

Heartbeat International

Survey of Affiliates

Note: The information in sections II and III of this survey will remain confidential. Overall statistics may be quoted, for example, "Heartbeat members serve x thousands of clients per year." The information in Section I may be shared with others. The information is used by Heartbeat to help us plan programs and services for you.

Organization Name _____

Address _____

City _____ **State** _____ **Zip** _____

Phone (_____) _____ **Fax** (_____) _____

E-mail _____ **Web** _____

I would describe our organization as _____

I. Please check all the services below which your organization *directly* provides:

- | | |
|---|---|
| <input type="checkbox"/> Pregnancy Tests | <input type="checkbox"/> On-site physician services for pregnancy confirmation and counseling |
| <input type="checkbox"/> Community Referrals/Networking | <input type="checkbox"/> On-site physician services for pre-natal care |
| <input type="checkbox"/> Crisis intervention "counseling" for positive and negative pregnancy tests | <input type="checkbox"/> On-site physician services for other (explain) _____ |
| <input type="checkbox"/> Material Aid (layettes, furniture, maternity clothes) | <input type="checkbox"/> Off-site partnership with physician |
| <input type="checkbox"/> Hotline; Hours staffed by your center _____ | <input type="checkbox"/> Adoption Support |
| <input type="checkbox"/> Maternity Home | <input type="checkbox"/> Host Homes/Shepherding Homes |
| <input type="checkbox"/> Adoption Agency | <input type="checkbox"/> Single Parent Support |
| <input type="checkbox"/> Men's Ministry | <input type="checkbox"/> Post-Abortion Support (What program do you use?) _____ |
| <input type="checkbox"/> College Campus satellite | <input type="checkbox"/> Abstinence education in schools |
| <input type="checkbox"/> Mobile Unit | <input type="checkbox"/> Abstinence education in the community |
| <input type="checkbox"/> Resale/Thrift Store | <input type="checkbox"/> Sexual Integrity Program |
| <input type="checkbox"/> Ultrasound on-site services | <input type="checkbox"/> Childbirth preparation classes |
| <input type="checkbox"/> STD Testing | <input type="checkbox"/> Parenting classes |
| <input type="checkbox"/> STD Treatment | <input type="checkbox"/> Incentive Programs (i.e. Earn While You Learn) |

II. Organizational Structure: check all that apply:

- Board of Directors or Trustees
- Advisory Board
- Director-Paid
- Director-Volunteer
- Other paid staff (please list titles)

- _____
- Other volunteer leaders (please list titles)
- _____

Do you consider yourself primarily a volunteer organization? Y / N (circle answer)

III. Please briefly answer the following questions:

1. If you have people in leadership (volunteer or paid) with professional credentials, what kinds of backgrounds do they have (medical, social service, counseling, business, public relations, education, etc.)? _____
2. How many active volunteers do you have working with clients? _____
3. How many clients do you serve each year by phone? _____
4. How many clients do you serve each year in person? _____
5. Approximately what is your operating budget for the current year? _____
6. Do you charge for any of your services? Y / N (circle answer)
7. Do you receive any state or federal funding? Y / N (circle answer)
8. Do you receive Medicaid reimbursement for any of your services? Y / N (circle answer)
9. If you have any satellite offices, please list the name, the director's name, the address, and phone number of each location (If you need more space, please attach an extra sheet.).

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

10. Are you affiliated with or connected with any other organizations besides Heartbeat? (if so, please list) _____
11. Do you consider yourself a Christian ministry? Y / N (circle answer)
If so, do all staff and volunteers sign a statement of faith? Y / N (circle answer)
12. When was the last Heartbeat national conference someone from your center attended? _____
If not within the last two years, what kept you from attending?

13. Do you have on-site medical services at your center? Y / N (circle answer) If yes, what year were services added? _____ Name of Medical Director _____
14. If no, are you considering adding medical services? Y / N (circle answer)
 - We are in the investigating/talking stage only
 - We have taken some physical steps toward medical services
 - We will have added medical services by _____
15. Have you used your complimentary MPM's this year? Y / N (circle answer)