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 Contact: Monica L. White, Program Manager 312-906-6033 or
 Jessica Papp, Program Specialist 312-906-6024 for more information.

**2007/2008 Community Services Directory
 Registration Form
 (Agency/ Clinic/Healthcare Provider)**

Section A:

| | |
|--------------------------------|--|
| Agency/Provider Name | |
| Practice Name | |
| Contact Person | |
| Address | |
| City | |
| State | |
| Zip Code | |
| Complete Phone Number | |
| Complete FAX Number | |
| Complete TDD# | |
| E-mail Address | |
| Website | |
| Hospital Affiliation(s) | |

Provider Type:

| | | |
|--|---|--|
| <input type="checkbox"/> (1) Physician | <input type="checkbox"/> (2) Pharmacist | <input type="checkbox"/> (3) Alternative |
| <input type="checkbox"/> (4) Mental Health | <input type="checkbox"/> (5) Dental | |

(For Each Section- Check All That Apply)

Medical Specialties:

Alternative Therapies:

Mental Health:

| | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Addiction |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Couples |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Optometry | <input type="checkbox"/> Exercise | <input type="checkbox"/> Depression/Suicide |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Domestic |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Hypnotherapy | <input type="checkbox"/> Family |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Massage | <input type="checkbox"/> Grief/Loss |
| <input type="checkbox"/> Infectious | <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> Meditation | <input type="checkbox"/> Group |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Podiatry | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Individual |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Reiki | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Tai Chi | <input type="checkbox"/> Sexual Identity |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Yoga | <input type="checkbox"/> Sexual Issues |
| | | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Pharmaceutical Services:

Languages Spoken: (Please List)

| | |
|--|-----------------------------------|
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Delivery |
| <input type="checkbox"/> Supplements | <input type="checkbox"/> Mail |
| <input type="checkbox"/> Other: _____ | |

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Section B:

Agency/Practice Description: (Please provide a brief description of the services your agency/practice offers. Attach additional sheets of paper if necessary.)

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| |
|--|

Include agency/practice in Spanish directory? Yes No If yes, provide a Spanish Agency/Practice Description below. (Attach additional sheets of paper if necessary):

Section C:

Geographic Location: (This refers both to your physical location and your service area. Check all that apply.)

| | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> (A) Downtown | <input type="checkbox"/> (D) West Side | <input type="checkbox"/> (G) South | <input type="checkbox"/> (J) Illinois |
| <input type="checkbox"/> (B) North Side | <input type="checkbox"/> (E) North | <input type="checkbox"/> (H) Southwest | <input type="checkbox"/> (K) National |
| <input type="checkbox"/> (C) South Side | <input type="checkbox"/> (F) Northwest | <input type="checkbox"/> (I) West | |

Section D:

Fees: (Check all that apply.)

| | | |
|--|--|--|
| <input type="checkbox"/> (D) Medicaid | <input type="checkbox"/> (F) Free | <input type="checkbox"/> (P) Public Aid Accepted |
| <input type="checkbox"/> (E) Set Fee | <input type="checkbox"/> (I) Private Insurance | <input type="checkbox"/> (Q) Medicare |
| <input type="checkbox"/> (S) Sliding Fee Scale | | |

Section E:

Yes No Evening/Weekend Hours Available? (Check One)
 Yes No Is the Facility Handicap Accessible? (Check One)
 Yes No Are Transportation Services Available? (Check One)

(Optional Information)

Are you currently accepting new patients? Yes No

Is your organization accredited? If so, by what organization(s)?

What were the findings of your last consumer/client satisfaction survey? What number of people were surveyed?

What is the average wait time for an appointment in your clinic/practice, etc.?

What documentation should a potential client/patient bring with them to their first appointment?

Any other information you would like to add about your agency/practice/clinic?

Confirmation Signature:

Date Signed: