

THE HEALTH LEADERSHIP PROGRAM AT DUKE

COMMUNITY AND PROJECT PROFILE

Participant name:

Your Community

Please check your Community type

Rural

Urban

Other (please specify):

Suburban

Using the US Census Bureau's Quick Facts tool (<http://quickfacts.census.gov/>) please answer the following questions about your community.

What is the total population of your county?

What percent of the population are female?

What is the percentage of persons under 5 years old?

What is the percentage of persons under 18 years old?

What is the percentage of persons 65 years old or older?

What is the ethnic makeup (in percent) of your county?

What is the median household income?

What is the percentage of persons below poverty?

Context for Your Project

What is the approximate number or size of your target population?

0 - 100

1000-5000

100 - 1000

5000+

What is the health insurance status of your target population (check all that apply)?

- | | |
|--|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private Insurance |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Uninsured |
| <input type="checkbox"/> Dual-eligible | <input type="checkbox"/> Other |
| <input type="checkbox"/> SCHIP | |

What populations or sub-populations are/will be targeted by your project (check all that apply)?

- | | |
|--|---|
| <input type="checkbox"/> New immigrant | <input type="checkbox"/> Homeless |
| <input type="checkbox"/> Adults | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Children | <input type="checkbox"/> Migrant |
| <input type="checkbox"/> Elderly | <input type="checkbox"/> Public Housing Residents |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Other (please specify): | |

What ethnic groups are/will be primarily targeted by your project (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White |
| <input type="checkbox"/> Other (please specify): | _____ |

What types of organizations are partners or potential partners on this project (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Area Health Education Center (AHEC) | <input type="checkbox"/> Medical/Dental Society |
| <input type="checkbox"/> Academic Medical Center | <input type="checkbox"/> Mental Health Program |
| <input type="checkbox"/> Business Non-Profit | <input type="checkbox"/> Migrant Health Center (MHC) |
| <input type="checkbox"/> Chamber of Commerce/Small Business Organization | <input type="checkbox"/> Other Hospital |
| <input type="checkbox"/> Community Based Social Service Organization | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Community Health Center (CHC) (<i>Federally Supported</i>) | <input type="checkbox"/> Primary Care Association |
| <input type="checkbox"/> Community Advocacy Group | <input type="checkbox"/> Private Hospital |
| <input type="checkbox"/> Educational Organization | <input type="checkbox"/> Private Provider/Group Practice |
| <input type="checkbox"/> Faith Based Organization | <input type="checkbox"/> Public Hospital |
| <input type="checkbox"/> Foundation | <input type="checkbox"/> Local Employers |
| <input type="checkbox"/> Free Clinic | <input type="checkbox"/> Rural Health Clinic (RHC) |
| <input type="checkbox"/> Homeless Shelter | <input type="checkbox"/> State Government |
| <input type="checkbox"/> School-Based Health Centers | <input type="checkbox"/> State Health Department |
| <input type="checkbox"/> Hospital (Low-income utilization rate greater than 25%) | <input type="checkbox"/> Substance Abuse Program |
| <input type="checkbox"/> Local/County Government | <input type="checkbox"/> Transit Authority |
| <input type="checkbox"/> Local/County Public Health Department | <input type="checkbox"/> Tribal Organization |
| <input type="checkbox"/> Managed Care Organization | <input type="checkbox"/> University |
| <input type="checkbox"/> Local Chapter of National Organization | <input type="checkbox"/> Veterans Administration |
| <input type="checkbox"/> Other (please specify): | _____ |

Are you a part of a consortium with your community partners? If so, what is the history of your Consortium (check all that apply):

- Formal – Incorporated non-profit (e.g. 501c3) Years: _____
- Informal – Collaborative Agreements (MOA/MOU Memorandum of Agreement/ Memorandum of Understanding) Years: _____
- No Formal Agreement Years: _____

What collaborative or integrated services/activities are/will be Included in your project? (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Disease/Chronic Condition/Case Management | <input type="checkbox"/> Pharmacy Assistance Program |
| <input type="checkbox"/> Coordinated Services | <input type="checkbox"/> Quality Management |
| <input type="checkbox"/> Coordination with Public Insurance Programs | <input type="checkbox"/> Referral Network |
| <input type="checkbox"/> Cultural Competence Training | <input type="checkbox"/> Shared Clinical Protocols |
| <input type="checkbox"/> Management Information System | <input type="checkbox"/> Shared/Common Enrollment/Patient Intake |
| <input type="checkbox"/> Electronic Medical/Health Records | <input type="checkbox"/> Sliding Fee Scales |
| <input type="checkbox"/> Outreach Services/Patient Education | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Translation Services | |
| <input type="checkbox"/> Other (please specify): _____ | |

What health care services are/could be provided by this project (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Dental | <input type="checkbox"/> Social Services/Enabling Services |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Specialty Care |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Prevention | <input type="checkbox"/> Tertiary Care |
| <input type="checkbox"/> Primary Medical Care Services | |
| <input type="checkbox"/> Other (please specify): _____ | |

OTHER RESOURCES

What other resources support/could support this project (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Grants | <input type="checkbox"/> Private Funding |
| <input type="checkbox"/> In-kind Contributions | <input type="checkbox"/> Federal Funding |
| <input type="checkbox"/> Faith-based Organization | <input type="checkbox"/> State/Local Funds |
| <input type="checkbox"/> Foundations | <input type="checkbox"/> Taxing Authority |
| <input type="checkbox"/> Patient Fees | <input type="checkbox"/> Tobacco Funds |
| <input type="checkbox"/> Other (please specify): _____ | |
| | _____ |