EBC.</b></p>	

**B.1.0 Program Information- CONTACTS and OTHER DETAILS** *(or volunteers in lieu of paid staff)*

Program Locations (addresses): (ex: List each site location from where the program operates separately.) Fill out this section for each additional location. This is the physical location a client would go receive services from your program.

<p><b>Location #1 Name:</b></p> <p><b>Physical Address:</b></p> <p><b># of kids 0-3 years and/or 3+ years served annually at this location:</b></p> <ul style="list-style-type: none"> <li>- 0-3 years:</li> <li>- 3+ years:</li> </ul> <p><b># of pregnant and lactating mothers served monthly at this location:</b></p> <p><b>How many are expected to order from EBC?</b></p> <p><b>What cities do the families live in (that receive services here?)</b></p>	<p><b>Supervisor Name:</b></p> <p>Title:</p> <p>Email:</p> <p>Phone Number:</p> <hr/> <p><b>Provider (person assigned to have access to EBC Ordering system) Name:</b></p> <p>Title:</p> <p>Email:</p> <p>Cell Phone:</p> <p>Office Phone:</p>
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<p><b>Location #2 Name:</b></p> <p><b>Physical Address:</b></p> <p><b># of kids 0-3 years and/or 3+ years served annually at this location:</b></p> <ul style="list-style-type: none"><li>- 0-3 years:</li><li>- 3+ years:</li></ul> <p><b># of pregnant and lactating mothers served monthly at this location:</b></p> <p><b>How many are expected to order from EBC?</b></p> <p><b>What cities do the families live in (that receive services here?)</b></p>	<p><b>Supervisor Name:</b></p> <p>Title:</p> <p>Email:</p> <p>Phone Number:</p> <hr/> <p><b>Provider (person assigned to have access to EBC Ordering system) Name:</b></p> <p>Title:</p> <p>Email:</p> <p>Cell Phone:</p> <p>Office Phone:</p>
<p><b>Location #3 Name:</b></p> <p><b>Physical Address:</b></p> <p><b># of kids 0-3 years and/or 3+ years served annually at this location:</b></p> <ul style="list-style-type: none"><li>- 0-3 years:</li><li>- 3+ years:</li></ul> <p><b># of pregnant and lactating mothers served monthly at this location:</b></p> <p><b>How many are expected to order from EBC?</b></p> <p><b>What cities do the families live in (that receive services here?)</b></p>	<p><b>Supervisor Name:</b></p> <p>Title:</p> <p>Email:</p> <p>Phone Number:</p> <hr/> <p><b>Provider (person assigned to have access to EBC Ordering system) Name:</b></p> <p>Title:</p> <p>Email:</p> <p>Cell Phone:</p> <p>Office Phone:</p>



**B.1.1 Program Information- ORDERING**

<b>Frequency of Ordering</b>  NOTE: EBC expects Programs to place and pick-up orders on a scheduled basis. Though EBC's preferred cycle is weekly, there are alternative cycles that may better meet the needs of the Program, (e.g. frequency clients are screened, distance between the Program and closest EBC Hub, etc.)	<input type="checkbox"/> Weekly <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly
<b>Preferred location for picking up the orders.</b>	<input type="checkbox"/> Central (Issaquah) <input type="checkbox"/> Northshore (Kenmore) <input type="checkbox"/> West Sound (Bremerton)
<b>Is your agency Staff or designated volunteer willing to pick-up on Thursday between 9:00 am to 11:00 am?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**C. How would the partnership help your families? What difference it will be make for you and your families?**

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**D. By signing this form, you acknowledge the above data is accurate to the best of your ability and understand that this application does not guarantee acceptance as an EBC Provider Partner.**

<b>Printed Name:</b> _____ <b>Signature:</b> _____ <b>Date:</b> _____
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