National Association of Community Health Centers, Inc.

...striving to assure the continued growth and development of primary care programs...

TABLE OF CONTENTS

OBJECTIVES OF NACHC

- *TO WORK FOR THE ELIMINATION OF THE DUAL SYSTEM OF HEALTH CARE AND TO DEVELOP QUALITY HEALTH CARE DELIVERY SYSTEMS RESPONSIVE TO THE NEEDS OF COMMUNITIES BEING SERVED.*

- *TO PROVIDE A VEHICLE WHEREBY COMMUNITY HEALTH CENTERS CAN UNITE AND MEET THE CHALLENGES TO THEIR SURVIVAL.*

- *TO PROVIDE EDUCATION AND TRAINING OPPORTUNITIES FOR COMMUNITY HEALTH CENTER BOARD MEMBERS, ADMINISTRATORS AND PROVIDERS TO ASSURE THAT THE HIGHEST PROFESSIONAL STANDARDS ARE MAINTAINED.*

- *TO DEVELOP A COMMUNICATIONS NETWORK TO GATHER, COMPILE, AND DISSEMINATE RELEVANT INFORMATION TO THE STAFFS AND COMMUNITY BOARDS OF COMMUNITY HEALTH CENTERS.*

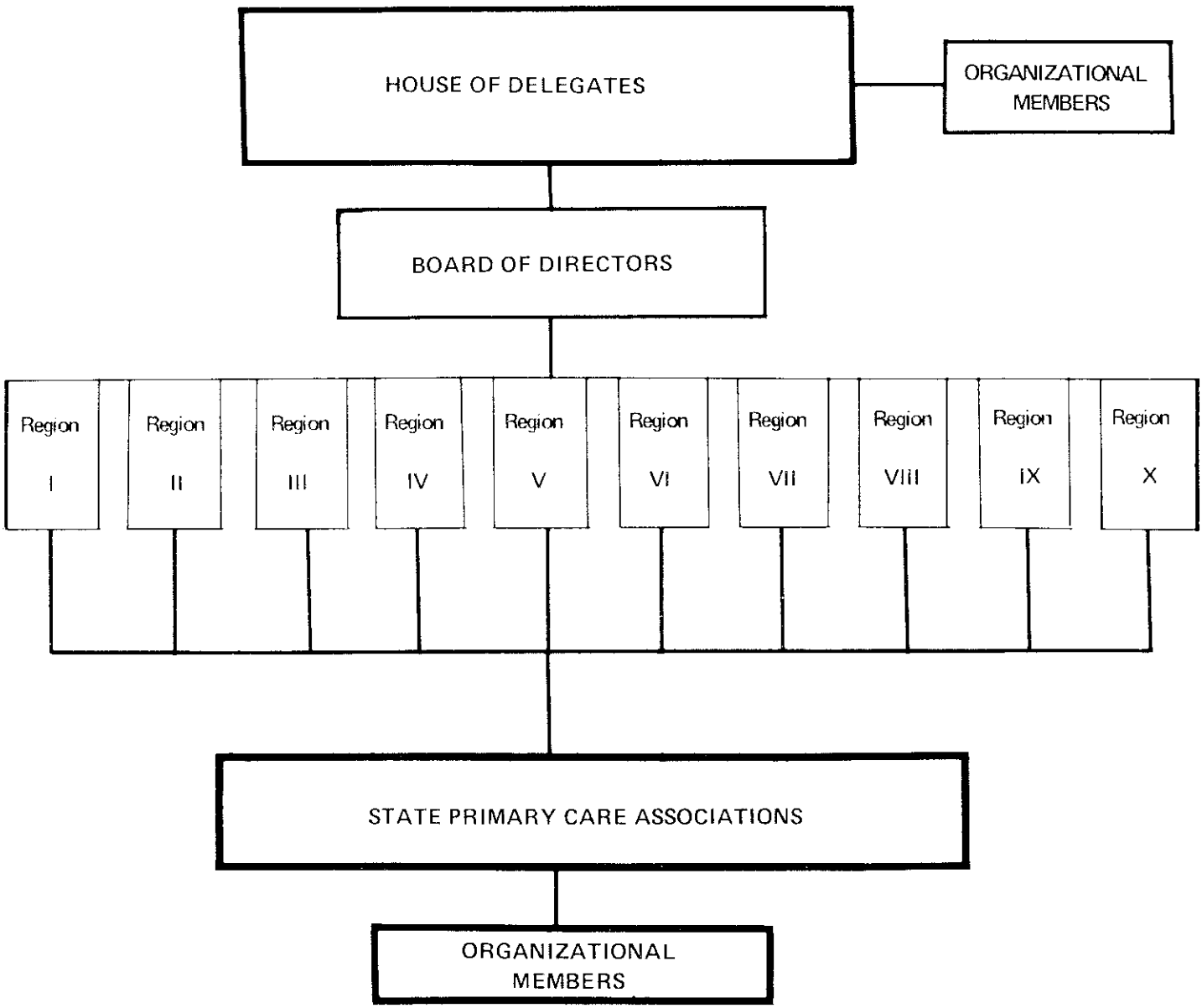
- *TO DEVELOP AND ASSIST IN THE IMPLEMENTATION OF IMPROVED MANAGEMENT TECHNIQUES FOR COMMUNITY HEALTH CENTERS.*

- *TO DEVELOP METHODS OF PERMANENT AND DEPENDABLE FINANCING FOR COMMUNITY HEALTH CENTERS.*

- *TO DEVELOP AND IMPLEMENT QUALITY COMMUNITY HEALTH EDUCATION PROGRAMS.*

- *TO MAINTAIN LIAISON WITH OTHER CONSUMER AND PROVIDER HEALTH CARE GROUPS.*

ORGANIZATIONAL STRUCTURE



THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

The National Association of Community Health Centers, Inc. (NACHC) was organized in early 1970 by a broad based coalition of health center administrators, providers and consumers. NACHC has become the national advocate for community health centers across the country and works to assure the continued growth and development of these programs.

The same type of dynamic broad-based coalition which established NACHC in 1970 still characterizes its membership today. Represented in the NACHC membership are migrant health programs, Indian health programs, neighborhood health centers, family health centers, maternal and infant care programs and community health centers (rural and urban).

NACHC REGIONS

The National Association of Community Health Centers is a national organization covering the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa and the Trust Territory of the Pacific Islands.

NACHC is divided into ten regions as follows:

REGION I: *CONNECTICUT, MAINE, MASSACHUSETTS, NEW HAMPSHIRE, RHODE ISLAND, VERMONT*

REGION II: *NEW JERSEY, NEW YORK, PUERTO RICO, VIRGIN ISLANDS, CANAL ZONE*

REGION III: *DELAWARE, DISTRICT OF COLUMBIA, MARYLAND, VIRGINIA, WEST VIRGINIA, PENNSYLVANIA*

REGION IV: *ALABAMA, FLORIDA, GEORGIA, KENTUCKY, MISSISSIPPI, NORTH CAROLINA, SOUTH CAROLINA, TENNESSEE*

REGION V: *ILLINOIS, INDIANA, MINNESOTA, MICHIGAN, OHIO, WISCONSIN*

REGION VI: *ARKANSAS, LOUISIANA, NEW MEXICO, OKLAHOMA, TEXAS*

REGION VII: *IOWA, KANSAS, MISSOURI, NEBRASKA*

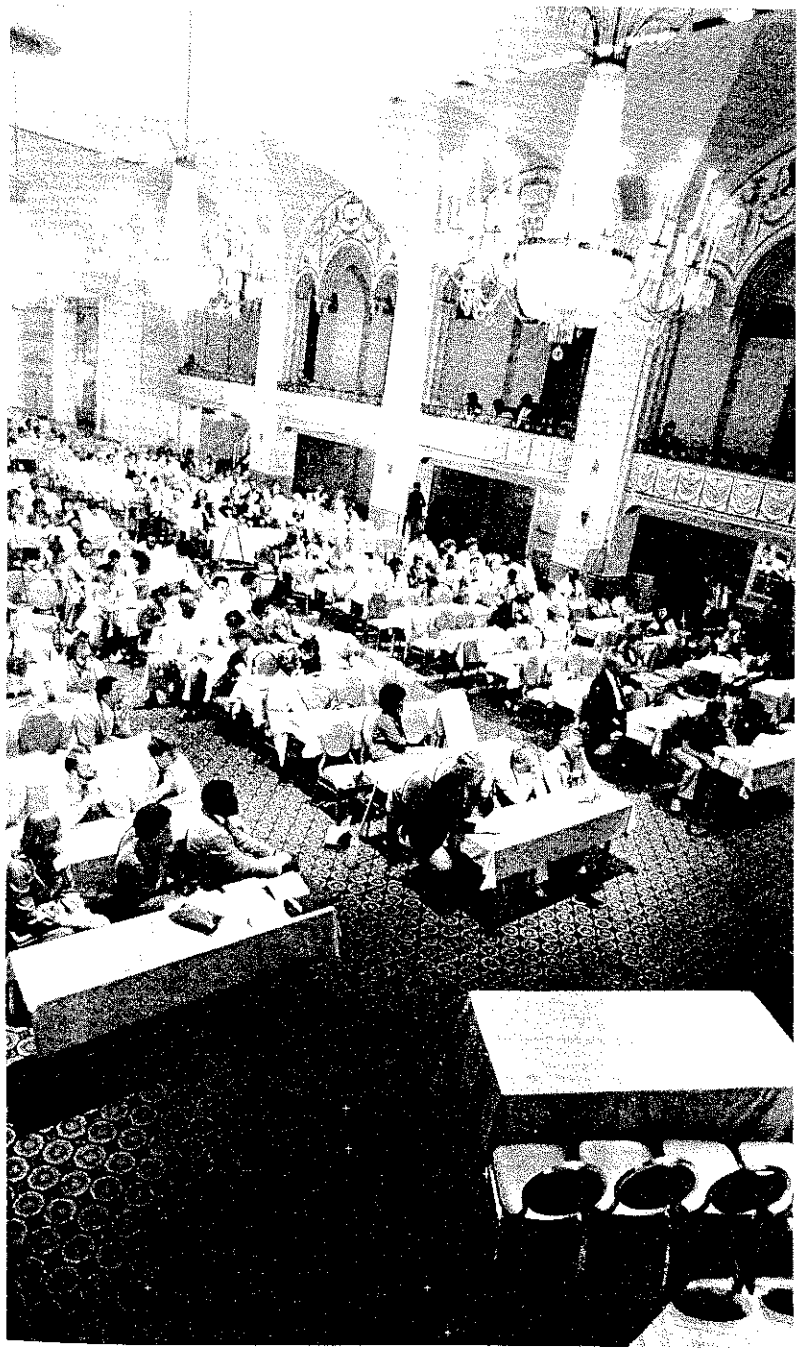
REGION VIII: *COLORADO, MONTANA, NORTH DAKOTA, SOUTH DAKOTA, UTAH, WYOMING*

REGION IX: *ARIZONA, CALIFORNIA, HAWAII, NEVADA, GUAM, AMERICAN SAMOA, TRUST TERRITORY OF THE PACIFIC ISLANDS*

REGION X: *ALASKA, IDAHO, OREGON, WASHINGTON*

GOVERNANCE AND ADMINISTRATION

Governance and administration of NACHC is accomplished through the House of Delegates, Board of Directors, Executive Committee, Regional Chapters, State Associations, Standing Committees and National Office staff.



HOUSE OF DELEGATES

The ultimate responsibility and authority for governance of NACHC is vested in the House of Delegates. The House is comprised of four (4) delegates (2 provider and 2 consumer) for each organizational member in good standing. The House of Delegates convenes annually to establish program and policy priorities for NACHC, elect national officers and review and approve financial reports and program budgets. Between meetings of the House of Delegates decision making authority is vested in the Board of Directors.

BOARD OF DIRECTORS

The NACHC 28 member Board of Directors is comprised of the 8 member Executive Committee, 10 Regional Chairpersons and 10 Regional Vice-Chairpersons elected by members of the region they represent.

The principal responsibility of the Board of Directors is the general management of the affairs of NACHC as well as all other powers relevant to the ongoing operation of NACHC. The Board of Directors meets at least two times annually. Other meetings may be called as deemed necessary by the President and/or Executive Committee.

When the Board of Directors is not in session, its powers are delegated to the Executive Committee.

EXECUTIVE COMMITTEE

Eight officers form the Executive Committee and guide overall activities of NACHC. The officers are:

President
President-Elect
Secretary
Treasurer
Immediate Past President
Speaker of the House
Vice Speaker of the House
Consumer Representative

The Executive Committee meets as necessary and is responsible for the implementation of NACHC programs and policies.

The officers who constitute the Executive Committee are elected by the House of Delegates from among Individual Members in good standing.

REGIONAL CHAPTERS AND STATE ASSOCIATIONS

The NACHC By-Laws make provisions for the establishment of Regional Chapters and State Associations. The By-Laws state:

STATE ASSOCIATIONS

Health care organizations participating as members of the NACHC may establish with ratification by the House of Delegates, a State or territorial chapter of the NACHC. The Board of Directors shall review and recommend on State charter applications to the House of Delegates. Upon ratification by the House, the Board of Directors shall issue a charter.

REGIONAL CHAPTERS

State Chapters with territorial chapters in each of the regions identified in Section I (Regions 1 - 10) may establish with the approval of the Board and ratification by the House of Delegates, a regional chapter of the National Association of Community Health Centers. The Board of Directors shall review and recommend on regional charter applications to the House of Delegates. Upon ratification by the House, the Board of Directors shall issue a charter.

COMMITTEES

The Executive Committee and Board of Directors rely on twelve committees to assist them in the formation of NACHC policies and programs. The following committees serve an essential role as communication links between the membership and the Board of Directors:

Budget and Finance
Ethics and Grievance
Education
Health Policy
Nominating
Rules
Constitution and By-Laws
Credentials
Legislative
Membership
Program Planning, Development and Evaluation
President's Advisory

These committees consist of Individual Members of the National Association and meet periodically during the year. Appointments to the committees are made by the President. All Individual Members in good standing are eligible for committee appointment.

DEPARTMENTAL ACTIVITIES

Program and policy implementation are the responsibility of NACHC's National Office Staff, under the direction of an appointed Executive Director. The national office staff includes professional and support staff in the areas of education and training, policy analysis, rural affairs, research, communication and membership services. In addition, the staff is able to call upon a pool of competent consultants with expertise in a broad range of policy and program areas.

DEPARTMENT OF EDUCATION AND TRAINING

The NACHC Department of Education and Training offers a wide range of educational services and activities not currently available nationwide. The Department's goal is to ensure quality ambulatory health care through the continuing education of CHC professionals and interested parties.

COMMUNITY HEALTH INSTITUTE—NACHC's largest educational activity, the CHI has expanded into a major national conference in primary health care. With over 40 workshops, the CHI addresses the year's most crucial health issues, as indicated via surveys of community health centers nationwide.

CONTINUING MEDICAL EDUCATION PROGRAM—The CME program is dedicated to disseminating the most up-to-date medical concepts to health care practitioners. Each year, the CME program provides these practitioners the opportunity to obtain CME credits from a noted medical university.

The Deparmtent organizes numerous issue-specific seminars throughout the year—the Medical Director's Conference, the Migrant Health Conference, and the Governing Board Seminars.

INTERNSHIP PROGRAM—the Department sponsors this program for graduate and undergraduate students. The program provides an opportunity for students to gain first-hand experience in the areas of policy analysis, legislative process, issue research, seminar planning and a working understanding of primary care management.

DEPARTMENT OF RURAL AFFAIRS

The Department of Rural Affairs (DRA) is the arm of NACHC which provides direct technical assistance to all centers and education, information dissemination and development services to rural medically underserved people and rural health care programs. These services are provided in an effort to facilitate the development of accessible, high quality, innovative, cost effective and cost-containing forms of organized community-based primary care systems.

The Department serves as liaison between NACHC and other rural organizations, thus allowing for a coordinated effort on behalf of rural medically underserved people through cooperation with organizations such as:

The Rural Coalition
Rural America
American Rural Health Association
National Rural Primary Care Association
National Association of Farmworker Organizations
National Consumer Cooperative Bank

Coupled with this effort is a cooperative and complementary working relationship with State Primary Care Associations thorughout the country.

Through information dissemination of legislation and regulations pertaining to rural health delivery is conducted in cooperation with NACHC's Department of Policy Analysis for rural participants. Background papers are researched and written, and testimony is given when needed.

Technical assistance to community health center programs can include (but is not limited to) the following areas:

Financial Management
Medical Care Administration
Marketing
Personnel Management
Board Skill Development
Program Development
Research/Data Collection
Management Information Systems

DEPARTMENT OF POLICY ANALYSIS

The Department of Policy Analysis is responsible for the analysis of federal legislation and implementation of rules and regulations. More specifically the Department

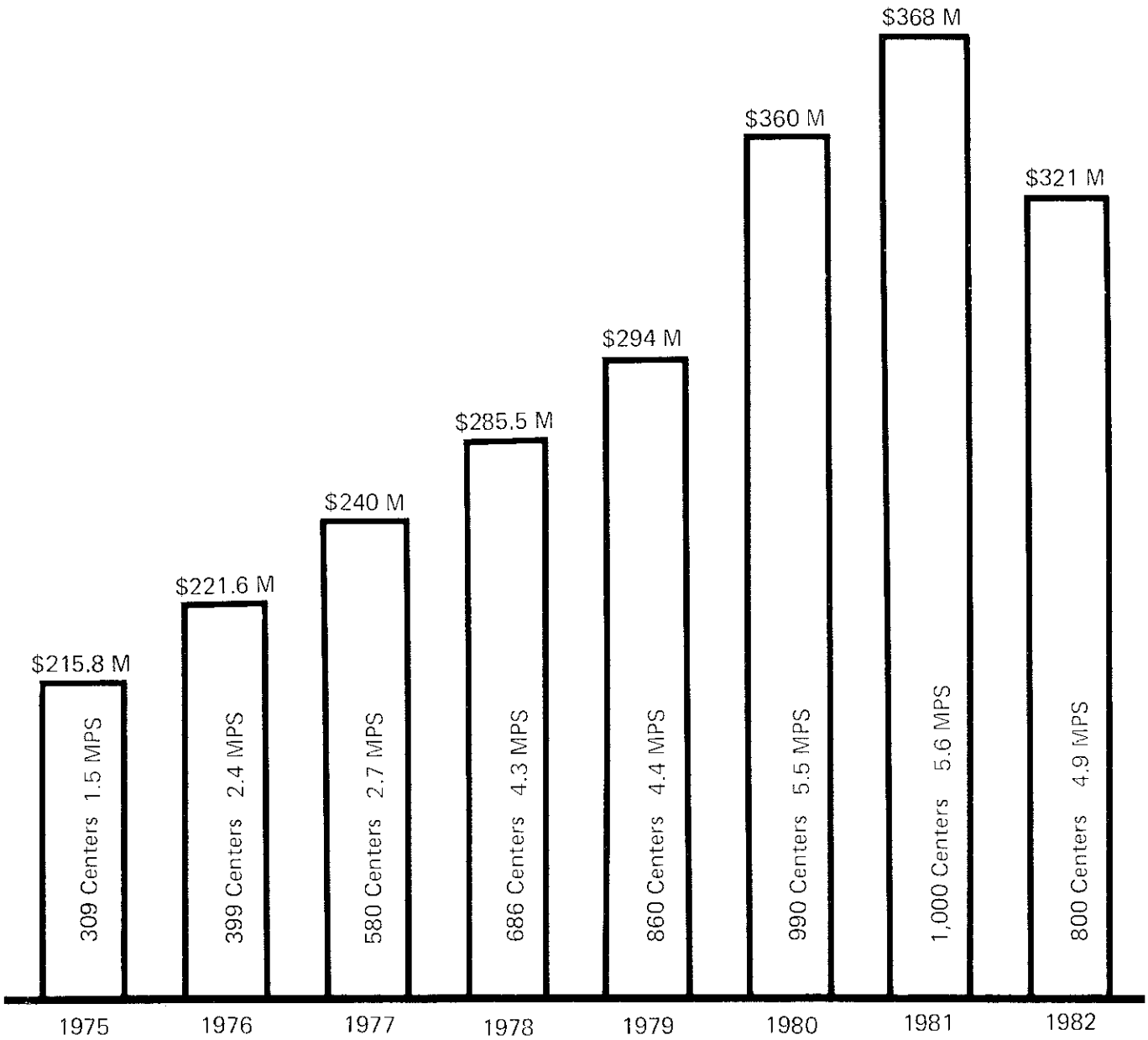
- *keeps the health centers abreast of current legislative and health policy developments*
- *provides legislators and decision makers with information about programs and their needs*
- *compiles data on health center accomplishments*
- *establishes a forum for active participation in the decision making process on important health issues*
- *works with State Primary Care Associations on policy related issues.*

As a direct result of these activities, NACHC has participated in key developments which include:

- *Amendments to Title 19—allows health centers to be reimbursed on a prepaid capitation basis*
- *Enactment of the Rural Health Clinic Act*
- *Amendments of Health Planning which provide for greater involvement of consumers and ambulatory care providers*
- *The elimination of residency requirements to allow migrants to qualify for Medicaid.*
- *Passage of authorization for health centers since 1975 including amendments which:*
  - *— allow health centers to retain services for which funding is prioritized,*
  - *— retained the consumer majority governing board requirement,*
  - *— qualified aged and disabled farmworkers to receive services,*
  - *— insured bilingual capacity in health centers to serve non-English speaking populations.*
- *Rejection of an "open-ended" Block Grant to states for the CHC program. The new Primary Care Block Grant assures both targeting of resources and the inclusion of all key elements of the CHC program and retains intact the migrant health program.*
- *Increased funding for community health centers and migrant health centers in each fiscal year.*

COMMUNITY AND MIGRANT HEALTH CENTERS
HISTORY AND GROWTH
(1975 – 1982)

The National Association of Community Health Centers has, since 1975, served as a strong advocate for those Americans who live in medically underserved areas. The result of NACHC's hard work is depicted in the chart below, showing progress since 1975. Even with the huge reductions in social domestic programs in 1982, today these centers are serving 3.4 million more people than in 1975. The record speaks for itself.



M = *millions appropriated per fiscal year by Congress*

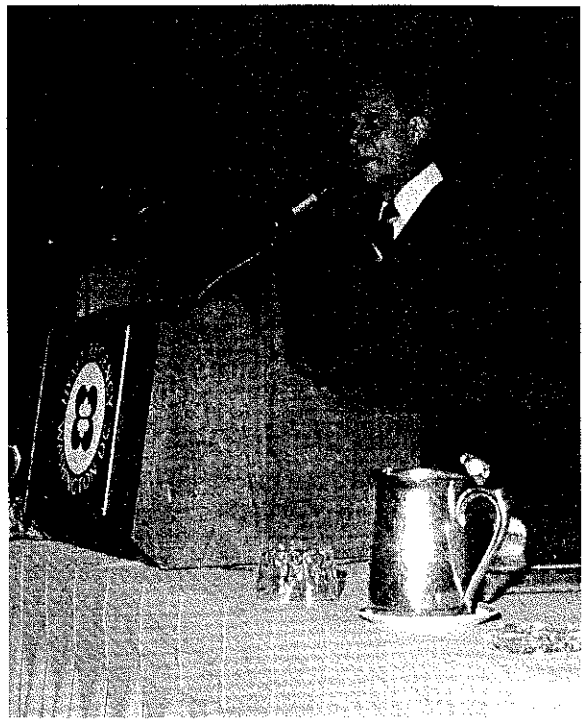
MPS = *millions of people actually served by centers per fiscal year*

Senator Edward Kennedy: *"The National Association of Community Health Centers has proven to be the leader in advocating for primary care programs. Their outstanding contribution in the struggle to insure quality health care to all Americans must be recognized as crucial. The expertise of the staff of the National Association has been key to our understanding of the issues facing the health care community."*

Congressman Henry Waxman *"We couldn't have done it without them. Health centers from across the country and NACHC representatives spent hundreds of hours explaining to members why we have to continue our support for health programs. I believe that it will be an even more critical role that the National Association of Community Health Centers will have to play in future struggles."*

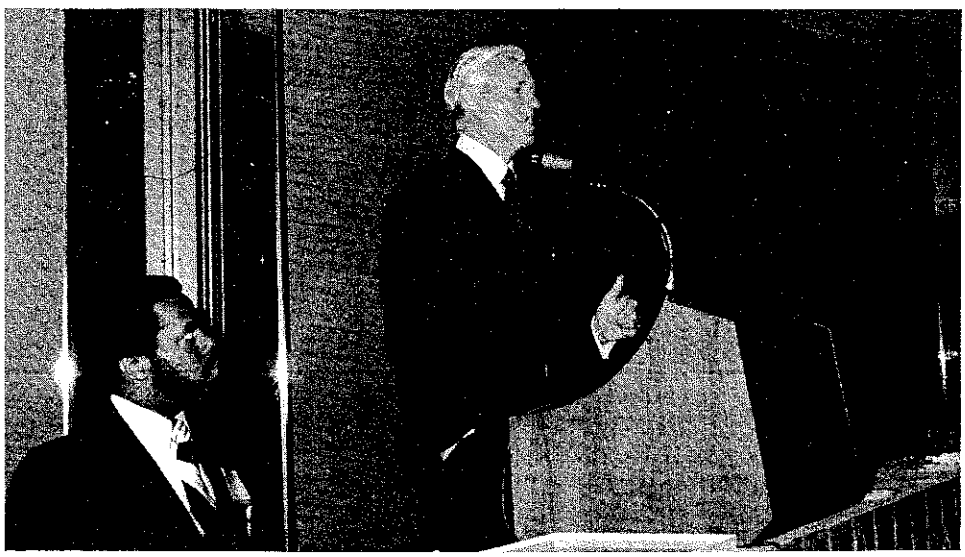
Congressman Edward Roybal, Member House Appropriations Committee and Congressional Hispanic Caucus:

"I have worked closely with Community and Migrant Health Center advocates from the National Association of Community Health Centers for many years. Their work has been the key toward the creation and maintenance of adequate health care for minorities, especially migrant farmworkers."



Congressman Louis Stokes:

"The National Association of Community Health Centers has provided crucial information to legislators to fight for and secure adequate funds for these health facilities. By doing so, the Association has insured the availability of quality health care for Americans from every sector of our society."



Senator Ernest Hollings (S.C.) Senate Appropriations Committee, when asked about his amendment to provide an additional $40 million for Community Health Centers in 1982:

"The National Association of Community Health Centers has been important in keeping Congress aware of the problems in providing quality health care to all Americans. I am proud to have worked with them in their endeavors. In incident after incident, NACHC provided information to get this amendment passed and met every argument."

DEPARTMENT OF RESEARCH

NACHC's Research Department, operates in the context of the following set of policies/ protocols:

1. *To research issues that affect the programmatic viability of community health centers.*

   Productivity
   Resource Availability
   System and Sub-System Interrelationships

2. *To research issues that affect the fiscal viability of community health centers.*

   Reimbursement Opportunities, Both Public and Private
   Federal Fiscal Policies Re: CHCs
   State Fiscal Polices Re: CHCs
   CHC Financial Management Systems

3. *To support the various NACHC departmental activities with timely, relevant research, including:*

   Data Collection and Analysis
   Generation and Maintenance of a Comprehensive, yet Flexible, Data Base for NACHC Activities

4. *To research the characteristics of users of CHCs and to develop a baseline of data regarding these characteristics.*

The Research Department is guided and supported in these efforts by a task force on research and data requirements, composed of NACHC members interested in evaluation research.

The Department has completed studies of:

STATE MEDICAID REIMBURSEMENT POLICIES REGARDING CHCs

SPACE ALLOCATIONS IN CLINICAL AREAS OF CHCs

SECTION 329 MIGRANT HEALTH CENTERS

DENTAL SERVICES IN CHCs

GENERAL CHC CHARACTERISTICS - including staffing, location, size, financing and system linkages.

The Department will continue to build a solid base of data and will recommend, via analysis, policy positions reflective of the interest in the viability of CHCs.

DEPARTMENT OF COMMUNICATION AND MEMBERSHIP SERVICES

The Department of Communication and Membership Services develops and produces information media used for communicating with the NACHC membership, health related organizations and the general public about health issues and NACHC activities. The Department also develops membership recruitment programs and member benefit packages.

NACHC communicates with its membership through the following publications:

PRIMARY CARE FOCUS—a bi-monthly news magazine devoted to articles of current interest to ambulatory programs. Included in the magazine is a job available and wanted listing as well as a clearinghouse listing announcing new health publications and materials available from NACHC and other sources .

WASHINGTON UPDATE—(published by the Department of Policy Analysis) provides timely and indepth analysis of current legislative and administrative initiaties which affect health service delivery.

The above publications are available through subscription.

MEMBERSHIP

NACHC By-Laws provide for three types of membership: organizational, individual and associate organizational.

ORGANIZATIONAL MEMBERSHIP

Organizational membership in NACHC is available to any organization actively engaged in operation of a health care program and is committed to the purpose of the National Association of Community Health Centers.

ORGANIZATIONAL MEMBERSHIP CRITERIA

Legal Certification

Applicant Organizations must present evidence of being legally sanctioned health care providers. Evidence of legal sanction may be one or more of the following:

a. *A certiticate or license issued by the appropriate state, county or municipal regulatory agency;*

b. *A current Medicaid and/or Medicare provider's number;*

c. *Federal grant Awards;*

d. *IRS 501(c)(3) certification;*

e. *Organizations not satisfying either of the criteria stated above (a,b or c) may petition the Membership Committee for special consideration. The petition should provide satisfactory evidence that the applicant organization meets the following criteria: (1) is a separate and fully organized entity; (2) has a governing board with appropriate policy making powers; and (3) has its own operating budget separate and distinct from the operating budgets of other organizational entities.*

Budget Documentation

Organizational membership fees are based on the applicant's total operating budbet, not federal grant budget levels only. Applicant organizations must provide a fully completed and signed Revenue and Expense Statement.

Eligible Organizations

Based upon the aforestated criteria, organizational membership would be available to all Community Health Centers (urban and rural), Migrant Health Centers, Health Maintenance Organizations, Health Networks and other similar health care delivery programs. Eligibility for organizational membership includes health care delivery programs sponsored or operated by municipal health corporations, State and municipal health departments, universities or colleges, hospitals, community action agencies and similar organizations. However, application must be made in the name of the community health center, migrant health center, etc.

Application Process

Applications for organizational membership may be submitted to the national office in Washington, D.C. Organizational membership is renewable annually and is based on a membership year beginning July 1—June 30. Applications received before or after the membership year are prorated to comply with the membership year.

The Board of Directors requires that the following information and documents be submitted with each application:

Annually—A fully completed application form (including a list of Board Members)

Biannually—(every two years)—A copy of the organization's by-laws and a copy of the current Internal Revenue Service tax status determination

With Initial Application Only—A copy of the organization's Articles of Incorporation, Corporate Charter or similar document.

Annual Budget	Fee
$ 0 — 100,000	$ 100
100,001 — 200,000	200
200,001 — 300,000	300
300,001 — 400,000	400
400,001 — 500,000	500
500,001 — 600,000	600
600,001 — 700,000	700
700,001 — 800,000	800
800,001 — 1,000,000	1,000
1,000,001 — 1,500,000	1,250
1,500,001 & Up	1,500

ORGANIZATIONAL BENEFITS

Each organizational member receives four votes in the NACHC House of Delegates (the NACHC policy making body). The four votes are carried by representatives of the organizational member (2 consumers and 2 providers). Each voting delegate casts a vote in elections for NACHC Officers as well as other matters which come before the House.

Each organizational member has access to the services provided by each of the Departments of NACHC as well as the following additional services and programs.

PRIMARY CARE MALPRACTICE INSURANCE—NACHC sponsors the Primary Care Malpractice Insurance Program for the purpose of providing adequate malpractice insurance coverage to organizational members. The program provides malpractice insurance coverage at a price which reflects the lower risk factors present in the special and limited market represented by NACHC members.

ACCREDITATION—NACHC is currently represented on the Board of the Accreditation Association for Ambulatory Health Care, Inc. AAAHC serves as the accrediting body for free standing ambulatory care programs. Benefits of accreditation range from consultation to recognition by third party payors.

LIAISON—Important program information is provided through liaison with outside government agencies such as:

Department of Agriculture
Community Services Administration
Department of Labor
National Center for Health Services Research
Bureau of Health Care Delivery and Assistance

In addition, NACHC works closely with sister organizations such as the American Health Planning Association (AHPA), American Hospital Association (AHA), American Public Health Association (APHA), and Group Health Association of America (GHAA) to collect, analyze and disseminate relevant information and data pertaining to the management and delivery of health services.

TECHNICAL ASSISTANCE—When required, NACHC can arrange for technical assistance in the following areas:

Financial Management—including control procedures and budgeting, financial reporting and management information systems.

Grants Management—updating of information on regulations and policy changes, audits, record keeping and reporting requirement.

Administration—development of communication skills, time management, delegation and productivity.

Continuity of Care—integration and continuity of services through coordination and contracts.

Program Evaluation—areas of self assessment in overall program effectiveness or specific service delivery.

INDIVIDUAL MEMBERSHIP

Individual membership is open to all persons who support the purposes of NACHC.

Individual Membership Benefits

Each individual member is entitled to participate in the NACHC Community Health Institute and other sponsored conferences at member rates, which are lower than non-member rates.

Individual members are eligible to hold office in NACHC and also to become Board and Committee members.

Membership in appropriate affiliated peer divisions is also available to individual members. These divisions are as follows:

Administrators	Nurses
Pharmacists	Board Members
Prepaid Delivery Systems	Dentists
Consumers	Providers and Mid-Level Practitioners
Handicapped	

Divisions develop resolutions and recommendations which are presented to the NACHC Executive Committee and Board of Directors for consideration. Each member of an affiliated division has the right to vote upon policy issues within the division and to choose division officers. Petitions are accepted from Individual Members for the development of new affiliated divisions.

The following awards are presented to Individual Members, nominated by their peers, each year at the Annual Convention and Community Health Institute.

JOHN GILBERT AWARD—recognizes excellence in community health leadership.

SAMUEL U. RODGERS ACHIEVEMENT AWARD—recognizes outstanding contributions made by health care providers.

ETHEL BOND MEMORIAL CONSUMER AWARD—recognizes dedication to and support of the consumer role in community health care.

PUBLIC SERVICE AWARD—recognizes significant contributions to community health center development made by individuals in the public sector.

INDIVIDUAL MEMBERSHIP FEES

Lifetime Membership . . . . . $ 300
Regular Individual 30

ASSOCIATE ORGANIZATIONAL MEMBERSHIP

Organizations supporting the purposes of NACHC and not actively engaged in the operation of a health care program are eligible for associate organizational membership in NACHC. The following entites are eligible for associate organizational membership:

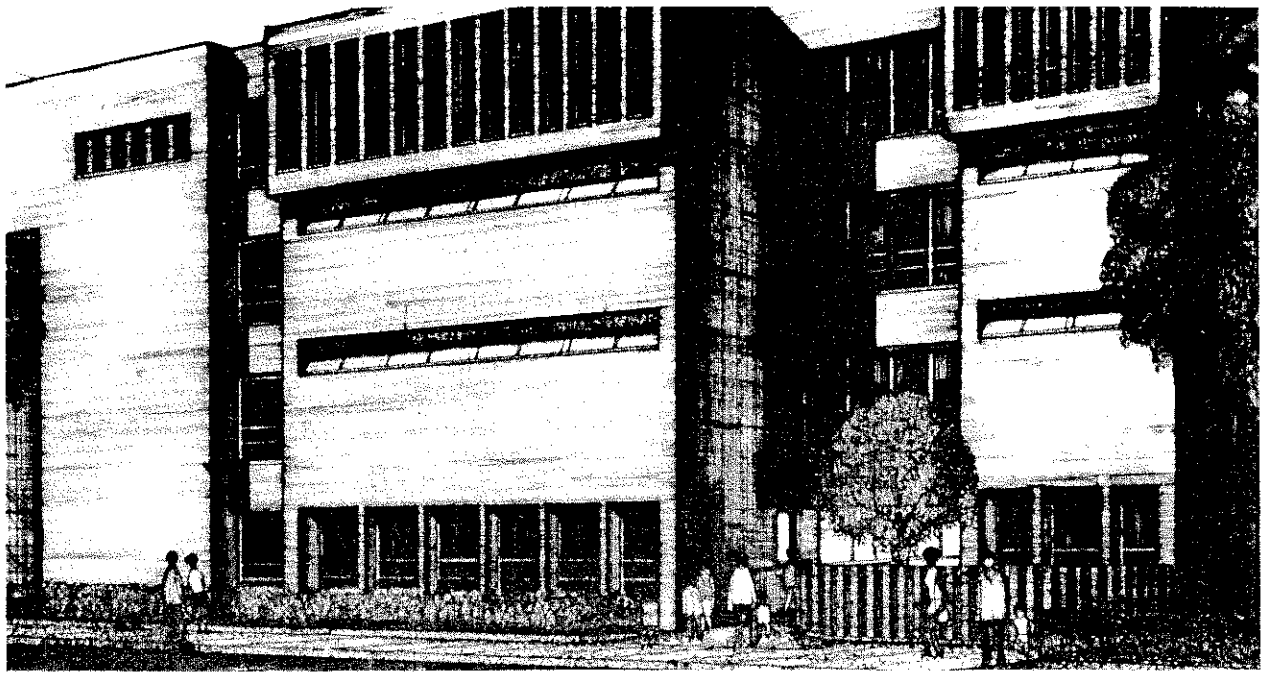
1. *Organizations not satisfying the criteria for organizational membership, i.e., educational or cooperative organizations, foundations, labor unions or interested insurance or commercial companies.*

2. *Satellite and outreach clinics not satisfying the test for organizational autonomy, e.e., (a) are not separate and fully organized entities; (b) do not have their own governing boards with appropriate policy making powers; (c) do not have separate and distinct operating budgets.*

Associate organizational members may present resolutions and recommendations to the NACHC Executive Committee for consideration by the Board and the House of Delegates, but have no voting rights.

Annual Budget	*Fee*
$ 0 – 100,000	*$ 100*
100,001 – 200,000	*200*
200,001 – 300,000	*300*
300,001 – 400,000	*400*
400,001 – 500,000	*500*
500,001 – 600,000	*600*
600,001 – 700,000	*700*
700,001 – 800,000	*800*
800,001 – 1,000,000	*1,000*
1,000,001 – 1,500,000	*1,250*
1,500,001 & Up	*1,500*

COMMUNITY HEALTH CENTERS TODAY



artist's conception of Upper Cardoza Neighborhood Health Center, Washington, D.C.

A community health center can best be described as a place where residents of a particular community receive a variety of ambulatory health services at one location. Centers are located in both urban and rural communities and usually serve communities thought of as medically underserved, low-income. The centers combine medical and social services.

Community health centers were initiated in 1965 by the Office of Economic Opportunity in response to the growing awareness of inadequate medical attention to the poor and its economic and social consequences. The centers are now under the sponsorship of the Department of Health and Human Services (DHHS). The policies and procedures which govern the centers are established by DHHS national and regional offices and the governing boards of the centers.

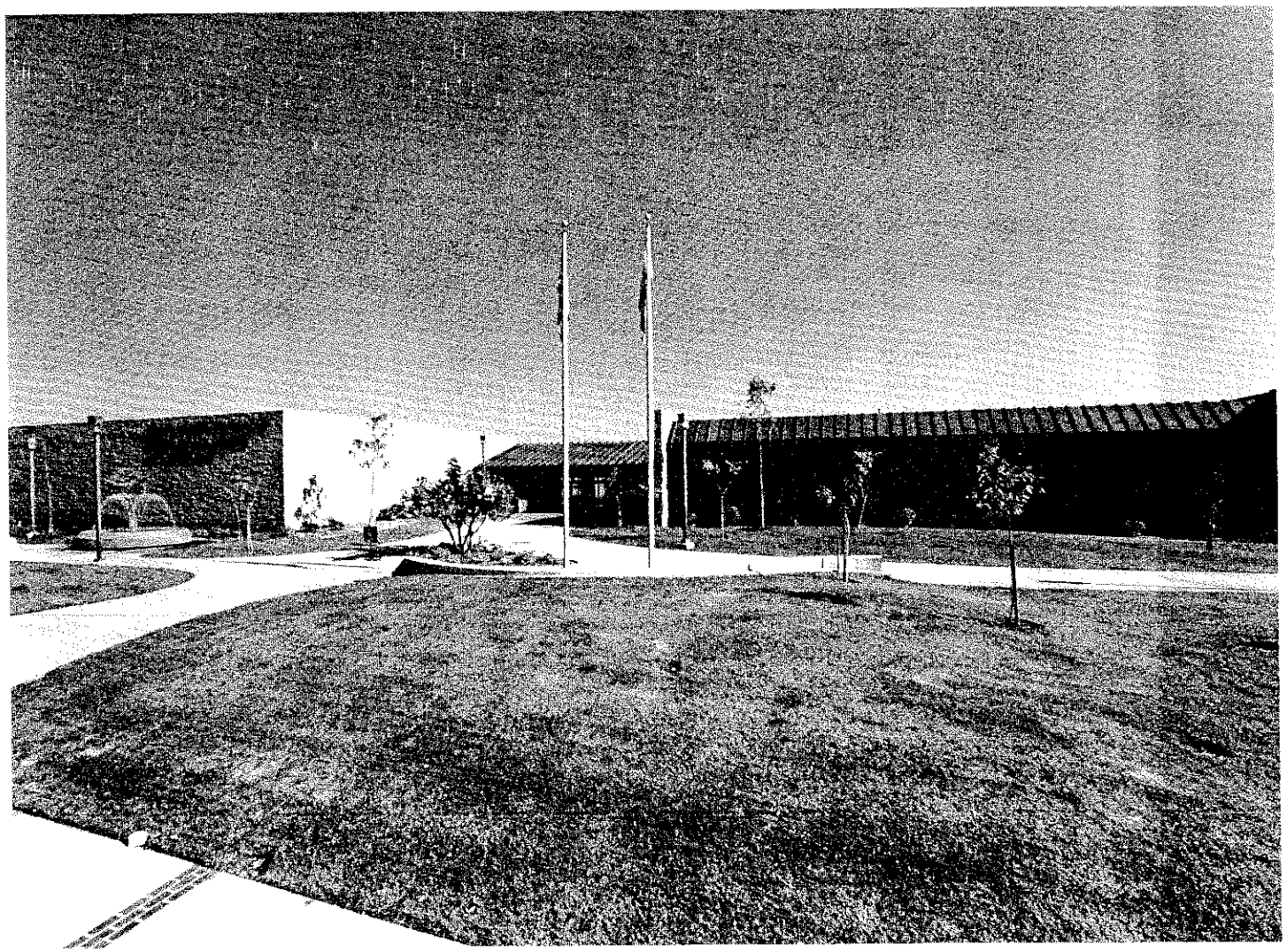
The goal of the community health center is to provide a wide range of family-oriented ambulatory health care services, including basic medical and laboratory services, pharmacy, x-ray, and in some instances dental services.

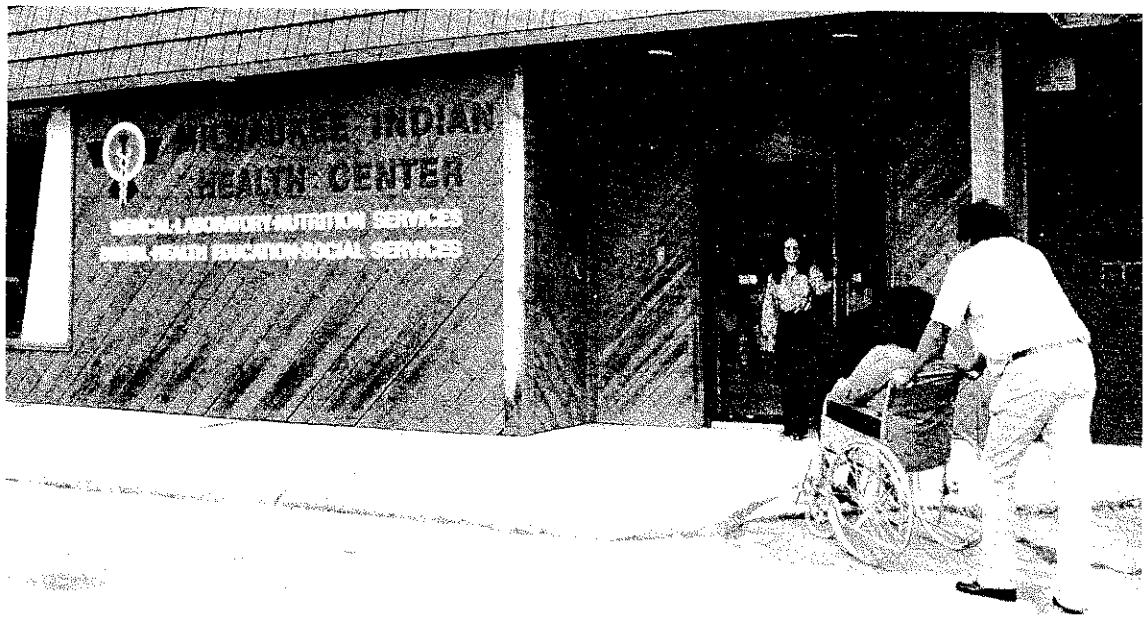
The "comprehensiveness" of health services provided by the centers varies according to the individual needs of each community. For example, a center located in an area which is known to have a high risk for lead poisoning may sponsor a screening project and/or an educational program which informs parents and children alike of the symptoms, causes, and effects of lead-based paint poisoning. Other centers may provide screening programs for sickle cell anemia or a drug abuse education program.

The scope of services available depends upon a variety of factors, such as federal funding level, state support, and private or institutional support. This is particularly the case with social and community services, transportation, training and community organization, physical and speeech thereapy and optometric services.

Most centers are open from nine to five, Monday through Friday, with provisions for emergency services after hours and on weekends. Centers also are open in the evening, one or two days a week, enabling patients to come in after work. Emergency services are provided either at the back-up hospital or by physicians in the centers. All patients registered at the center are given an emergency telephone number. The centers have an administrator who is responsible for the day-to-day management of the center and for executing the policy set by the Board of Directors. Duties include hiring personnel, carrying out programs, and preparing the budget and grant applications. The administrator may be a physician, but more often he is trained in health services administration. The medical director of the center is responsible for all medical treatment and procedures offered in the center. The centers also employ the usual range of secretaries, accountants and billing clerks.

Centers, by law, are required to have a governing board, the majority of whose members must be individuals who receive health care services at the center and who "as a group represent the individuals being served by the center." The law (P.L. 94-63 requires that the board meet at least once a month, that it establish general polices for the center (including the selection of services to be provided by the center and a schedule of hours during which services will be provided), approve the center's annual budget, and approve the selection of a director for the center.





How Does a Center Operate

When a new patient arrives at the center in a nonemergency situation, he/she is usually channeled by the receptionist to a clinical nurse and/or a family health worker who takes the patient's history and vital signs. At this initial registration, basic socioeconomic data related to general health and family conditions are recorded. An individual and family registration record is prepared and becomes an integral part of the patient's chart. A medical chart is developed and a permanent record number is assigned. The identification number is recorded for those patients who have private health insurance, Medicaid or Medicare. Patients who appear eligible for Medicaid and/or Medicare benefits are referred to a staff member who assists them in completing the necessary forms and arranges for an interview with the appropriate agency.

The initial health assessment includes a complete medical history and physical, a battery of laboratory tests, and when necessary, referral to the appropriate special or social services worker. For women, the initial health assessment usually includes a pelvic exam, a Papanicolaou smear and, when requested, family planning assistance.


SAN FRANCISCO
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