**Section/Form #1: About Your Clinic**

**Contact Information of person completing this form:**

Name:

Title:

**Organization Information:**

Organization Name:

Organization Phone:

Organization Physical Address:

Organization County:

Organization Mailing Address(if different):

Primary Contact Name:

Primary Contact Position/Title:

Primary Contact Email:

Secondary Contact Name:

Secondary Contact Position/Title:

Secondary Contact Email:

Additional Contact (If applicable)

Additional Contact (if applicable)

**Additional Information for IAFCC Website:**

In addition to the clinic name, physical address, and phone number, IAFCC would like to also display the information below to assist patients and volunteers in getting in contact with the clinic.

Is the clinic currently accepting new patients?

How does a patient contact the clinic if they wish to enroll as a patient?

Website URL

Other: You can use the other option to let us know if you do not want certain information on the IAFCC website or if there are other links or forms we should include with your clinic information on the IAFCC Website.

**About your Organization:**

**My organization is considered a:**

* *Free Clinic*
* *Charitable Clinic*
* *Hybrid Charitable Clinic*
* *Free-Charitable Pharmacy*

**Hours of Operation Per Week**

**Does your organization have any satellite locations? If yes, please list each satellite site and phone number below.**

**Does your organization have mobile capabilities to extend your services into the community? If yes, please explain.**

**Is your organization a subsidiary of another organization? If yes, list the organizational nature of affiliation.**

**What criteria does your organization use to determine if a patient is eligible to receive services? Check all that apply.**

* *Must be uninsured*
* *Must be a legal resident*
* *Must live in the county that clinic is located*
* *Must be working or actively seeking work*
* *Must be ineligible for medicaid or other insurance coverage*
* *Must be less than a certain percentage of FPL*
* *Other*

*if applicable: What documentation is required to enroll at your clinic?*

*If applicable: What is the FPL required to enroll at your clinic?*

**Does your organization charge patients for any services?**

* Yes, and a fee is required
* Yes, but a fee is not required
* No, but we accept donations
* No, we do not accept payment of any kind

**Attach Fee Schedule**

**Do you bill for third party reimbursement?**

* Yes
* No

**If yes to the previous question, which of the following do you bill for reimbursement?**

* Medicaid
* Medicare
* Private Insurance
* Dental Insurance

**Do you intend to start billing for third party reimbursement in the next year?**

* Yes
* No

**Does your clinic provide interpretation services for your patients? If so, for which languages?**

* *Arabic*
* *Hindi*
* *Polish*
* *Spanish*
* *Gujarati*
* *Urdu*
* *Mandarin*
* *French*
* *Russian*
* *Punjabi*
* *Hmong*
* *Sudanese*
* *Vietnamese*
* *Somali*
* *Burmese*
* *Rohingya*
* *Tibetan*
* *ASL*
* *Only English*
* *Other:*

**Target Population:**

**As free and charitable clinics, we understand that it is your goal to treat those in need. That being said, does your clinic specifically seek to address the health needs of an*y of the following groups (i.e. target populations)? Check all that apply.***

* *Homeless*
* *Immigrants*
* *Primary Language other than English*
* *Uninsured*
* *Underinsured*
* *Children*
* *Adults*
* *Seniors (65+)*
* *Veterans*
* *LGBTQ+*
* *Transgender and/or gender non-conforming/non-binary*
* *HIV/AIDS*
* *Individuals with substance abuse disorders*
* *Individuals with a history of psychiatric disorder*
* *Formerly Incarcerated*
* *Victims of Intimate Partner Violence*
* *Other*

**Clinic Services and Referrals:**

**Electronic Health Record:**

**Does your clinic currently use an Electronic Health Record system?**

* Yes
* No

**If yes, or in the process of implementing, which system?**

**If no, What are the major barriers to acquiring an Electronic Health Record System?**

**(Select one OR Other to further explain)**

* Too expensive
* Lack of expertise in setting up EHR
* Lack of expertise in operating EHR
* Lack of staff or volunteer time
* Cannot transfer paper records to EHR
* Lack of clinic staff buy-in
* Other

**Which of the following best describes the services provided by your clinics (mark only one oval per row)**

*Note: We recognize that your clinic(s) may have multiple resources to provide a given service. If applicable, please choose the option that best reflects your clinic's primary resource. "Refer Out" means that there is an agreement between your clinic and an external provider and that external provider will serve patients referred by your clinic.*

|  | On-Site | Refer Out  | Not available - Planning to add in next 12 months  | Not available - Would like to add but not currently planned  | Not available - Not a priority  |
| --- | --- | --- | --- | --- | --- |
| Urgent/Acute Care  |  |  |  |  |  |
| Yearly Physicals |  |  |  |  |  |
| Immunizations - Non-COVID Immunizations - COVID |  |  |  |  |  |
| COVID Testing |  |  |  |  |  |
| Laboratory |  |  |  |  |  |
| X-Ray (non-dental) |  |  |  |  |  |
| Chronic Disease Management  |  |  |  |  |  |
| Dental Care |  |  |  |  |  |
| Vision Screening |  |  |  |  |  |
| Family Planning |  |  |  |  |  |
| Prenatal/ Obstetrical Care  |  |  |  |  |  |
| Gynecological  |  |  |  |  |  |
| STI Testing/Treatment  |  |  |  |  |  |
| HIV Testing  |  |  |  |  |  |
| TB Testing  |  |  |  |  |  |
| Substance Abuse Treatment/ Counseling  |  |  |  |  |  |
| Mental Health Treatment/ Counseling |  |  |  |  |  |
| Specialty Services  |  |  |  |  |  |
| Eyeglasses |  |  |  |  |  |
| Case Management  |  |  |  |  |  |
| Health Education |  |  |  |  |  |
| Pharmacy  |  |  |  |  |  |
| Rx Dispensary |  |  |  |  |  |

*Are you currently accepting new patients for all of the above services that are selected as ‘On-site”? Please elaborate:*

**Which three referral services would be most important to your patient population? Please list below.**

**FORM 2: 2023 DATA**

**Clinical Services Provided, Common Conditions,**

**SECTION 1: Valuation Tool - Required for generation of clinic and aggregate dashboard**

**Valuation Tool Questions: (do not collect options)**

**Note:** *If you do not collect data or provide the services for any of the questions in this section, please type n/a before moving onto the next question.*

**1.What was your total cash-operating expenditure in the past year?**

*Note: Either your most recently completed fiscal or calendar year (by 12/31/21). Exclude capital spending as well as donated time, goods, and services.*

**2.What is the approximate total revenue received from patient fees and reimbursements of services in the past year?**

**3. Approximately how many volunteer-hours were provided at your clinic within the past year?** *Please provide your best estimate.*

**4.Total number of NEW Patients in Past Year**

*Note: A new patient is someone who is completely new to the clinic or has not been seen by the clinic within the past 3 years.(Provide answer as a whole number)*

**5. Total number of patients served in past year (new and established combined)**

*Note: this is different from total number of visits. A patient could come in multiple times in a year. For this question, this would only count as 1 patient served*

**6. Number of dental visits**

*Note: this is different from number of dental PATIENTS. One patient could have more than one visit in a year*

**7. Total Number of all Medical VISITS (both primary care AND specialty visits for both new and established patients)**

*Note: specialty visits include all specialties such as gyn, cardiology, endocrinology, etc. - DO NOT include mental/behavioral health or dental visits in this total*

**8. Number of Mental Health/Behavioral Health VISITS**

**9. Total Patients VISITS (sum of above visits)**

**10. Of the total MEDICAL visits, approximately what number of MEDICAL visits would have occurred at the ED if the clinic was not in operation? If an estimation cannot be provided, consider surveying patients this question during the visit.**

*Note: Please enter N/A if an estimation cannot be provided*

**11. Of the total DENTAL visits, approximately what number of DENTAL visits would have occurred at the ED if the clinic was not in operation? If an estimation cannot be provided, consider surveying patients this question during the visit.**

*Note: Please enter N/A if an estimation cannot be provided*

**12. Number of In-House Imaging Tests in past year**

*Note: Imaging tests done off-site, but PAID BY THE CLINIC can be counted in the above total. If someone else (i.e., the hospital or radiology center performing imaging test) is donating the services or paying the cost, please do not include this in your totals.*

**13. Number of In-House Lab Tests in past year**

*Note: Imaging tests done off-site, but PAID BY THE CLINIC can be counted in the above total. If someone else (i.e., the hospital or radiology center performing imaging test) is donating the services or paying the cost, please do not include this in your totals.*

**14. Number of In-House COVID Tests in past year**

*Note: COVID tests done off-site, but PAID BY THE CLINIC can be counted in the above total. If someone else (i.e., the hospital) is donating the services or paying the cost, please do not include this in your totals.*

**15. Number of COVID Vaccinations in past year provided in your clinic by an outside organization (e.g. the state or local public health department or a private provider)**

**16. Number of COVID Vaccinations in past year provided independently by your clinic (vaccines administered by clinic personnel, not by an outside organization)**

**17. Choose what best describes your pharmaceutical facilities. Note: a pharmacy distributes medications packaged from their own bulk supplies, while a dispensary distributes pre-packaged samples and medications.**

* On-site licensed/certificate/permitted pharmacy
* Onsite Dispensary
* Other

**18.What was the total number of 30-day on-site prescriptions filled or medications dispensed by the clinic in the past year. Note that this is different from the number of medications prescribed by the clinic. Please provide your best estimate.**

*Note:Medications that are dispensed at the clinic (via outside programs such as patient assistant programs) but are not paid for by the clinic should NOT be counted in the number of prescriptions. Only medications paid for by the clinic are counted. ex: A three month prescription paid for by the clinic will count as 3 prescriptions.*

**Your Patients Medical Conditions:**

*Note: Of the total number of patients you serve, what percentage of those patients receive the following services (please provide best estimate)? Please use whole numbers (20% instead of 0.20). Note that patients can be counted towards more than one category (have multiple screenings).*

***The sum of the percentages may exceed 100%.***

**(19)** *% Diabetes Screening/Management* \_\_\_\_\_\_\_\_\_ %

**(20)** *% Hypertension Screening/Management* \_\_\_\_\_\_\_\_\_ %

**(21)** *% Cancer Screening/Management* \_\_\_\_\_\_\_\_\_ %

**(22)** *% Obesity Screening/Management* \_\_\_\_\_\_\_\_\_ %

**(23)***% Dental Screening/Management* \_\_\_\_\_\_\_\_\_ %

**(24)** *% Sexual Health Screening/Management* \_\_\_\_\_\_\_\_\_ %

**(25)** *% Dyslipidemia/Hypercholesterolemia Screening/Management* \_\_\_\_\_\_\_\_\_ %

**(26)** *% Mental Health Screening/management* \_\_\_\_\_\_\_\_\_ %

**(27)** *% Influenza Immunization* \_\_\_\_\_\_\_\_\_ %

**(28)** *% Other Immunizations (ex: shingles, pneumonia, COVID, etc)* \_\_\_\_\_\_\_\_\_ %

**(29)** % Asthma/COPD Management \_\_\_\_\_\_\_\_\_ %

**(30)** % Dermatology Screening & Management \_\_\_\_\_\_\_\_\_ %

**(31)** % Heart Disease Screening & Management \_\_\_\_\_\_\_\_\_ %

**(32)** % Vision Screenings and Exams \_\_\_\_\_\_\_\_\_ %

**(33)** % Arthritis/Musculoskeletal Screening/Management \_\_\_\_\_\_\_\_\_ %

**(34)** % Physicals (school, sport, or general) \_\_\_\_\_\_\_\_\_ %

**(35)** % Acute Injury Management \_\_\_\_\_\_\_\_\_ %

**(36)** % Hearing Screening and Exam \_\_\_\_\_\_\_\_\_ %

**Number of Specialty VISITS Performed at Clinic \*\*specialty visits include all specialties such as gyn, cardiology, endocrinology, etc. - DO NOT include mental/behavioral health, vision or dental visits in this total**

**What other medical conditions, if any, are challenging to address or are a high priority for your clinic?**

**What are the most prevalent barriers to the management of your clinics' most common conditions? (Please select up to three)**

* Medications
* Diagnostic Tests
* Specialists
* Procedures
* Funding Avenues
* Patient Lifestyle Modifications
* Food Access
* Literacy
* Patient Education
* Patient Competing Priorities

**Section 2: Other Offerings**

**EXPANDED - Dental**

**PHARMACY**

**Number of pharmaceutical VISITS**

**How do you arrange medications for your patients?**

* *Physician Prescription*
* *Physician Samples*
* *Drug Company PAP*
* *Drug Company Bulk Donation/Replacement*
* *Charitable Distributor Donation (i.e. AmeriCares)*
* *Charitable Fill Pharmacy On-Site*
* *Charitable Fill Pharmacy Off-Site*
* *Stock Bottles*
* *Pay outside pharmacy/pharmacy voucher*
* *Pay for specific (not stock or bulk) patient medications*
* *Generics through $4 Walmart Plan*
* *Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**If applicable, What are the major barriers preventing establishment of on-site pharmaceutical facilities? (Select One)**

* Too expensive
* Lack of staff or volunteer time
* Lack of staff or volunteer expertise
* Lack of site for pharmaceutical facility
* Other

**Behavioral Health Questions:**

IAFCC is teaming with another team from Northwestern's Second Opinions Group to work towards recruiting volunteer and paid behavioral health staff. With this, the team wants to ask a few extra questions in hopes of gathering some more data and a better understanding of behavioral health services offered and needed across member clinics. This section is not required but would be extremely helpful towards a project that could potentially add value to your clinic down the road. At this link you can find an explanation of the below terms if needed: [Behavioral Health Definitions](https://drive.google.com/file/d/1O-5Cqd_DAPg-ZmDzTYb02FMh_tHEMkcK/view?usp=share_link)

If you selected OTHER for any of the above answers please explain the best that you can below:

**80. Number of Case Management/Social Services VISITS**

* 4. **Time to BH care.** For clinics that provide in-clinic, telehealth, or direct referral delivery of BH care: How long do patients need to wait, on average, before securing an in-clinic, telehealth, or direct referral appointment?
* a. Less than two (2) **weeks**.
* b. Two (2) to four (4) **weeks**.
* c. One (1) to three (3) **months**.
* d. Greater than three (3) **months**.months

For clinics with in-house providers that deliver care through in-person or telehealth visits: Which two (2) of the options below account for most of the ways in which in-house BH providers are compensated? Check up to two (2).

a. BH providers are full-time paid staff on clinic payroll.

b. BH providers are part-time paid staff on clinic payroll.

c. BH providers are uncompensated volunteers working directly with the clinic.

d. BH providers are uncompensated volunteers working primarily with an external organization with temporary affiliation to the clinic.

e. BH providers are full-time OR part-time paid staff of an external organization that are temporarily or permanently affiliated with the clinic.

**Section2-3: Patient Demographics**

**Your patients’ gender (38-42)**

* *% Male Patients*
* *% Female Patients*
* *% Transgender FTM (female-to-male) Patients*
* *% Transgender MTF (male-to-female) Patients*
* *% Gender Non-Conforming Patients*

**Your patients’ ages (43-45):**

* *% 0-17 years old*
* *% 18-64 years old*
* *% 65+ years old*

**Your patients’ race/ethnicity (46-54):**

* *% Latino or Hispanic*
* *% White*
* *% Black or African American*
* *% Asian*
* *% American Indian or Alaskan Native*
* *% Native Hawaiian or Pacific Islander*
* *% Multi-racial or Bi-Racial*
* *% Other*
* *% Unknown*

**Your patients income level (55-57):**

*What percentage of patients seen in the past year fall into the following Federal Poverty Level (FPL) income brackets? Please provide your best estimate of percentages in the fields below. Please use whole numbers (e.g., 20%, not 0.20). Please make sure percentages add up to 100%.*

* Below 100% of FPL \_\_\_\_\_\_\_\_\_ %
* Between 100% and 200% of FPL \_\_\_\_\_\_\_\_\_ %
* Over 200% of FPL \_\_\_\_\_\_\_\_\_ %

**Your patients language**

**What percent of your patient population does not speak English as their primary language?**

*Note: Please provide best estimate of percentage (list as percent number, example: 20% not 0.20).*

**Besides English, which of the following languages are spoken by your patients? Check all that apply.**

* *Arabic*
* *Hindi*
* *Polish*
* *Spanish*
* *Gujarati*
* *Urdu*
* *Mandarin*
* *French*
* *Russian*
* *Punjabi*
* *Hmong*
* *Sudanese*
* *Vietnamese*
* *Somali*
* *Burmese*
* *Rohingya*
* *Tibetan*
* *ASL*
* *Only English*
* *Other:*

**Separate Section or Form:**

**—---------**

**FOR IAFCC:**

**Which of the following best describes your sources of financial support in the past year? Please rate your top five sources of support.**

Note: 1= most financial support from this source moving towards least

For this section you will select 1-5 for your top 5 sources of support and all other options should be left blank.

* Patient Fees
* Medicare/Medicaid
* Patient Insurance
* Federal Government
* State Government
* Local Government
* Individuals
* Corporations
* Civic Groups/Professional & Member Organizations
* Foundations
* Hospitals
* Medical School/University
* Health Professions Training Program
* Religious Organizations/Faith Community
* Special Events

**Staff & Volunteers :**

**How many total (clinical/non-clinical) paid full-time employees work at your clinic?**

**How many total (clinical / non-clinical) paid part-time employees work at your clinic?**

**How many paid employed providers do you have (MDs, DOs, PAs, NPs, DDSs, DMDs, RDHs)?**

**How many volunteers do you have at your organization?**

**How many of your volunteers are providers (MDs, DOs, PAs, NPs, DDSs, DMDs, RDHs)?**

**How many of your volunteers support in other capacities (admin, reception, teach classes, etc)?**

**Approximately how many paid employed-hours were worked at your clinic within the past year? Please provide your best estimates**

**Barriers & Needs:**

**What challenges at your clinic keep you up at night?**

**How can we best help address these challenges?**

**Is there anything on the application that we didn't ask that you would like us to know about your clinic?**

**What are three things you would like IAFCC to address and/or continue this year?**

**Please submit a copy of necessary documentation with your application:**

1. **501(c)3**
2. **W9 Form**
3. **Copy of most recent board of directors**

**I give IAFCC permission to share data and information of this report in IAFCC external communications and mutually beneficial efforts to support the association and our member clinics.**

**Signature of Person Filling out form:**