

Organization Name: _____

Site Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Site (Non-Referral) Services Provided

- | | | |
|---|---|---|
| <input type="checkbox"/> Primary Care | <input type="checkbox"/> Podiatry | <input type="checkbox"/> Laboratory * |
| <input type="checkbox"/> Dental - Preventive* | <input type="checkbox"/> Asthma Care | <input type="checkbox"/> Mammography * |
| <input type="checkbox"/> Dental - Restorative * | <input type="checkbox"/> Cardiology | <input type="checkbox"/> Nursing Home * |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Case Management | <input type="checkbox"/> RX-Pharmacist Dispensed * |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Cervical Cancer Screening * | <input type="checkbox"/> RX-Clinician Dispensed * |
| <input type="checkbox"/> Pediatric | <input type="checkbox"/> Developmental Screening * | <input type="checkbox"/> DHS School Based/ Linked * |
| <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Diabetes Education | <input type="checkbox"/> School Located Non-DHS * |
| <input type="checkbox"/> Prenatal Care | <input type="checkbox"/> ER Diversion Agmnt w/ Hospital * | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Chiropractic Services | <input type="checkbox"/> Family Planning | <input type="checkbox"/> Administrative |
| <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> HIV-AIDS Service | <input type="checkbox"/> Deaf Services |
| <input type="checkbox"/> Optometry | <input type="checkbox"/> Immunizations | <input type="checkbox"/> WIC/Head Start |

Other Specialty Care (Specify): _____

Hours Open per Week
(check one)

- <10
 11-31
 32-50
 >50

Weekends and Evenings
(check all that apply)

- Open after 6 p.m.
any weekday
 Open Saturday
 Open Sunday

Section 330 Grant Type for this Site
(Check all that apply)

- Grant: Community Health Center
(regular CHC grant, not special population)
 Grant: Homeless Grant: Community
 Grant: Migrant / Seasonal Farm worker
 Grant: Public Housing
 Look-Alike

Contact Information

Name: _____ Title: _____

Phone: _____ E-mail: _____

Please return new site information to Barry Lacy, blacy@iphca.org or fax (217) 541-7380. Questions or requests for electronic copy of existing site profiles contact Barry Lacy as indicated above or by calling (217) 541-7379.

* Please refer to the Site and Service Audit Definition sheet for clarification of these terms

Office Use Only - Do Not Complete Below This Line.

| | | | |
|-----------|-------------|------------------------------|--------------|
| CD: _____ | CO: _____ | <input type="checkbox"/> WEB | SHLTR: _____ |
| SD: _____ | | <input type="checkbox"/> DB | |
| HD: _____ | MPCD: _____ | | DNM: _____ |