Appendix C

Revised Resource Organization Questionnaire (Fifth Version)
(OMB Control No. 0920-0255)

****Note: All proposed changes in the attached are highlighted in gray.**

Form approved
OMB No.0920- 0255
Exp. date: __xx/xx/20xx

CDC National Prevention Information Network
Resource Organization Online Questionnaire

The National Prevention Information Network (NPIN) is a clearinghouse service provided by the U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention (CDC). A primary goal is to serve as a comprehensive source for information about organizations in the United States that provide services and resources related to HIV/AIDS-, Viral Hepatitis-, STD-, and TB-related infections. NPIN is authorized to collect this information by Section 301 of the Public Health Service Act (42 U.S.C. 241). This information is organized and maintained by the NPIN online database. The mission of NPIN is to serve the information needs of State and local HIV/AIDS/Viral Hepatitis/STD/TB program personnel and other professionals. The general public also has access to this information from the NPIN website (http://cdcnpin.org) or by calling CDC-INFO (formerly the CDC National AIDS and STD Hotline), which provides referrals from the NPIN database to local service organizations.

One of NPIN's most pressing needs is to gather and update information about HIV/AIDS-, Viral Hepatitis-, STD-, and TB-related resources and services. The information you provide about your organization or program will be added to the CDC NPIN database and will be made available to professionals and other users. Your participation is voluntary.

Instructions

This Resource Organization Questionnaire is designed to help us learn as much information as we can about the services of your organization. It is comprised of 6 Sections. The first section (11 questions) is intended for all respondents to answer. The following 3 sections ask about your organization's clients; direct services your organization provides to clients; and the education, information, and research services your organization provides, as well as the materials it produces. The final 2 sections inquire about access procedures and any additional comments. The Questionnaire is designed to cover many different types and sizes of organizations; therefore, some questions may not apply to your organization. A number of skip patterns allow you to by-pass sections of the Questionnaire that are not applicable to your organization.

Complete the Questionnaire online. *Please note that the last section asks for your name and phone number. This information is important if we need to clarify your answers. Also, we urge you to attach electronic copies of information about your organization, particularly if additional space is needed to fully describe your services.*

When completed, you may submit the Questionnaire online by clicking the Submit button. You may also print a hard copy of the completed questionnaire and return it to the following address or fax it to (888) 282-7681. For additional information, please call (800) 458-523l.

CDC National Prevention Information Network
Information Sciences Department
PO Box 6003
Rockville, MD 20849-6003

Public reporting burden of this collection of information is estimated to average 17 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, or respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0255).

I. ORGANIZATION INFORMATION

1. Organization Name (including any department, division, or office). Attach your organization's letterhead, if possible.

____

____

____

____

____

2. Indicate the following (if any) by which your organization is known:

Acronym: ____

Other name: ____

Previous name(s): ____

Program name(s): ____

3. Organization's corporate address and mailing address, if different: (Include other site addresses on a separate sheet of paper and attach).

Corporate Address:	Mailing Address:
Street 1: ______________________________	Street 1: ____________________________________
Street 2: ______________________________	Street 2: ___________________________________
City: ______________________________	City: ____________________________________
State: ______________________________	State: ____________________________________
ZIP: ______________________________	ZIP: ____________________________________
County: ______________________________	County: ___________________________________
Country: ______________________________	Country: ___________________________________

4. List your organization's telephone number(s). Please note geographic restrictions and hours of service

Main Telephone: (_____)___________________ Toll-Free: (___)__________________________

Fax: (_____)______________________________ Hotline: (___)____________________________

TDD/Deaf Access: (_____)_________________ Publications: (_____)______________________

Spanish (______)____________________ Other (________)___________________________

5. List your organization's Internet addresses.

E-mail Address: ____

Website Address: ____

6. Key staff (Please indicate (*) the name to whom mail should be addressed).

Name: ____________________ Title:____________________ E-mail:_________________

Name: ____________________ Title:____________________ E-mail: _________________

Name: ____________________ Title:____________________ E-mail: _________________

7. Check the geographic area your organization serves, and specify name of area or jurisdiction.

____ Cities: ____

____ Counties: ____

____ States: ____

____ Regions: ____

____ Countries: ____

____ Other: ____

Removed question: Is the organization a member of any consortia, task forces or coalitions? If so, please list: ____

Removed question: If your organization is a government agency, check the appropriate government level below.

❑ Federal ❑ State ❑ County ❑ City ❑ Other

8. If your organization is non-government, check the description that best characterizes your organization:

   ❑ For-Profit ❑ Not-For-Profit ❑ Not-For-Profit 501c3

9. Is your organization minority owned or operated?

   ❑ Yes ❑ No

10. If your organization is not-for-profit, is it affiliated with a religion or religious denomination?

    ❑ Yes ❑ No

    If yes, which religion or denomination?
    ____

11. What kinds of HIV/AIDS, Viral Hepatitis, STD, and/or TB work does your organization do?
    ____
    ____
    ____
    ____
    ____

II. CLIENT INFORMATION

1. Primary client groups your organization serves or targets.

   ____
   ____
   ____
   ____

III. CLIENT SERVICES OF YOUR ORGANIZATION

Added question:

1. Does the organization provide services in languages other than English? ❑ Yes ❑ No

   If yes, please specify:
   ____

2. Does your organization provide direct services to clients who are infected or affected by HIV, STDs, TB or Viral Hepatitis? ❑ Yes ❑ No

IF NO, SKIP TO SECTION IV. IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS.

3. HIV ANTIBODY/Viral Hepatitis/STD/TB TESTING AND COUNSELING (Check terms that best describe your services)
   - ❑ Anonymous HIV-Antibody Testing Services
   - ❑ Anonymous HIV Test-related Counseling
   - ❑ Confidential HIV-Antibody Testing Services
   - ❑ Confidential HIV Test-related Counseling
   - ❑ HIV-Test Related Counseling
   - ❑ Partner notification
   - ❑ Oral testing
   - ❑ Rapid oral testing
   - ❑ Rapid blood testing
   - ❑ Home test kits
   - ❑ Anergy testing
   - ❑ Viral load testing
   - ❑ Viral Hepatitis testing
     - ❑ Hepatitis B testing
     - ❑ Hepatitis C testing
   - ❑ STD Testing
   - ❑ TB Testing

4. TREATMENT (Check terms that best describe your services)
   - ❑ Dental Care
   - ❑ Direct Observed Therapy (DOT) Short Course
   - ❑ Eye Care
   - ❑ Family Planning
   - ❑ Health Fairs
   - ❑ Immunizations
     - ❑ HAV Immunizations
     - ❑ HBV Immunizations
     - ❑ HPV Immunization
   - ❑ Infusion Therapy
   - ❑ Mobile Health Services
   - ❑ OB / GYN Care
   - ❑ Gynecological Care
   - ❑ Obstetrics
   - ❑ Prenatal Education and Counseling
   - ❑ Occupational Therapy
   - ❑ Pediatric Care
   - ❑ Well Baby Care
   - ❑ Physical Therapy
   - ❑ Primary Care
   - ❑ Respiratory Therapy
   - ❑ School Clinics
   - ❑ College Health Services
   - ❑ Speech Therapy
   - ❑ STD Treatment
   - ❑ Viral Hepatitis treatment
     - ❑ Hepatitis B treatment
     - ❑ Hepatitis C treatment
   - ❑ TB Treatment
   - ❑ Worksite Clinics
   - ❑ Other/Comments:

   ____

5. HIV/AIDS Treatments and Therapies (Check terms that best describe your services)

- ❑ Alternative Therapies
- ❑ Acupuncture
- ❑ Aroma Therapy
- ❑ Art Therapy/ Music Therapy / Dance Therapy
- ❑ Chiropractic Therapy
- ❑ Herbal Therapy
- ❑ Holistic Therapy
- ❑ Homeopathic Therapy
- ❑ Massage
- ❑ Meditation
- ❑ Nutrition Therapy
- ❑ Traditional Chinese Medicine
- ❑ Clinical Trials
- ❑ Drug Therapy
- ❑ Combination Therapy
- ❑ Other/Comments: ____________________

6. COUNSELING (Check terms that best describe your services)

- ❑ Abstinence Counseling
- ❑ Bereavement Counseling
- ❑ Caregiver Counseling
- ❑ Crisis Intervention Counseling
- ❑ Family Counseling / Couples Counseling
- ❑ Group Counseling
- ❑ Individual Counseling
- ❑ Safer Sex Counseling
- ❑ Sexual Abuse Counseling
- ❑ Sexuality Counseling
- ❑ Stress Management Counseling
- ❑ Mental Health Counseling
- ❑ Substance Abuse Counseling

7. SUPPORT GROUPS ❑ Yes ❑ No

If yes, please list the types of support groups:

____

____

8. SPIRITUAL SERVICES (Check terms that best describe your services)

- ❑ Faith Based AIDS Services
- ❑ Clergy Education
- ❑ Parishioner Education
- ❑ Spiritual Counseling / Pastoral Counseling
- ❑ Spiritual Retreats

9. SUPPORT SERVICES (Check terms that best describe your services)

- ❑ Adult Day Care for Persons with HIV/AIDS
- ❑ Advocacy
- ❑ Case Management, Administration
- ❑ Buddy Programs
- ❑ Child Services
- ❑ Adoption Services
- ❑ Child Day Care Services
- ❑ Foster Care Services
- ❑ Clothing Banks
- ❑ Food Services
- ❑ Emergency Food Services/Soup Kitchens
- ❑ Food Banks/Pantries
- ❑ Meal Preparation and Home Delivery
- ❑ Funeral Planning Assistance
- ❑ Home Health Aides Services
- ❑ Home Skilled Nursing Care
- ❑ Homemaker Services
- ❑ Personal Care Services
- ❑ Pet Care Services
- ❑ Respite Care Services
- ❑ Hospice Services
- ❑ Housing Services
- ❑ Assisted Living Services
- ❑ Emergency Housing Services
- ❑ Housing Opportunities for Persons with AIDS / HOPWA
- ❑ Medical Supplies and Equipment Services
- ❑ Recreational and Social Program Services
- ❑ Transportation Services
- ❑ Visiting Programs

10. REFERRAL SERVICES (Check terms that best describe your services)

- ❑ Counseling Referral
- ❑ Legal Referrals
- ❑ Medical Referrals
- ❑ HIV Antibody Testing Referrals
- ❑ STD Testing Referrals
- ❑ Viral Hepatitis Testing Referrals
- ❑ Viral Hepatitis Vaccination Referrals
- ❑ TB Testing Referrals
- ❑ Social Services Referrals
- ❑ Financial Referrals for Individuals
- ❑ Housing Referrals / Shelter Referrals

11. LEGAL ASSISTANCE SERVICES (Check terms that best describe your services)

- ❑ Estate Planning and Wills
- ❑ Immigration Legal Services
- ❑ Litigation Support
- ❑ Powers of Attorney

12. FINANCIAL ASSISTANCE AND SERVICES TO INDIVIDUALS (Check terms that best describe your services)

- ❑ Emergency Financial Assistance
- ❑ Funeral Financial Assistance
- ❑ Housing Financial Assistance
- ❑ Insurance Financial Assistance
- ❑ Personal Financial Planning
- ❑ Pharmacy Assistance Services
- ❑ Drug Purchasing Services
- ❑ Mail Order Drug Services
- ❑ Viatical Settlements
- ❑ Funding
- ❑ Fundraising

13. FINANCIAL SERVICES TO ORGANIZATIONS (Check terms that best describe your services)

- ❑ Funding
- ❑ Fundraising
- ❑ Grant Management

IV. HOTLINE/INFORMATION/RESEARCH/EDUCATION SERVICES OF YOUR ORGANIZATION

1. Does your organization provide hotline, information, research, education, or advocacy services specific to HIV/AIDS, Viral Hepatitis, STDs, or TB?
   ❑ Yes ❑ No

IF NO, SKIP TO SECTION V. IF YES, PLEASE ANSWER THE QUESTIONS BELOW

2. HOTLINE SERVICES

2a. Does your organization operate a hotline? ❑ Yes ❑ No

If no, please skip to Question 3.

2b. Is your hotline:

An AIDS hotline?	❑ Yes	❑ No
An STD hotline?	❑ Yes	❑ No
A TB hotline?	❑ Yes	❑ No
A viral hepatitis hotline?	❑ Yes	❑ No

If no to all of the above, please specify what type of hotline:
____

Revised question wording:
2c. Please describe the operation of the services provided by your hotline in the space below.

Type	Telephone #	Type	Telephone #

3. INFORMATION SERVICES (Check terms that best describe your services)

- ❑ Electronic Information Resources
- ❑ Information Dissemination
- ❑ Audiovisual Materials Dissemination
- ❑ Print Materials Dissemination
- ❑ Treatment Information Dissemination
- ❑ Library Services and Resource Centers
- ❑ Materials Production
- ❑ Audiovisual Materials Production
- ❑ Newsletter Publication / Circulation
- ❑ Print Materials Production, Databases
- ❑ Networking

4. RESEARCH (Check terms that best describe your services)

- ❑ Behavioral Research
- ❑ Contact Tracing
- ❑ Data Analysis
- ❑ Epidemiological Reporting
- ❑ Pediatric AIDS Research
- ❑ Pharmaceutical Research
- ❑ Vaccine Development Research
- ❑ Surveillance

5. EDUCATION SERVICES (Check terms that best describe your services)

- ❑ Curriculum Design / Curriculum Development
- ❑ Conferences
- ❑ Emergency Medical Technician Education
- ❑ Health Education
- ❑ Safer Sex Education
- ❑ School or University Education
- ❑ Health Professional Education
- ❑ Nurse Education
- ❑ Physician Education
- ❑ Viral Hepatitis Prevention
- ❑ HIV/AIDS Prevention
- ❑ Intervention Strategies
- ❑ Nutrition Education
- ❑ Outreach
- ❑ Bleach Distribution
- ❑ Condom / Female Condom / Dental Dam Distribution
- ❑ Needle Cleaning or Needle Sterilization
- ❑ Needle Exchange or Distribution
- ❑ Peer Education
- ❑ Street Outreach
- ❑ Parent Education
- ❑ Partner Communication
- ❑ Patient Education
- ❑ Provider Education
- ❑ Public Awareness Campaigns
- ❑ NAMES Quilt
- ❑ Speakers Bureau
- ❑ STD Prevention
- ❑ TB Prevention
- ❑ Training Programs
- ❑ Buddy Training
- ❑ Caregiver Training
- ❑ Continuing Education
- ❑ Train the Trainer
- ❑ Volunteer Training

6. WORKPLACE PROGRAMS (Check terms that best describe your services)

- ❑ Americans with Disabilities Act / ADA
- ❑ Employee assistance programs
- ❑ Employee education
- ❑ Employment Counseling
- ❑ Employment Training
- ❑ Managers / Supervisors Education
- ❑ Occupational Safety and Health
- ❑ Return to Work Programs
- ❑ Technical Assistance
- ❑ Union Training

Added response category

7. HEALTH CARE PLANNING (Check terms that best describe your services)
   - ❑ HIV/AIDS Program Administration
   - ❑ State/Regional Planning or Coordination
   - ❑ Policy Analysis or Recommendation
   - ❑ HIV/AIDS Activism

8. MATERIALS PRODUCTION. Does your organization produce HIV/AIDS education and prevention newsletters or other materials? (**DO NOT CHECK** if you distribute materials produced by another source).

   ❑ Yes ❑ No

   ❑Newsletter: Title: ____________________ Frequency: ________________________

   ❑Other Print materials ____

   ❑Audiovisual materials ____

V. ACCESS PROCEDURES

Please check applicable items below and use the lines for explanation or additional information

1. Hours of operation

   Please be specific: ____

2. Payment and Access

❑ No Fee
❑ Fee
❑ Fee Sliding Scale
❑ Donations Accepted
❑ Appointment Required
❑ Age Restrictions: ___________________
❑ Medicaid
❑ Medicare
❑ Insurance
❑ Walk-ins Accepted
❑ Other Restrictions: __________________

3. Eligibility Requirements (or Restrictions):

____

VI. ADDITIONAL COMMENTS

The CDC National Prevention Information Network (CDC NPIN) and the CDC-INFO (formerly the CDC National AIDS Hotline) Hotline refer callers to organizations every day. We want to be certain that the information we provide about your organization is as complete as possible. Please provide any details about your organization that are not captured in this questionnaire. Feel free to attach written materials that describe your organization (e.g., brochure).

____
____
____
____
____

Thank you for providing information about your organization. Please complete the following and sign this questionnaire. This information will be used for clarification purposes only and will not be included in the CDC National Prevention Information Network (NPIN) databases.

Your Name: ____

Title or position: ____

Phone:____

Date: ____

Signature: ____

If you need help completing this questionnaire,
contact the CDC NPIN: (800) 458-5231.

If available, please send us at least one copy of the print and/or audiovisual material(s) produced by your organization.

☐ Materials enclosed ☐ Materials being forwarded separately