

**ORGANIZATION SUMMARY FOR NON-SECURE, NON-RESIDENTIAL PROGRAMS**

*Revised 3/2/2017*

An Organization Summary is a form completed by the agency applying for accreditation that provides the Performance Based Standards & Expected Practices Accreditation Department with descriptive information about the program or facility. Please complete a separate summary for each program or facility and return to the ACA. If you have any questions, please contact your Accreditation Specialist. *This form is fillable so you can type directly into the grey boxes.* Upon receipt of this organization summary please contact your Accreditation Specialist to determine the date it needs to be submitted.

|  |  |
| --- | --- |
| Introduction | |
| Governing Authority/  Parent Agency: |  |
| Name of  Facility/Program: |  |
| Physical Address: |  |
| Mailing Address: |  |
| Primary Facility  Telephone Number: |  |
| Primary Contact Person: |  |
| Primary Contact Person’s Phone Number: |  |
| Airport Information | 1st Preference:  Distance from the facility:  2nd Preference:  Distance from the facility: |

|  |  |
| --- | --- |
| Accreditation & Manual Information | |
| ACA Accreditation Status: | Initial |
|  | Reaccreditation  Date of last ACA Accreditation:  Applicable Manual & Edition: |
| Is this agency or facility accredited by any other organization? | No |
|  | Yes  If yes, please provide the name of the organization(s) and the date(s) of the most recent accreditation: |

|  |  |
| --- | --- |
| Demographics | |
| Program Slots Available: |  |

|  |  |
| --- | --- |
| Organizational Information | |
| State the mission of the agency or facility  (attach additional pages if necessary) |  |
| Describe any current significant court interventions  (i.e. consent decrees or settlement agreements) |  |
| Total Number of  Full Time Staff: |  |
| Number of Field  or District Offices:  (if applicable) | Are these facilities to be included in the accreditation? |
| Number of Satellite Facilities:  (if applicable) | Are these facilities to be included in the accreditation? |
| Facility Administrator/Title: |  |
| Telephone Number & Email Address: |  |
| Existing ACA Member?  If yes, please include ACA Membership Number. |  |
| Facility Accreditation Manager: |  |
| Telephone Number & Email Address: |  |
| Existing ACA Member?  If yes, please include ACA Membership Number. |  |
| State/Regional Accreditation Manager:  (if applicable) |  |
| Telephone Number & Email Address: |  |
| Existing ACA Member?  If yes, please include ACA Membership Number. |  |

Signature:

Printed Name:

Title:

Date:

**Submitted by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**