

**COMMUNITY BENEFIT REPORTING FORM FY20
MERCY JOPLIN**

PROGRAM GENERAL INFORMATION

Please fill out these forms as completely as possible and to the best of your ability for any programs completed this fiscal year or planned for the remainder of FY20. If you are not sure, simply leave the question or item blank. Thank you!

Title of Program: _____

Description: _____

Category of Program (Choose the ONE BEST FIT / PRIMARY FOCUS):

A. COMMUNITY HEALTH IMPROVEMENT SERVICES

- A1. Community Health Education
- A2. Community Based Clinical Services
- A3. Health Care Support Services
- A4. Social and Environmental Improvement Activities

B. HEALTH PROFESSIONS EDUCATION

- B1. Physicians/Medical Students
- B2. Nurses/Nursing Students
- B3. Other Health Professions Education
- B4. Scholarships/Funding for Professions Education

C. SUBSIDIZED HEALTH SERVICES

(THIS CATEGORY FOR FINANCE USE ONLY.)

- C1. Emergency and Trauma Services
- C2. Neonatal Intensive Care
- C3. Hospital Outpatient Services
- C4. Burn Unit
- C5. Women's and Children's Services
- C6. Renal Dialysis Services
- C7. Subsidized Continuing Care
- C8. Behavioral Health Services
- C9. Palliative Care

D. RESEARCH

- D1. Clinical Research
- D2. Community Health Research

E. CASH AND IN-KIND CONTRIBUTIONS

- E1. Cash Donations
- E2. Grants
- E3. In-Kind Donations

F. COMMUNITY-BUILDING ACTIVITIES

- F1. Physical Improvements/Housing
- F2. Economic Development
- F3. Community Support
- F4. Environmental Improvements
- F5. Leadership Development/Training for Community Members
- F6. Coalition Building
- F7. Advocacy for Community Health Improvement
- F8. Workforce Development

G. COMMUNITY BENEFIT OPERATIONS

- G1. Assigned Staff
- G2. Community Health Needs/Health Assets Assessment
- G3. Other Resources

Dept. Name: _____

Dept. Number (if applicable): _____

Phone: _____ **Email:** _____

Contact Name and Title: _____

Program Details

Community need being addressed: _____

How was need determined (assessed) if known? _____

Objectives: _____

Is this program duplicated in the community? _____

Does this program address an unmet community need? _____

Is this a collaborative effort? If so, who are your partners and what are their respective roles? _____

Do you have any measurable indicators for evaluating the reach or success of the program? If so, what

are they and how are they measured? _____

Target Audiences:

Targeted For: Living in Poverty Broader Community

Geographic Area or County: _____

Genders: Male Female Both

Special Needs Populations:

- Persons with disabilities
- Racial, cultural and ethnic minorities
- Uninsured/underinsured
- Other (specify) _____
- Other (specify) _____
- Other (specify) _____

Age of Targeted Audience:

- Infants
- Children
- Teens
- Adults
- Seniors
- All Ages