

CBISA™ Program Form

General

Title of Program: _____

Category of Program (Choose the ONE BEST FIT / PRIMARY FOCUS):

- | | |
|---|---|
| A. COMMUNITY HEALTH IMPROVEMENT SERVICES | E. CASH AND IN-KIND CONTRIBUTIONS |
| <input type="checkbox"/> A1. Community Health Education | <input type="checkbox"/> E1. Cash Donations |
| <input type="checkbox"/> A2. Community Based Clinical Services | <input type="checkbox"/> E2. Grants |
| <input type="checkbox"/> A3. Health Care Support Services | <input type="checkbox"/> E3. In-Kind Donations |
| B. HEALTH PROFESSIONS EDUCATION | F. COMMUNITY-BUILDING ACTIVITIES |
| <input type="checkbox"/> B1. Physicians/Medical Students | <input type="checkbox"/> F1. Physical Improvements/Housing |
| <input type="checkbox"/> B2. Nurses/Nursing Students | <input type="checkbox"/> F2. Economic Development |
| <input type="checkbox"/> B3. Other Health Professions Education | <input type="checkbox"/> F3. Community Support |
| <input type="checkbox"/> B4. Scholarships/Funding for Professions Education | <input type="checkbox"/> F4. Environmental Improvements |
| C. SUBSIDIZED HEALTH SERVICES | <input type="checkbox"/> F5. Leadership Development/Training
for Community Members |
| <input type="checkbox"/> C1. Emergency and Trauma Services | <input type="checkbox"/> F6. Coalition Building |
| <input type="checkbox"/> C2. Neonatal Intensive Care | <input type="checkbox"/> F7. Advocacy for Community Health
Improvement |
| <input type="checkbox"/> C3. Hospital Outpatient Services | <input type="checkbox"/> F8. Workforce Development |
| <input type="checkbox"/> C4. Burn Unit | G. COMMUNITY BENEFIT OPERATIONS |
| <input type="checkbox"/> C5. Women's and Children's Services | <input type="checkbox"/> G1. Assigned Staff |
| <input type="checkbox"/> C6. Renal Dialysis Services | <input type="checkbox"/> G2. Community Health Needs/
Health Assets Assessment |
| <input type="checkbox"/> C7. Subsidized Continuing Care | <input type="checkbox"/> G3. Other Resources |
| <input type="checkbox"/> C8. Behavioral Health Services | |
| <input type="checkbox"/> C9. Palliative Care | |
| D. RESEARCH | |
| <input type="checkbox"/> D1. Clinical Research | |
| <input type="checkbox"/> D2. Community Health Research | |

Description: _____

IRS Reportable _____ Indirect Factor: None Manual In Unit In Community Special

Targeted For: Living in Poverty Broader Community

Dept. Name: _____

Phone: _____ Email: _____

Contact Name: _____

Objectives

Community need being addressed: _____

How was need determined (assessed) _____

Objectives: _____

(a) Improve Access

(b) Enhance Community Health

(c) Advance Knowledge

(d) Relieve/Reduce Burden

Is this program duplicated in the community?

Does this program address an unmet community need?

Is this a collaborative effort? If so, who are your partners and what are their respective roles?

Indicators

Intended Outcomes / Baseline / Strategies: _____

Outcome Indicators:

Short Term (< 1 year) _____

Intermediate Term (1 – 5 years) _____

Long Term (> 5 years). _____

Setting/Format

Setting / Location:

- Community
- Home
- In Facility
- Inpatient
- Outpatient
- Workplace
- Other _____
- Other _____

Format:

- Clinic
- Events/Meetings
- Health Fairs/Screenings
- Newsletter
- Seminars
- Speaker's Bureau
- TV/Radio
- Other _____
- Other _____

Target Audience

Target Audiences:

County: _____

Genders: Male Female Both

Special Needs Populations:

- Persons with disabilities
- Racial, cultural and ethnic minorities
- Uninsured/underinsured
- Other (specify) _____
- Other (specify) _____
- Other (specify) _____

Age of Targeted Audience:

- Infants
- Children
- Teens
- Adults
- Seniors
- All Ages

Healthy Communities (additional data entry form)