Thank you for taking the time to complete this survey. The information you provide will enable the Bureau of Health Planning to maintain a current Health Improvement Partnership listing and identify education, training, technical assistance and resources to support the activities of the partnerships.

Name of partnership ____________________________________________
Address ______________________________________________________
County _______________________________________________________

Contact information for person representing the partnership
Name: _______________________________________________________
Title: _______________________________________________________
Telephone __________________________ Fax _______________________
Email _______________________________ Website ___________________

Please briefly describe the organization of the partnership (i.e., non-profit, for profit, etc.).
________________________________________________________________

Does the partnership have a mission statement?  ☐ Yes  ☐ No  If yes, please attach.
Which best describes the status of the partnership?  ☐ New  ☐ 1-3 years ☐ 3+ years

What geographic area is served by the partnership?
☐ County or counties (list) _______________________________________

☐ Group of townships/boroughs (list) _______________________________

☐ Neighborhoods (list) _________________________________________

Indicate the members of the partnership
☐ Civic organizations or coalitions ☐ Local college/university
☐ Consumer/volunteer ☐ Local government
☐ County/municipal health department ☐ Long-term care facility
☐ Emergency medical service ☐ Police department
☐ Faith community ☐ School district
☐ Healthcare providers
☐ Hospital and/or health system (please specify) ______________________
☐ Human services
Other __________________________________________________________
COMMUNITY HEALTH IMPROVEMENT INITIATIVES

1) If one has been done, when was the last needs assessment completed for your community?
   Date: ________________________

2) List three community health improvement priorities identified by the above assessment.
   1. __________________________________________
   2. __________________________________________
   3. __________________________________________

3) Please list no more than three current or future health improvement initiatives planned by your partnership for the next 12 months.
   1. __________________________________________
   2. __________________________________________
   3. __________________________________________

4) Describe your most successful health improvement initiative in the past 12 months.
   __________________________________________
   __________________________________________
   __________________________________________

5) Please offer any comments or suggestions to assist the program in improving quality.
   __________________________________________
   __________________________________________
   __________________________________________

Signature ________________________ Date ________________________
Print name ________________________

Please send this survey to:

   ATTN: Health Improvement Partnership Program Manager
   Division of Plan Development
   Bureau of Health Planning
   Department of Health
   625 Forster St., Room 1031
   Harrisburg, PA  17120-0701
   Email: ra-dhhipp@pa.gov