The Academy CAN!
Community Health Care Center Application Form

Please type or print (please attach additional pages if necessary):

A. *Clinic Information*

Community Health Center: _____

Uniform Data System (U.D.S.) #: _____

Director: _____

Contact Person (if different from above): _____

Address: _____

_____

City, State, Zip: _____

Phone: ( )_____ Fax: ( )_____

E-mail: _____

Type of Funding: _____

B. *Staff and Services*

1. Health professionals on staff:

-Allergists	_____ FTE	-Nurse practitioners	_____ FTE
-Other subspecialists	_____ FTE	-RNs, LPNs, etc.	_____ FTE
-Primary care physicians	_____ FTE	-Research-related staff	_____ FTE
-Physician assistants	_____ FTE	-Other:_____	_____ FTE

2. How many of the above professionals are involved in the provision of allergy/asthma services?_____

3. Please describe the range of allergy / asthma treatment and diagnostic resources at your center (e.g. spirometer):

4. With what teaching hospital, if any, are you currently affiliated?

5. With which allergists, if any, do you have current working relationships? Please list their names and affiliations. How would you characterize your relationship? (formal or informal, consulting, hospital-based, etc.?)

6. Do you currently have a program that specifically addresses allergy and asthma care needs?

YES ___ NO ___

If YES, please describe your program:

C. *Patients*

1. Please indicate the distribution of patient groups served by your clinic (each total should equal 100%):

Race/ethnicity:

African/American:	_____	Native American:	_____
Asian/Pacific Islander:	_____	Non-Hispanic White:	_____
Hispanic:	_____	Other:	_____

Household Income:

Below $15,000:	_____	$30,000 - $45,000:	
$15,000 - $30,000:	_____	More than $45,000:	

Age:

0-17: ____ 18-65: ____ Over 65: ____

2. In a typical month, roughly how many patients with allergic disease (including asthma) do you treat? Make your best guess._____

3. Is it feasible to schedule many of these patients during the volunteer hours that the allergist would be on site? YES ___ NO ___

D. Partnership Program

A number of key ingredients will help to create an effective partnership. Please provide feedback on how your community health center would address the following. Your responses will aid our ability to choose appropriate sites:

1. Describe the neighborhood or community within which your clinic is located (e.g., is it a high-need area for allergy/asthma services, based on demographic, epidemiological, or hospitalization data?) *Attach any materials containing relevant data to support your description below*.

2 Provide objective and subjective evidence of need for allergy/asthma services at your center and attach any materials containing relevant data to support your description below.

3. The AAAAI is interested in accommodating community health center needs by providing allergist-volunteers who are committed, flexible and culturally sensitive. Are there any other specific expectations that your health center would have of the allergist-consultant in attempting to develop an ideal partnership experience?

4. An allergist-consultant can perform various roles at your health center. Please indicate below the types of activities that you foresee as part of a visiting allergist-consultant's monthly involvement. Be as specific as possible.

5. Please describe how you plan to accommodate the allergist-volunteer with space, staff support, patient scheduling, teaching opportunities and any other needs associated with his or her role at your center.

6. Do you currently have contact with any area allergist who you would prefer that we approach as a potential volunteer for your center? (Check one answer below)

   YES ___ NO ___

   If YES, please provide name and address below:

7. The success of collaborations often relies heavily on the enthusiasm and support of staff for the project. What evidence can you provide for this type of partnership?

8. In what ways do you envision your collaboration with the allergist providing opportunities for their further career development?

9. Please briefly describe any past history or current experience with successful partnerships involving subspecialty physicians as consultants:

Please fax this application to Megan Brown, **fax number (414) 272-6070** or return to:

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