

Resources and Services Database of the CDC National Prevention
Information Network

0920-0255

Attachment 3-A

Resource Organization Initial Questionnaire

**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 (12 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. 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) 458-5231.

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 vary from 13-20 minutes per response, with average of 16 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:

Street 1: _____

Street 2: _____

City: _____

State: _____

ZIP: _____

County: _____

Country: _____

4. List your organization's telephone number(s).

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: _____
Metropolitan Area: _____
Countries: _____
Other: _____

8. Is your organization a government agency?

- Yes No

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

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

10. Is your organization minority owned or operated?

- Yes No

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

- Yes No

If yes, which religion or denomination?

12. 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

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)

- HIV Test Counseling
- Conventional Blood HIV Testing
- Conventional Oral HIV Testing
- Rapid Oral HIV Testing
- Rapid Blood HIV Testing
- Home HIV Test Kits
- Partner notification
 - Mobile Testing
 - TB Testing
- Viral Hepatitis Testing
 - Hepatitis A Testing
 - Hepatitis B Testing
 - Hepatitis C Testing
 - Hepatitis C Rapid Testing
- STD Testing
 - Chlamydia Testing
 - Syphilis Testing
 - Gonorrhea Testing
 - Herpes Testing
 - Home STD Test Kits

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

- Clinical Trials
- Medical Adherence Education and Counseling
- Dental Care
- Direct Observed Therapy (DOT) Short Course
- Family Planning
- HAV Immunizations
- HBV Immunizations
- HPV Immunization
- Gynecological Care
- Primary Care
- STD Treatment
- Viral Hepatitis Treatment
 - Hepatitis B Treatment
 - Hepatitis C Treatment
- TB Treatment
- Other/Comments:

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

- Alternative/Complementary Medicine
- HIV/AIDS Medical Treatment
- Nutrition Therapy
- Other/Comments: _____

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

- Counseling
- Sexuality Counseling
- Substance Abuse Treatment

7. SUPPORT GROUPS Yes No

8. Does your organization provide any FAITH BASED AIDS SERVICES?

- Yes No

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

- Case Management, Administration
- Food Services
- Child Care
- Home Care Assistance
- Respite Care Services
- Housing Services
- Housing Opportunities for Persons with AIDS / HOPWA
- Transportation Services

10. REFERRAL SERVICES Yes No

11. LEGAL SERVICES Yes No

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

- Emergency Financial Assistance
- Housing Financial Assistance
- Financial Assistance to Individuals
- Drug Purchasing Assistance, including AIDS Drug Assistance Programs (ADAP)

13. Does your organization provide funding to organizations?
 Yes No

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:

- 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
- Materials - Print/Audiovisual
- Treatment Information

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

- Behavioral Research
- Other Research

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

- Curriculum Development
- Conferences
- Safer Sex Education
- Health Professional Education
- Hepatitis Prevention/Education
- HIV/AIDS Prevention/Education
- Nutrition Education
- Condom / Female Condom /Dental Dam Distribution
- Needle Cleaning, Needle Exchange or Needle Distribution
- Peer Education
- Street Outreach
- Public Awareness Campaigns
- NAMES Quilt
- Speakers Bureau
- STD Prevention/Education
- TB Prevention/Education
- Training Programs
- Train the Trainer
- Abstinence Education
- Capacity Building
- Harm Reduction
- Networking
- Technical Assistance

6. Does your organization provide EVIDENCE-BASED BEHAVIORAL INTERVENTIONS? Yes No

If yes, please list the types of evidence-based behavioral interventions (level, risk category, race/ethnicity, sex/gender) provided:

7. Does your organization provide EVIDENCE-BASED BEHAVIORAL INTERVENTION TRAINING? Yes No

If yes, please list the types of evidence-based behavioral intervention training (level, risk category, race/ethnicity, sex/gender) provided:

8. Does your organization provide ONLINE TRAINING PROGRAMS? Yes No

If yes, please list the online training programs provided:

9. WORKPLACE PROGRAMS Yes No

10. PLANNING AND ADMINISTRATION (Check terms that best describe your services)

- Program Administration
- Advocacy/Activism
- Community Planning
- Grant Management

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

- | | |
|---|--|
| <input type="checkbox"/> No Fee | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Fee | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Fee Sliding Scale | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Donations Accepted | <input type="checkbox"/> Free Testing |
| <input type="checkbox"/> Appointment Required | <input type="checkbox"/> Walk-ins Accepted |
| <input type="checkbox"/> Other Restrictions: | _____ |

Age Restrictions: _____

Free Testing: Yes No

If yes, please list the types of free testing (HIV, STD, Hepatitis B, or Hepatitis C) provided:

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.**