

CHILDREN'S AIDS FUND

CARE PROVIDER NETWORK SURVEY

All community-based organizations, hospitals, clinics or other institutions applying for any of the Children's AIDS Fund (CAF) programs must have an up-to-date survey on file with CAF.

Please complete the following questions as accurately as possible. Your cooperation will help us serve you and your clients more effectively and efficiently. If you have any questions about anything in the survey, please call CAF toll free at 866-829-1560.

GENERAL INFORMATION

Organization Name _____

Contact Person(s) and Title(s) _____

Mailing Address _____

City/State/Zip _____

Shipping Address (if different from above) _____

Telephone _____ FAX _____

Email _____

YOUR CLIENT BASE

1. Please indicate by percentage the ethnic/racial make-up of your client base:

____ African American ____ Hispanic/Latino ____ Caucasian
____ Native American ____ Oriental/Pacific Islander ____ Other (please explain below)

2. Please indicate by percentage the ages of your client base:

____ Birth-2 years ____ 6-8 years ____ 12-15 years ____ 18-25 years
____ 3-5 years ____ 9-11 years ____ 16-18 years ____ Over 25 years

3. Please indicate by percentage the overall gender of your client base:

____ Female ____ Male

4. Please indicate by percentage the following segments of your client base:

____ HIV-infected children (birth through age 18) ____ HIV-positive mothers
____ HIV-impacted children (birth through age 18) ____ HIV-positive fathers
____ Uninfected parents of HIV-positive children

5. What percentage of your pediatric HIV-positive client base is hemophiliac? _____
6. What is the approximate number of your annual client base? _____
7. What is the average length of time you serve each client? _____

YOUR SERVICES

8. Which of the following services do you provide for clients? (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Bereavement Support | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Client Family Support Groups | <input type="checkbox"/> Client Support Groups |
| <input type="checkbox"/> HIV Counseling/Testing | <input type="checkbox"/> HIV Education/Prevention Client Programs |
| <input type="checkbox"/> HIV Education/Prevention Community Programs | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Job Training/Career Counseling | <input type="checkbox"/> Inpatient Medical Care |
| <input type="checkbox"/> Mentoring Programs | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Parenting Education | <input type="checkbox"/> Outpatient Medical Care |
| <input type="checkbox"/> Respite Care | <input type="checkbox"/> Permanency Planning |
| <input type="checkbox"/> Substance Abuse Programs | <input type="checkbox"/> Social Service/Financial Assistance |
| <input type="checkbox"/> Other (Please describe) _____ | <input type="checkbox"/> Tutoring Programs |

9. Please indicate the areas covered by your services: (check all that apply)

- Local County-wide State-wide Regional National

10. Please describe ongoing volunteer programs your organization generates to serve your client base (if different from above), for example: holiday parties, special events or trips, education seminars, etc.

11. Please indicate by percentage the make-up of your organization's funding/support:

- | | |
|---|--|
| <input type="checkbox"/> State Funding | <input type="checkbox"/> City/County Funding |
| <input type="checkbox"/> Federal Funding | <input type="checkbox"/> Foundation Grants |
| <input type="checkbox"/> Local Corporate Grants | <input type="checkbox"/> National Corporate Grants |
| <input type="checkbox"/> Individual/Private Donations | |
| <input type="checkbox"/> Local non-profit organizations/community service/civic programs | |
| <input type="checkbox"/> Regional non-profit organizations/community service/civic programs | |
| <input type="checkbox"/> National non-profit organizations/community service/civic programs | |

Please list local civic groups, foundations or companies who provide support for your programs.

YOUR COMMUNITY

12. Please list other organizations, agencies or institutions in your community serving your client base (no abbreviations, please).

13. Please describe other services available in your community for HIV-infected and affected children and families:

14. Please describe services that are needed but not available in your community for HIV-infected and affected children and families _____

CAF SERVICES

15. Please indicate which CAF services you have utilized in the past (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Holiday Gift Program | <input type="checkbox"/> Referrals for local assistance/service programs |
| <input type="checkbox"/> Emergency Financial Assistance | <input type="checkbox"/> Referrals to other care givers serving a similar population |
| <input type="checkbox"/> Assistance with clothing or other material goods for clients | |
| <input type="checkbox"/> Information and Resource Materials | <input type="checkbox"/> Have not used any CAF services |

16. Please indicate your level of satisfaction with the CAF services you have utilized (please check one):

- | | |
|---|--|
| <input type="checkbox"/> Very satisfied | <input type="checkbox"/> Not satisfied |
| <input type="checkbox"/> Satisfied | <input type="checkbox"/> Disappointed |
| <input type="checkbox"/> Not applicable | |

17. Please describe additional programs you would like to see CAF initiate:

18. Please describe the kinds of information you would like to receive from CAF

Thank you very much for your time and cooperation. Your responses will help us shape a future program that will hopefully provide a broader variety of programs to compliment your ongoing services.

Please return completed survey and printed materials about your program to:

Children's AIDS Fund
P.O. Box 16433
Washington, DC 20041
Tel: 703/433-1560 OR Toll Free 866-829-1560
Fax: 703/433-1561 OR Toll Free 800-557-8529
Email: info@childrensaidsfund.org