AMERICAN LUNG ASSOCIATION.

Asthma Treatment and Services Community Assessment

Please fill out one Section A. Agency Information for your agency and copy and complete one Section B. Asthma Services Provided for EACH asthma service your agency provides.

Please return the completed assessment.

A. Agency Information		
1. Agency Name:		
2. Address: City:		State: Zip:
3. Phone:	4. FAX:	5. Hours/Days of Operation:
6. Contact Person:		7. Email:

Please fill out one Section B. Asthma Services Provided for EACH asthma service your agency provides.

B. Asthma Services Provided	
1. Name of Service:	
2. Short Description of Service:	
3. Available to Age Groups (Select all that apply): ❑ Senior (65+) ❑ Adult (18-64) ❑ Teen (13-17) ❑ Child (6-12) ❑ Young Child (0-6)	4. Primary ethnic group(s) served (select all that apply): ❑ Hispanic ❑ Black ❑ White ❑ Asian/Pacific Islander ❑ American Indian, Eskimo, Aleut ❑ Other ❑ All
5. Cost of the service provided?	6. Date(s)/Time(s) service provided:
7. Location service is provided: ❑ Clinic ❑ Hospital ❑ Home ❑ Agency office ❑ Community ❑ Other: _____	