COMMUNITY BENEFITS REPORTING FORM

Pursuant to RSA 7:32-c-l

FOR FISCAL YEAR BEGINNING
07/01/2016

to be filed with:
Office of the Attorney General
Charitable Trusts Unit
33 Capitol Street, Concord, NH 03301-6397
603-271-3591

Section 1: ORGANIZATIONAL INFORMATION

Organization Name Families First of the Greater Seacoast

Street Address 100 Campus Drive, Suite 12

City Portsmouth **County 08 - Rockingham** **State NH** **Zip Code 3801**

Federal ID # -222757341 **State Registration # 3027**

Website Address: www.FamiliesFirstSeacoast.org

Is the organization's community benefit plan on the organization's website? Yes

Has the organization filed its Community Benefits Plan Initial Filing Information form? Yes

IF NO, please complete and attach the Initial Filing Information Form.
IF YES, has any of the initial filing information changed since the date of submission?
Yes IF YES, please attach the updated information.

Chief Executive:	Helen B. Taft	603-422-8208 x120	
	htaft@familiesfirstseacoast.org		
Board Chair:	Linda Sanborn	603-433-8838	LSanborn@bnncpa.com
Community Benefits Plan Contact:	David Choate	603-422-8208 x143	
	dchoate@familiesfirstseacoast.org		

Is this report being filed on behalf of more than one health care charitable trust? No

Section 2: MISSION & COMMUNITY SERVED

Mission Statement: To contribute to the health and well-being of the Seacoast community by providing a broad range of health and family services to all, regardless of ability to pay.
Has the Mission Statement been reaffirmed in the past year (*RSA 7:32e-I)*? Yes

Please describe the community served by the health care charitable trust. "Community" may be defined as a geographic service area and/or a population segment.

Service Area (Identify Towns or Region describing the trust's primary service area):
We serve mainly the Seacoast region of New Hampshire, including Portsmouth, Hampton, Seabrook, Exeter, Dover, Rochester and surrounding towns.

Service Population (Describe demographic or other characteristics if the trust primarily serves a population other than the general population):
Families First's services are available to all Seacoast residents, but our primary target population is people with low incomes, uninsured patients, homeless people, and families with children. Many are experiencing risk factors such as single parenthood, psychosocial issues, low education, chronic illness and poor parenting skills

Certain programs at the Families First Health Center have more limited target audiences, due to requirements set by funders of those programs or simply due to the nature of the programs:
- Mobile health care teams visit sites convenient for people experiencing homelessness and other low-income individuals in Portsmouth, Rochester, Dover, Hampton and Exeter.
- Mobile dental teams visit sites in Portsmouth, Rochester and Exeter.
- Our school-based children's dental program is for children who attend elementary schools in Portsmouth, Newington, Greenland or Seabrook; Head Start programs in Portsmouth, Hampton and Seabrook; and the Seacoast Community School at the Community Campus in Portsmouth.
- Our Dental Center prioritizes Families First primary care and prenatal patients, senior citizens, veterans, and children and teens. However, we can often assist people who don't fall into these categories, especially in emergency situations.

FAMILIES FIRST HEALTH CENTER CLIENTS
Of the 4,920 patients who came to Families First for health care in fiscal year 2016:
- 22% were uninsured, and 46% were covered by Medicaid.
- 24% were homeless.
- Two-thirds were living at or below the federal poverty level (i.e. less than $20,160 for a family of three) and another 30% were below 200% of poverty.
- 43% were adult women; 27% were adult men; 30% were children under age 21.
- 94% were non-Hispanic; 6% were Hispanic (including multiracial)
- 87% were White (including Hispanic); 3% were Black/African American; 5% were Asian; 2% were more than one race; and 3% refused to report race.
- 32% resided in Portsmouth; 17% in Hampton or Seabrook; 25% elsewhere in Rockingham County; 18% in Strafford County; and 8% in Maine.

Section 3: COMMUNITY NEEDS ASSESSMENT

In what year was the last community needs assessment conducted to assist in determining the activities to be included in the community benefit plan?
2016 *(Please attach a copy of the needs assessment if completed in the past year)*

Was the assessment conducted in conjunction with other health care charitable trusts in your community? Yes

Based on the needs assessment and community engagement process, what are the priority needs and health concerns of your community?

	NEED (Please enter code # from attached list of community needs)
1	101
2	120
3	122
4	320
5	370
6	407
7	505
8	530
9	603

What other important health care needs or community characteristics were considered in the development of the current community benefits plan (e.g. essential needs or services not specifically identified in the community needs assessment)?

	NEED (Please enter code # from attached list of community needs)
A	121
B	201
C	303
D	350
E	430
F	601
G	604

Please provide additional description or comments on community needs including description of "other" needs (code 999) if applicable. *Attach additional pages if necessary*:

The priority needs listed in the preceding tables were obtained from the Seacoast Public Health Network's (SPHN) Community Health Improvement Plan for 2015-2017, issued in 2015; and the Exeter Community Health Needs Assessment, led by Exeter Health Resources (EXETER) in 2016.

The following community needs were identified in one or both community needs assessments and are addressed by Families First as follows:

ACCESS TO CARE DUE TO INSURANCE COVERAGE COST BARRIERS (EXETER)

To help patients with cost barriers such as high deductibles and high co-pays, Families First Health Center offers a sliding fee scale to underinsured as well as uninsured patients. In the last fiscal year, the Health Center served 4,920 patients, of whom 22% were uninsured; others were underinsured. In FY15, Families First provided $1.66 million in charity care, and $4.2 million in uncompensated care. We also screen all patients for Medicaid eligibility and help them enroll if possible, after which they will have no deductible and little or no co-pays.

SUBSTANCE ABUSE AND ADDICTION (EXETER)
YOUTH SUICIDE/SUBSTANCE & PRESCRIPTION DRUG ABUSE (EXETER)
ALCOHOL AND SUBSTANCE MISUSE (SPHN)

In late December 2016, we saw our first patient in our new Medication-Assisted Treatment (MAT) program, which since then has served more than 60 people. This program incorporates medications (Suboxone and Vivitrol), group and individual counseling, acupuncture, referrals to Safe Harbor Recovery Center for recovery coaching, and other supportive services. We have two physicians certified to prescribe these medications, two substance abuse counselors, a nurse manager dedicated solely to the MAT program, and a care coordinator. We use the SBIRT (Screening, Brief Intervention, and Referral to Treatment) tool with all patients, which screens for risk of substance misuse as well as active substance misuse. And we began distributing Narcan (an overdose antidote) to patients who use opioids and their family and friends. The staff described in the Mental Health section, below, are also an important part of addressing substance misuse, as untreated mental illness is a big risk factor for substance misuse.

We do an adolescent risk assessment with all patients ages 12-18 once a year that asks about exposure to drugs and alcohol, social isolation, depression and other risk factors for substance misuse. If active substance use is identified, the treatment services described above are available to young people.

To reduce the likelihood of prescription drug abuse by our patients and their family members, we follow the NH State Board of Medicine's most current guidelines for prescribing narcotic pain medication. Our EMR has built-in prompts to remind providers to check the Prescription Drug Monitoring Program databases for New Hampshire and Maine before prescribing controlled medications. Patients being prescribed these medications are asked to sign contracts agreeing to conditions such as taking medications only as prescribed. Our policy is not to replace prescriptions for controlled medications if the patient claims the prescription is lost. We use an embosser on written prescriptions for controlled meds so they can't be duplicated or falsified. In the MAT program we prevent diversion by initially administering medications on-site only, giving each patient the lowest effective dose and so they won't be tempted to give any away, drug-testing to make sure the level of medication that was prescribed is in the patient's system, and educating patients about proper medication storage.

Our parenting classes and family programs build “protective factors” that researchers have identified as reducing the likelihood that children will grow up to abuse substances. (Protective factors include close family relationships, consistency of parenting, and clear parental expectations regarding alcohol and other drug use.)

MENTAL HEALTH CARE ACCES (EXETER and SPHN)

Families First Health Center integrates behavioral health counseling with primary care. We have one full-time and one part-time behavioral health counselor, who provide brief, solution-focused therapy to patients who have a mental health condition and/or a physical condition that is impacted by behavior. Also, a part-time psychiatric nurse practitioner and a part-time volunteer psychiatrist come on site so that we can work with patients who are on complicated psychiatric medications.

TRANSPORTATION

The main way Families First removes transportation barriers to accessing health care is through our mobile program, which brings medical, dental, substance abuse counseling and care coordination services to shelters and other sites convenient for homeless people and people with low incomes. On a limited basis, we also assist patients with transportation to Families First and other health-related appointments by giving them gas cards or taxi or bus vouchers, or by having home visitors drive patients to appointments.

AFFORDABLE HOUSING / HOMELESSNESS (EHR)

About one-fourth of Families First’s patients are homeless. We provide medical and dental care and care coordination to these patients at Families First Health Center and at mobile clinics at about a dozen sites (shelters, soup kitchens, Salvation Army, etc.) in five towns. Our care coordinators -- as well as our home visitors, who work with families and seniors -- can help people get into public housing and obtain veterans, disability and other benefits that enable them to pay rent. Families First’s executive director sits on the Greater Seacoast Coalition on Homelessness, described below.

ELDER CARE AND SUPPORT SERVICES (EXETER) AND INJURY PREVENTION (reducing falls in older adults) (SPHN)

Families First provides medical and dental care to seniors. We accept Medicare, and we offer sliding-fee discounts to help seniors with Medicare co-pays and with dental care. We have a prescription assistance program that assists patients with costs that Medicare doesn’t cover. We offer a caregivers group monthly, and we partner with other organizations to offer senior luncheons twice a month. Families First is the Seacoast’s site for the Senior Companion Program of NH. We provide home visits to our most vulnerable senior patients.

One of the strategies identified in the network’s Seacoast Community Health Improvement Plan was to “convene a community-partner-led regional injury prevention workgroup to guide planning and execution of objectives.” A Families First employee serves as facilitator of this

work group. At meetings, group members go over activities they've provided related to fall risk; share information about opportunities for increasing visibility and doing education around falls prevention; and discuss progress toward the objectives in the group's three-year work plan, which are: 1) Convene workgroup, look at assessment tools used in homes and senior centers, and increase availability of Falls Prevention Master Trainers; 2) Identify evidence-based fall prevention programs, assess them, and take steps to increase availability of these programs throughout the community; and 3) Educate medical providers and pharmacists about medications and combinations of medications that can increase fall risk.

HEART DISEASE / STROKE (SPHN)

Families First assists patients with setting self-management goals, provides tools for self-monitoring (including free blood-pressure cuffs), prescribes medications to control hypertension and followup to specialty care if needed. Families First is participating in the Million Hearts Campaign which has enabled Families First to implement best practices in the management of hypertension in the office setting. The clinical staff has been re-trained in taking blood pressures and new protocols in blood pressure management have been implemented.

NUTRITION / OBESITY (SPHN)

Families First Health Center provides nutrition education and counseling to all patients in its prenatal program. Counseling is available to other Families First Health Center patients on a more limited basis.

OTHER

In addition to the needs identified in the two community needs assessments, Families First also has programs and services to meet the following other needs from the "List of Potential Community Needs" distributed with this reporting form:
Availability of Dental/Oral Health Care
Perinatal Care Accesss
Breast Cancer
Cervical Cancer
Colorectal Cancer
Diabetes
Asthma
Access/Availability of Chronic Disease Screening Services
Immunization Rates
Influenza/Pneumonia
Family/Parent Support Services
Transportation Services
Information and Referral
Prescription Assistance

Section 4: COMMUNITY BENEFIT ACTIVITIES

Identify the categories of Community Benefit activities provided in the preceding year and planned for the upcoming year (note: some categories may be blank). For each area where your organization has activities, report the past and/or projected unreimbursed costs for *all* community benefit activities in that category. For each category, also indicate the *primary* community needs that are addressed by these activities by referring to the applicable number or letter from the lists on the previous page (i.e. the listed needs may relate to only a subset of the total reported costs in some categories).

A. Community Health Services	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Community Health Education	1 2 1	$74,615.00	$78,346.00
Community-based Clinical Services	3 -- 1	$33,504.00	$35,179.00
Health Care Support Services	6 -- 2	$249,864.00	$262,357.00
Other: Family/Parent Support Services	4 3 --	$555,935.00	$583,732.00

B. Health Professions Education	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Provision of Clinical Settings for Undergraduate Training	-- -- --		
Intern/Residency Education	-- -- --		
Scholarships/Funding for Health Professions Ed.	-- -- --		
Other:	-- -- --		

C. Subsidized Health Services	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Type of Service:	-- -- --		
Type of Service:	-- -- --		
Type of Service:	-- -- --		
Type of Service:	-- -- --		

D. Research	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Clinical Research	-- -- --		
Community Health Research	-- -- --		
Other:	-- -- --		

E. Financial Contributions	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Cash Donations	-- -- --		
Grants	-- -- --		
In-Kind Assistance	-- -- --		
Resource Development Assistance	-- -- --		

F. Community Building Activities	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Physical Infrastructure Improvement	-- -- --		
Economic Development	-- -- --		
Support Systems Enhancement	-- -- --		
Environmental Improvements	-- -- --		
Leadership Development; Training for Community Members	-- -- --		
Coalition Building	-- -- --		
Community Health Advocacy	-- -- --		

G. Community Benefit Operations	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Dedicated Staff Costs	-- -- --		
Community Needs/Asset Assessment	-- -- --		
Other Operations	-- -- --		

H. Charity Care	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Free & Discounted Health Care Services	1 2 --	$2,162,220.00	$2,270,331.00

I. Government-Sponsored Health Care	***Community Need Addressed***	***Unreimbursed Costs (preceding year)***	***Unreimbursed Costs (projected)***
Medicare Costs exceeding reimbursement	1 2 --	$309,567.00	$325,045.00
Medicaid Costs exceeding reimbursement	1 2 --	$680,544.00	$714,572.00
Other Publicly-funded health care costs exceeding reimbursement	-- -- --		

Section 5: SUMMARY FINANCIAL MEASURES

Financial Information for Most Recent Fiscal Year	***Dollar Amount***
Gross Receipts from Operations	$3,600,264.00
Net Revenue from Patient Services	$2,612,871.00
Total Operating Expenses	$6,213,135.00
Net Medicare Revenue	$267,994.00
Medicare Costs	$309,567.00
Net Medicaid Revenue	$1,606,413.00
Medicaid Costs	$2,286,957.00
Unreimbursed Charity Care Expenses	$2,162,220.00
Unreimbursed Expenses of Other Community Benefits	$1,904,029.00
Total Unreimbursed Community Benefit Expenses	$4,066,249.00
Leveraged Revenue for Community Benefit Activities	$3,306,257.00
Total Community Benefits including Leveraged Revenue for Community Benefit Activities	$4,066,249.00

Section 6: COMMUNITY ENGAGEMENT in the Community Benefits Process

List the Community Organizations, Local Government Officials and other Representatives of the Public consulted in the community benefits planning process. Indicate the role of each in the process.	***Identification of Need***	***Prioritization of Need***	***Development of the Plan***	***Commented on Proposed Plan***
1) Exeter Hospital (Loree Hazard, Debra Vasapolli, Mark Whitney)	☒	☒	☒	☒
2) Seacoast Mental Health Center (Jay Couture)	☒	☒	☒	☒
3) United Way of the Greater Seacoast (Cindy Boyd, Lauren Wool)	☒	☒	☒	☒
4) Lamprey Health Care (Anita Rozeff, Greg White)	☒	☒	☒	☒
5) Families First Health & Support Center (Helen Taft, Margie Wachtel)	☒	☒	☒	☒
6) Exeter Area YMCA (James Page, Andrew Walker)	☒	☒	☒	☒
7) Seacoast Public Health Network (Maria Reyes)	☒	☒	☒	☒
8) Easter Seals NH (Susan Silsby)	☒	☒	☒	☒
9) Richie-McFarland Children's Center (Peggy Small-Porter)	☒	☒	☒	☒
10) Online survey (sent to employees of Steering Committee agencies, and others)	☒	☐	☐	☐
11) UNH Survey Center Household Telephone Survey	☒	☐	☐	☐
12) Community forums, key leader interviews	☒	☐	☐	☐
13) Portsmouth Regional Hospital (Stacey Angers, Justin Looser)	☒	☒	☒	☒
14) Foundation for Seacoast Health (Deb Grabowski)	☒	☒	☒	☒
15) Lincoln Street School SAU16 (Jim Hayes)	☒	☒	☒	☒
16) Raymond Coalition for Youth (Celeste Clark)	☒	☒	☒	☒
17) City of Portsmouth (Brinn Chute)	☒	☒	☒	☒
18) Southern NH Area Health Education Center (Paula Smith)	☒	☒	☒	☒
19) Rockingham Community Action (Patte Ardizzoni)	☒	☒	☒	☒
20) Portsmouth Housing Authority (Kelly Mann, Craig Welch)	☒	☒	☒	☒
21) Exeter Fire Department (Brian Comeau)	☒	☒	☒	☒
22) Homeless Teen Coalition (Katy McDermott)	☒	☒	☒	☒
23) ServiceLink Resource Center (Stephanie Stevens)	☒	☒	☒	☒
24) Connor's Climb, Epping High School, Seacoast Medical Reserve Corps, Seacoast Coalition on Homelessness, Seacoast Youth Services	☒	☐	☐	☐
25)	☐	☐	☐	☐

Please provide a description of the methods used to solicit community input on community needs (attach additional pages if necessary): Input on community needs was gathered through the process of preparing the Seacoast Public Health Network's Community Health Improvement Plan in 2015, and the Exeter Community Health Needs Assessment in 2013. Families First staff participated in both of these endeavors. Information on how community input was solicited for each plan follows:

EXETER COMMUNTY HEALTH NEEDS ASSESSMENT (2016)

The process for the 2016 Community Health Needs Assessment (CHNA) included gathering and reviewing both qualitative and quantitative data through the use of a random telephone survey conducted by the University of New Hampshire, open community forums, online surveys, key leader interviews, outreach to support agencies, and the review of relevant secondary data sources. As a component of the forums and online surveys, respondents were asked to participate in prioritizing qualitative health needs. Details on the methods of obtaining input, the individuals and organizations providing input are included in the attached CHNA report. Here is a summary:

1. UNH Survey Center Household Telephone Survey

Utilizing the University of New Hampshire Survey Center, a random household telephone survey was conducted as a means to collect information regarding community members' health status and to identify their healthcare needs. The telephone survey was conducted annually in 2010, 2011, 2012 and 2013 between 2013 and 2016. In total, 8,645 healthcare decisionmakers residing within the hospital's service area participated in the survey.

2. Community Forums

A total of four Community Forums - to be held in Exeter, Raymond, Plaistow and Seabrook - were planned and promoted to the general public. The community forums were promoted via email, social media, paid print advertisements and direct-mail. Invitations were sent to key community leaders, including Rockingham County's 843 elected state representatives. Only the Exeter forum had attendees (21), so three additional "pop-up" forums were held during existing community events (a meeting of the Rockingham County Community Resource Network, a senior luncheon and a church dinner).

During the Exeter community forum, an overview of the CHNA requirements and the process through which the CHNA Steering Committee intended to gather information was reviewed with attendees. In addition, copies of the 2008 Community Needs Assessment were distributed, and key findings from the 2013 report were reviewed, along with notable environmental changes since that time, i.e., changes in the economy, unemployment rates, Medicaid expansion and the impact of the NH Insurance Exchange.

Following the overview, community members engaged in an open discussion and provided verbal insight into the significant heath needs of their communities. Comments and or discussion points were recorded for consideration by the Steering Committee.

3. Online Surveys

Exeter Hospital (together with its affiliates Core Physicians and Rockingham VNA & Hospice), and other Steering Committee members, offered a voluntary online health needs assessment to each organization's employee base. Steering Committee members also sent a link to the survey to other groups and posted it on Facebook. A total of 1,111 people from 20 organizations responded to the survey.

4. Key Leader Interviews
Interviews were conducted with key leaders who were identified as having broad knowledge of the health needs of the communities served, including underserved and "low income" populations. In total, 27 key leader interviews were conducted in May, June and July 2016.

5. Secondary Research Sources:
Additional secondary resources were reviewed to further understand the health status of people living within Rockingham County.

In addition to participating in both of these needs assessments, Families First also participates on an ongoing basis in coalitions that are working to help clients access the continuum of services they need and address gaps in services communitywide. These include the Seacoast Collaborative (Care Coordination Subgroup). Led by Portsmouth Regional Hospital, this group consists of many of the health and human services in the Portsmouth area and its aim is to improve care coordination activities in the Seacoast, with a focus on transitions of care.

SEACOAST PUBLIC HEALTH NETWORK (2015)

In 2013, the state of New Hampshire published the State Health Improvement Plan (SHIP) 2013-2020, which highlights ten key health areas currently facing the population (tobacco, obesity/diabetes, heart disease/stroke, healthy mothers and babies, cancer prevention, asthma, injury prevention, infectious disease, emergency preparedness, and misuse of alcohol and drugs). In the fall of 2014, the Public Health Networks, including the Seacoast, were tasked with creating Community Health Improvement Plans (CHIP), by selecting five priority areas from the New Hampshire SHIP. Starting in January of 2015, the Seacoast Public Health Network and its Public Health Advisory Council (PHAC) gathered and reviewed data to inform the selection process, interviewed and involved various community organizations, voted on priorities, and strategically planned the Seacoast CHIP.

The six-month process included robust methods for indicator selection: a review of county and regional data to choose priorities, interviews of community stakeholders and partners, and a comprehensive strategic planning session. In began with reviewing needs assessments completed within the last three years; the key one identified was Exeter Hospital's 2013 assessment, for which Families First and several other PHAC members served on the steering committee. Next, the PHAC was educated on a variety of local, county, and regional data sets in order to better inform their selection of health priorities.

Beginning in January 2015, the SPHN staff coordinated and facilitated a regional process to develop the Seacoast CHIP. This process included presentations from experts of primary data sources and facilitated discussion to inform the PHAC's selection of health indicators. Topics included identified partnerships within the region; Exeter Hospital's 2013 Community Needs Assessment; the CHIP template and expectations; 2014 and 2015 Rockingham County Health Rankings data; Seacoast regional data based on the SHIP indicators; County Health Rankings trend data from 2010-2015; and results from individual surveys of seacoast organizations to illustrate initiatives already being conducted in the region in relation to SHIP indicators.

PHAC members voted on which indicators would be included in the CHIP. Finally, members and staff attended the statewide PHAC meeting to gain an understanding of developing strategies to complete tasks.

A PHN staff member surveyed local organizations and stakeholders via phone and in person interviews to clarify the scope of work already being accomplished within each health indicator.

On May 19, 2015, the SPHN partnered with Community Health Institute to facilitate a CHIP Strategic Planning Session. Various community stakeholders were invited to participate and establish goals, objectives, and strategies to address the selected indicators.

In order to make this an even more robust process and ensure community involvement, the PHAC requested a deeper understanding of what stakeholders and partners were already accomplishing within the SHIP health priority areas. This was the impetus for the SPHN staff to organize and conduct numerous stakeholder interviews in order to collect information on programs, strengths, gaps, and goals and see how the SPHN could best include them in the CHIP in order to work towards a more coordinated and collaborative public health network.

Most of the interviews were with members of the Public Health Advisory Council. In addition, interviews were conducted with representatives of Connor's Climb, Epping High School and Seacoast Youth Services.

In order to begin strategizing these priority areas and identifying goals, objectives, and strategies. The PHAC and various community stakeholders attended a CHIP Strategic Planning Session on May 19, 2015. CHIP data, methods, and process of indicator selection was presented to the group and discussion was opened up for any concerns about the proposed health priority areas. Subsets of attendees participated in breakout sessions on Substance Misuse, Chronic Disease (Obesity; Heart Disease/Stroke), Mental Health (includes reducing suicide deaths) and Injury Prevention (focus on reducing falls in seniors).

As a result of this strategic planning meeting, the SPHN had the data and community input needed to complete an informed, holistic, and inclusive CHIP for the Seacoast Public Health Region.

Section 7: CHARITY CARE COMPLIANCE

Please characterize the charity care policies and procedures of your organization according to the following:	**YES**	**NO**	Not Applicable
The valuation of charity does not include any bad debt, receivables or revenue	☒	☐	☐
Written charity care policy available to the public	☒	☐	☐
Any individual can apply for charity care	☒	☐	☐
Any applicant will receive a prompt decision on eligibility and amount of charity care offered	☒	☐	☐
Notices of policy in lobbies	☐	☐	☒
Notice of policy in waiting rooms	☒	☐	☐
Notice of policy in other public areas	☒	☐	☐
Notice given to recipients who are served in their home	☐	☐	☒

List of Potential Community Needs for Use on Section 3

100 - Access to Care; General
101 - Access to Care; Financial Barriers
102 - Access to Care; Geographic Barriers
103 - Access to Care; Language/Cultural Barriers to Care
120 - Availability of Primary Care
121 - Availability of Dental/Oral Health Care
122 - Availability of Behavioral Health Care
123 - Availability of Other Medical Specialties
124 - Availability of Home Health Care
125 - Availability of Long Term Care or Assisted Living
126 - Availability of Physical/Occupational Therapy
127 - Availability of Other Health Professionals/Services
128 - Availability of Prescription Medications

200 - Maternal & Child Health; General
201 - Perinatal Care Access
202 - Infant Mortality
203 - Teen Pregnancy
204 - Access/Availability of Family Planning Services
206 - Infant & Child Nutrition
220 - School Health Services

300 - Chronic Disease – Prevention and Care; General
301 - Breast Cancer
302 - Cervical Cancer
303 - Colorectal Cancer
304 - Lung Cancer
305 - Prostate Cancer
319 - Other Cancer
320 - Hypertension/HBP
321 - Coronary Heart Disease
322 - Cerebrovascular Disease/Stroke
330 - Diabetes
340 - Asthma
341 - Chronic Obstructive Pulmonary Disease
350 - Access/Availability of Chronic Disease Screening Services

360 - Infectious Disease – Prevention and Care; General
361 - Immunization Rates
362 - STDs/HIV
363 - Influenza/Pneumonia
364 - Food borne disease
365 - Vector borne disease

370 - Mental Health/Psychiatric Disorders – Prevention and Care; General
371 - Suicide Prevention
372 - Child and adolescent mental health
372 - Alzheimer's/Dementia
373 - Depression
374 - Serious Mental Illness

400 - Substance Use; Lifestyle Issues
401 - Youth Alcohol Use
402 - Adult Alcohol Use
403 - Youth Drug Use
404 - Adult Drug Use
405 - Youth Tobacco Use
406 - Adult Tobacco Use
407 - Access/Availability of Alcohol/Drug Treatment

420 - Obesity
421 - Physical Activity
422 - Nutrition Education
430 - Family/Parent Support Services

500 – Socioeconomic Issues; General
501 - Aging Population
502 - Immigrants/Refugees
503 - Poverty
504 - Unemployment
505 - Homelessness
506 - Economic Development
507 - Educational Attainment
508 - High School Completion
509 - Housing Adequacy

520 - Community Safety & Injury; General
521 - Availability of Emergency Medical Services
522 - Local Emergency Readiness & Response
523 - Motor Vehicle-related Injury/Mortality
524 - Driving Under Influence
525 - Vandalism/Crime
526 - Domestic Abuse
527 - Child Abuse/Neglect
528 - Lead Poisoning
529 - Work-related injury
530 - Fall Injuries
531 - Brain Injury
532 - Other Unintentional Injury

533 - Air Quality
534 - Water Quality

600 - Community Supports; General
601 - Transportation Services
602 - Information & Referral Services
603 - Senior Services
604 - Prescription Assistance
605 - Medical Interpretation
606 - Services for Physical & Developmental Disabilities
607 - Housing Assistance
608 - Fuel Assistance
609 - Food Assistance
610 - Child Care Assistance
611 - Respite Care

999 – Other Community Need