**Agency/Organization Name:**

**Phone:**

**Address:**

**City:**

**State:**

**Zip code:**

**Website:**

**Clinic Contact Person:**

**Phone:**

**E-mail address:**

**Corporate Ownership/Health Care System Name (if applicable):**

|  |  |
| --- | --- |
| Organization Type | Predominant Specialty |
| [ ]  | Private Practice | [ ]  | Family Medicine |
| [ ]  | CHC | [ ]  | Internal Medicine |
| [ ]  | RHC | [ ]  | Pediatrics |
| [ ]  | Hospital Owned Clinic | [ ]  | Multispecialty |
| [ ]  | Other:  | [ ]  | Other:  |

**Number of Providers by Type and Specialty:**

|  |  |
| --- | --- |
| Provider Type (FTE) | Provider Specialty (FTE) |
|  | Physicians |  | Family Medicine |  | Psychology |
|  | Nurse Practitioners |  | Internal Medicine |  | Social Work |
|  | Physicians Assistants |  | General Pediatrics |  | Diet/Nutrition |
|  | Other Providers |  | OB/GYN |  | Psychiatry |
|  | Other Clinic Staff  |  |  |

Has your clinic ever participated in:

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Practice Transformation Initiative | [ ]  | [ ]  |
| PCMH Programs | [ ]  | [ ]  |
| Quality Improvement Learning Collaborative | [ ]  | [ ]  |
| Other: If yes, what type:   | [ ]  | [ ]  |

Please indicate which START Initiative Track your organization is interested in:

[ ]  Track 1: Screening and Referral Pathway

[ ]  Track 2: Treatment Pathway

