The Ohio Association of Free Clinics 2018 Annual Survey

Clinic Contact Information

Clinic Name

Clinic Physical Address

City | State | ZIP Code

Clinic Mailing Address

City | State | ZIP Code

Clinic Phone | **Clinic E-Mail**

Clinic Website

Executive Director Name

Executive Director Phone | Director E-Mail

Medical Director Name

Medical Director Phone | Medical Director E-Mail

Alternate Contact Name

Alternate Contact Phone | Alternate Contact E-Mail

Clinic Characteristics

Model of Care

How would you describe your clinic? Select all that apply.

- ☐ Free Clinic
- ☐ Charitable Clinic
- ☐ Hybrid Clinic
- ☐ Charitable Pharmacy
- ☐ Charitable Dental Clinic
- ☐ Charitable Vision Clinic
- ☐ Referral Network/ Clinic Without Walls

Does your clinic have a state or federal certification? ◯ Yes ◯ No

If so, what certification? _____

Hours and Operation

Is the clinic open year-round? ◯ Yes ◯ No **If not, what months is it open?** _____

How often is your clinic open?

◯ Daily ◯ Weekly ◯ Every other week ◯ Monthly

Please indicate <u>clinic</u> hours of operation on each applicable day per week. If not open, put "closed".

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please indicate <u>office</u> hours of operation on each applicable day per week. If not open, put "closed".

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Does your clinic operate more than one site? ◯ Yes ◯ No

If so, please enter applicable information below.

_____

Second Site Address

_____ _____ _____

City State ZIP Code

_____ _____ _____

Phone Days of Operation Hours of Operation

_____

Third Site Address

_____ _____ _____

City State ZIP Code

Phone	Days of Operation	Hours of Operation

Fourth Site Address

City	State	ZIP Code

Phone	Days of Operation	Hours of Operation

Does your clinic operate a mobile unit? ◯ Yes ◯ No

If so, please indicate the information below.

Phone	Days of Operation	Hours of Operation

Affiliations

Is your clinic an affiliate of another organization? Select all that apply.

- ☐ Hospital/ Health system
- ☐ Homeless Shelter
- ☐ University
- ☐ Church or Religious Federation
- ☐ Medical Group Practice
- ☐ Nonprofit Social Service Agency

Other:

Does your clinic have a religious affiliation? ◯ Yes ◯ No

If so, what?

Is your clinic considered student-run? ◯ Yes ◯ No

If so, which college/ university are you affiliated with?

Patients and Demographics

Patients

From January 1, 2017 to December 31, 2017, how many unique patients did your clinic see?

Infants (>1)	
Children (1-18)	
Men	
Pregnant Women	
Women	
TOTAL	0

What qualifies a patient to be seen at your clinic? Please provide a short narrative. Include any income or residency requirements.

To whom does your clinic provide care? Please select all that apply

☐ Uninsured ☐ Underinsured ☐ Covered by Medicaid ☐ Covered by other insurance

In 2017, roughly how many patients at your clinic fell into each insurance category?

Uninsured	Underinsured	Covered by Medicaid	Covered by other insurance

Demographics

In 2017, roughly what percentage of your clinic population fell into the racial/ethnic categories listed below?

Hispanic/ Latino %		American Indian/ Alaskan Native %	
White %		Native Hawaiian/ Pacific Islander %	
Black/ African-American %		Other %	
Asian %		Don't know/ Not tracked %	

Which, if any, special populations represent groups served by your clinic. Please select all that apply. Note: "special populations" refers to subcategories of underserved populations.

☐ Homeless
☐ Persons with substance use disorders
☐ LGBTQ Individuals
☐ Veterans
☐ Rural populations
☐ Persons with disabilities
☐ Immigrants/ Undocumented
☐ Persons with HIV/ AIDS
☐ Prison re-entry populations
☐ Not applicable; does not target special population

Other:

Please list the top three languages <u>other than English</u> that patients at your clinic speak.

1.

2.

3.

Do you provide any type of interpretation services in your clinic? Select all that apply.

- ☐ Live interpretation by volunteer
- ☐ Live interpretation by staff
- ☐ Live interpretation by student
- ☐ Interpretation via phone
- ☐ Interpretation via video system
- ☐ None; does not provide interpretation
- ☐ Other

Other: _____

Does your clinic participate and/or provide in any cultural competency trainings? If so, please provide a narrative. Include who provides the training, who from your clinic attends, and what the topic or group the training covered.

Visits and Services

Visits

From January 1, 2017 to December 31, 2017, roughly how many visits were performed in your clinic and/or referred by your clinic?

Visit Type	**On-site** (services performed in clinic)	**Off-site** (referrals/ performed off-site)
Medical (Primary Care)		
Specialty		
Dental		
Vision		
Behavioral Health Care		
Case Management/ Social Services		
Nursing Visit/ Follow-up		

What, if any, type of specialty care does your clinic provide on-site? Separate all specialties with commas.

What, if any, type of specialty care and other types of non-medical care does your clinic refer off-site through a volunteer network? Separate all specialties and types with commas.

From January 1, 2017 to December 31, 2017, roughly how many educational sessions were performed in your clinic?

Prescription Education	Disease Management	Lifestyle/ Prevention	Other
Describe "other":			

Services

From January 1, 2017 to December 31, 2017, roughly how many of each service was provided in your clinic?

Prescriptions	Laboratory Tests	Diagnostic Tests	Other
Describe "other":			

*Note: "Prescription" refers to one thirty day supply of medication.

In what way, if any, do you assist patients in procuring prescriptions? Select all that apply.

- ☐ Dispense medications from clinic pharmacy or dispensary
- ☐ Participate in Rx Assistance Programs
- ☐ Arrangement with local pharmacy
- ☐ Use of charitable pharmacy (off-site)
- ☐ Discount Pharmacy Card
- ☐ $4/ $10 Gift Cards for generic list
- ☐ Other
- ☐ None; does not assist

Other:

What laboratory tests do you provide on-site? Please separate all types with commas.

What diagnostic tests do you provide on-site? Please separate all types with commas.

If laboratory and/or diagnostic tests are not available on-site, in what way, if any, do you assist patients in accessing tests?

Does your clinic provide physicals? ◯ **Yes** ◯ **No**

If so, does the patient need to provide their own form? ◯ Yes ◯ No

Staff and Volunteers

Staff

Approximately how many paid staff (full or part-time) work in the clinic?

What role(s) do paid staff serve in the clinic? Please list title, number of people filling this role, and hours in clinic weekly. (Ex. Medical Director, 1, 10 hours). Please use a new line for each position.

Volunteers

Approximately how many volunteers excluding providers serve in the clinic?

What role(s) do volunteers excluding providers serve in the clinic? Please list role, number of people filling this role, and hours in clinic weekly. (Ex. Clinic Manager, 1, 10 hours). Please use a new line for each position.

Approximately how many volunteer providers serve in the clinic?

What type of care do the volunteer providers provide in the clinic? Please list occupation/ specialty, number of people providing this type of care, and hours in clinic weekly. (Ex. Dentist, 1, 10 hours). Please use a new line for each position.

Approximately how many students (all types), if any, serve in the clinic?

What type of students, if any, serve in the clinic? Please list type of students, number of students, and average hours in the clinic weekly. (Ex. Pharmacy, 12, 3 hours). Please use a new line for each type of student.

Volunteer Coordinator Name

Volunteer Coordinator Phone

Volunteer Coordinator E-Mail

Please provide a brief description of how volunteers are recruited and trained. Please be sure to include any barriers or strengths your clinic has in recruiting, training, and retaining volunteers of all types.

Budget and Finance

How much was your clinic's gross cash operating budget (expenses) in 2017? Specify the dollar amount in the space provided. Exclude capital, donated time, and in-kind gifts (contributions of goods and services other than cash). Please use calendar year. If your clinic opened in 2017, put "Not Applicable." **$**

Please upload a copy of a Board- approved budget for 2018* **2018 Budget**

Please upload a copy of your organization's most recent form 990 and/or an independent audit* **990 And/Or Audit**

*The upload button will redirect you to the OAFC Dropbox to submit the files. Before uploading, please save files as ClinicName_Budget, ClinicName_990, or Clinic Name_Audit (as appropriate). If you have any problems, please contact Beth Collier at OAFC at bcollier@ohiofreeclinics.org or 614-914-6458 x5.

From what sources did your organization receive monetary support in 2017? Select all that apply.

- ☐ Individual donors
- ☐ United Way
- ☐ Patient Fees
- ☐ Private Grants
- ☐ Corporations
- ☐ Insurance reimbursements
- ☐ Church or religious federation
- ☐ Civic/ Professional Groups
- ☐ Medical School/ University
- ☐ Local government
- ☐ Uninsured Care Funds (UCF)
- ☐ State government (**not** UCF)
- ☐ Federal government
- ☐ Other

Other:

Approximately how much of your revenue comes from patient fees and/or donations?

Administration

Technology

Does your clinic currently have an Electronic Health Record (EHR) system? ◯ Yes ◯ No

If not, do you plan to install one? ◯ Yes ◯ No If so, what system?

If so, when? If not, why not?

Quality Care

Has your board approved a plan to implement OAFC Quality Standards of Care? ◯ Yes ◯ No

Did your clinic completed the 2017 OAFC Quality of Care Standards? Note: the 2017 standards were completed electronically. ◯ Yes ◯ No

If not, why not?

AmeriCorps VISTA

Have you ever hosted an AmeriCorps VISTA member in your organization?

◯ Yes (Full-Year) ◯ Yes (Summer) ◯ Yes (Full-year and Summer) ◯ No

AmeriCorps VISTA members **work on projects related to capacity building, including grant writing and volunteer training. Are you interested in learning more about hosting a VISTA in your clinic?** ◯ Yes ◯ No

Board and Administration

Please upload a copy of your 2018 Board Roster with contact information and officer positions labeled.* 2018 Board Roster

*The upload button will redirect you to the OAFC Dropbox to submit the files. Before uploading, please save files as ClinicName_Board If you have any problems, please contact Beth Collier at OAFC at bcollier@ohiofreeclinics.org or 614-914-6458 x5

Is the information listed for your clinic correct on our website? ◯ Yes ◯ No

Corrections:

Please list staff, volunteers, Board members, etc. who should receive OAFC email updates. Please list name and then e-mail. (Ex. John Doe, jdoe1@yourfreeclinic.com). Please list one per line.

Additional Comments

Anything you'd like to let us know?

Thank you so much for completing the 2018 Annual Survey!

If you have any questions or concerns, please don't hesitate to contact Beth Collier at OAFC at bcollier@ohiofreeclinics.org or at 614-914-6458 x5.

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