340B Pre-Screening Questionnaire

SECTION A: GENERAL INFORMATION					
Organization:	Name:				
	Street Address				
	Phone:				
	Website:				
Point of Contract for your	Name:				
organization:	Street Address:				
	Phone:		Fax:		
	Email:		URL:		
Previous 340B Subrecipient?	□ Yes	to	🗆 No		
If yes, provide dates.					
SECTION B: ORGANIZATION IN					
Type of organization (check a					
	Governmen	•	□ Foundation		
□Non-Profit Org	□For Profit O	rg	□Other:		
Facility Type (check all that ap	ply):				
☐ HIV Counseling/Testing Site	🗌 STD Clinic		🗆 Drug Treatment		
Private MD/HMO		al Facility/Jail	Prenatal		
🗌 Job Corps	🗌 Mental Hea	alth services	School-Based Clinic		
□ Other:					
SECTION C: POPULATIONS SER					
Age (check all that apply): Children/Youth (<12)	Adolescent	c (12_17)	☐ Young Adults (18-24)		
\square Adults (25-59)	Seniors (60				
Race/Ethnicity (check all that a		<u>'</u>]			
□ White, non-Hispanic		on-Hispanic	Hispanic		
American Indian/Alaskan Na		lawaiian/Pacific Island			
Special Populations (check all	that apply):				
□ HIV+	-	OU populations	LGBTQ populations		
Sex Workers	Other:				
SECTION D: SERVICES PROVIDED					
Harm Reduction (check all that apply):					
Syringe Exchange		istributions	Fentanyl Test Strip Distribution		
☐ Risk Assessment/Counseling	g 🛛 🗆 Condom Di	stribution	☐ Other:		
	-				
Hepatitis (check all that apply)		C			
Hepatitis Screening	🗆 Hepatitis B	Case Management	Hepatitis C Treatment		
Hepatitis Vaccines					
HIV (check all that apply):		wation			
HIV Testing	HIV Test Ed		□ HIV Referrals		
HIV Case Management	🗆 HIV Preven	tion (PEP and PrEP)			

STD (check all that apply):		
🗆 Chlamydia/Gonorrhea	🗆 Chlamydia/Gonorrhea	Gonorrhea resistance testing
Screening	Treatment	
Extra-genital testing	Expedited Partner Therapy	
Syphilis Screening	Syphilis Treatment	
SECTION E: BILLING SOURCES/PRAC		
Medicaid	Medicare	Private Insurance
□ Sliding Fee Schedule	Family Planning	□ Other:
SECTION F: PROJECT PARAMETERS/		
Estimated Number of 340B Patients	::	
Type of Support Requested:		
🗆 In-Kind	Type/Quantity:	
Direct Recipient	Amount:	
Project Plan (Describe intent of fun	ding, and benefits to program):	

Service Locations (list all locations providing services to 340B eligible patients):

Name:				
Street Address:				
City:	State:	Zip:		
County:	Phone:	Fax:		
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