Hello,

This survey was developed by the New York State Department of Health (NYS DOH) to examine the unmet health and resource needs faced by pregnant people in New York State, in accordance with the mandates of Chapter 217 of the Laws of 2022. This survey also aims to assess the impact of limited services pregnancy centers on the ability of people to obtain accurate and non-coercive health care information, timely access to a comprehensive range of reproductive and sexual health care services in alignment with their health care needs and support their personal decision-making. The information NYS DOH is collecting through this survey will be reviewed and used to inform a public report, containing findings and policy recommendations for solutions to address any service gaps or negative impact in the State identified through the study.

A limited services pregnancy center (LSPC) is defined in Chapter 217 of the Laws of 2022 as a facility or entity, including a mobile facility, with the primary purpose of providing services to clients who are or may be pregnant, and either:

1. is not a health care facility licensed by the state of New York under Article 28 of the Public Health law or Articles 31 and 32 of the Mental Hygiene law, or
2. is not providing services under the direction of a health care provider licensed under Title 8 of the Education Law who is acting within their scope of practice, and
3. does not provide or refer for the full range of comprehensive reproductive and sexual health care services reimbursed under the state's Medicaid program, including but not limited to contraception, testing and treatment of sexually transmitted infections, abortion care, and prenatal care.

Your facility has been identified as a **potential** limited services pregnancy center. **If you believe your facility does not meet the above definition of an LSPC and thus this survey is not applicable to you, then please select "Not Applicable to my facility" below and add your facility name so we can take you off the mailing list for future communication regarding this request. Please use the enclosed envelope to return this page with your response.**

If you believe your facility does meet the above definition of an LSPC, please complete the survey and provide back to the NYS DOH within 20 business days of receipt. You can mail it back to the NYS DOH, using the enclosed envelope. You can also scan the QR code or type the survey link into your browser to complete the survey electronically. Survey link: https://apps.health.ny.gov/pubpal/builder/LSPC-Survey23

If you have any questions, please contact the NYS DOH at LSPC.Queries@health.ny.gov

Sincerely,

Division of Family Health

New York State Department of Health

Would you like to proceed with this survey?

☐Yes, continue with the survey

☐No, not applicable to my facility. Facility Name:

Scan this QR code to access the survey:

I. **Contact Information**

A. Today's Date (MM/DD/YYYY):

B. Please provide contact information for the facility:

1. Name of Facility:
   Alternate Names of Facility:
2. Address (Building number, Street, City, ZIP):

C. Please provide contact information for the Facility Point of Contact

1. Name and Title: 2. Email address:

II. **Client Demographics**

The following questions pertain to the demographics of your facility's clients or patrons. Please answer these questions to the best of your knowledge. **NYS DOH is not asking that you provide any personally identifiable information regarding any of your clients.** The public report will only publish basic demographic information in the aggregate so that it is impossible to identify information about your clients.

A. Please provide the following demographic information on clients accessing services at your facility

1. What is the average total number of clients visiting your facility per month? _____
2. Please provide the average number of clients that visit your facility per month by each of the demographic categories below:

Age group	Number of Clients
<15	
15-19	
20-29	
30-39	
40+	
Primary Race	**Number of Clients**
Alaskan Native/ American Indian	
Asian	
Black/ African American	
Pacific Islander/ Hawaiian Native	
White	
Other	
Unknown	
Ethnicity	**Number of Clients**
Hispanic	
Non-Hispanic	
Unknown	
Marital Status	**Number of Clients**
Married	
Unmarried	
Unknown	
Other	
Primary Payor of Service	**Number of Clients**
Government insurance (including but not limited to Medicare, Medicaid)	
Private Insurance	
Self-Pay	
No Charge	

B. Please provide information on health services, social support, staffing and operational support available at your facility:

1. What reproductive and sexual health services, including but not limited to the list below, are available to clients at your facility? Please check all that apply

Service	Services provided at facility (Check all that apply)	Services commonly sought by clients (Check all that apply)	Licensed health care practitioner (staff and/or volunteers) provides the service (Check all that apply)	Referrals to other providers if service is unavailable (Check all that apply)	Facility charges clients for services (Check all that apply)
Preconception health services					
Contraceptive services (birth control) including but not limited to oral contraception, diaphragms, condoms, hormonal patches or injections, sterilization, IUDs and implants)					
Medical services and Prenatal care (including but not limited to ultrasounds, pap smears, medical exams)					
Health education in reproductive and sexual health					
Comprehensive, all-options pregnancy counseling and education					
Abortion care (medication or procedural)					
Routine medical examination and general counseling					
Counseling and testing for HIV					
Testing and treatment for sexually transmitted infections					
Routine screening for breast and cervical cancer					
Other (Please specify)					

6. What social support and services, including but not limited to the list below, are provided at your facility? Please check all that apply.

☐Pregnancy Tests

☐ Educational Programs (including but not limited to classes and outreach materials on parenting, child-raising)

☐Practical assistance with supplies (for example: diapers, clothes, formula, meals)

☐Pregnancy options consultations (including but not limited to education on parenting, adoption, abortion)

☐Recovery or support groups

☐ Referrals to other community resources (for example: shelters, community centers, childcare)

☐Other services you may connect your clients with:

7. What information do you provide clients who visit your facility?

a. Do you help enroll your clients in public benefits programs or connect them with other services?

☐Yes ☐No

If yes, which of the following programs and services?

☐Medicaid

☐Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

☐Supplemental Nutrition Assistance Program (SNAP)

☐Other programs:

b. Does your facility inform clients whether medical professionals are available on the premises, on staff, or as volunteers?

☐Yes ☐No

8. Does your facility collect information from clients?

☐Yes ☐No

If yes, please answer the questions below:

a. What personal and/or identifying information do you collect at client intake? (Please check all that apply and list other personal information you collect).

☐First and Last Name

☐Date of Birth

☐Home address

☐Health Insurance information

Please provide details on other personal or identifying information collected:

b. What medical information do you collect? (Please check all that apply and list additional medical information you collect, as applicable)

☐Medical history (for example pre-existing medical conditions, past surgeries and procedures)

☐Family history (for example information on genetic disorders, diabetes, hypertension etc)

☐Reproductive history (for example parity, pregnancy outcomes, family planning methods etc.)

☐Sexual history (for example number of partners, methods of STI prevention etc)

Please provide details on other medical information collected:

State of Clients' Residence	Number of Clients
New York State	
Out-of-State	
Distance clients travel to facility	**Number of Clients**
<1 mile	
1-5 miles	
5-10 miles	
>10 miles	

3. What geographic areas do your clients commonly come from? Check all that apply:
   a. ☐Same county as your facility
   b. ☐Surrounding or adjacent counties
   c. ☐Other NYS Counties
   d. ☐Don't know

III. Facility Information

The following questions pertain to your facility and services provided at your facility. Please answer these questions to the best of your knowledge.

A. Please provide information on funding sources and organizational support your facility receives:
   1. Does your facility receive public funding, either directly or indirectly? Check all that apply and please include details on the type of funding:
      a. State funding: ☐Yes ☐No
         Source(s):
      b. Federal funding: ☐Yes ☐No
         Source(s):
      c. Tax subsidies: ☐Yes ☐No
         Source(s):
      d. Please provide details on other subsidies:

   2. Does your facility operate within an umbrella organization or as an affiliate of a larger organization?
      ☐Yes ☐No

      If yes, please include the following details
      a. Name of organization:

      b. Please select all that applies to the affiliated organization:
         ☐ Organization operates only within NYS
         ☐ Organization operates within NYS as well as other states
         ☐ Organization receives state or federal public funding

2. What is the distance from your facility to the nearest licensed medical facility providing the full spectrum of comprehensive reproductive and sexual healthcare, including birth control and abortion?

a. ☐<1 mile
b. ☐1-5 miles
c. ☐5-10 miles
d. ☐>10 miles

3. Have your clients informed you that they have experienced a delay in receiving the health care they were seeking, including but not limited to abortion or the initiation of prenatal care, due to a visit to your facility?

☐Yes ☐No

4. Please include details below on the number of state-certified medical professionals that are working at your facility. Please also indicate how many are full time (FT), part time (PT) or are volunteers (V), and if they provide medical services or counseling on-site during regular business hours. Use "N/A" if not applicable. **NYS DOH is not asking that you provide any personally identifiable information regarding any of these professionals.**

State certified staff	Number of staff			Number staff and/or volunteers who provide on-site medical services or counseling
	Full Time Staff	Part Time Staff	Volunteers	
Physicians (MD/DO)				
Advanced Practice Clinicians (NP/PA/CNM/CM/LNM)				
Registered Nurses				
Medical Assistants (PHN/LPN)/ Technicians				
Sonographer				
Administrative Staff				
Patient Navigator				
Health Educator/Community Health Worker				
Counselors				
Others: (Include job title and number)				

5. Please list and describe facility guidelines, operational manuals and handbooks for staff in connection with the provision of services to clients?

a. If they are accessible online, please provide the name of the resource and the webpage link.

b. Would you be willing to share hard copies of these materials if NYS DOH provided the postage?
☐Yes ☐No

c. Under which of these circumstances would client information be shared with a third party? Check all that apply

☐Referral to another provider
☐Transfer to another facility
☐Improve clients access to resources
☐Client information not shared
Other:

d. How does your facility securely store medical and other client records?

e. Is your record-keeping in compliance with federal and state requirements governing medical privacy? For example, HIPAA compliant. (Please respond Yes/No and provide more information if possible)
☐Yes ☐No

Additional Information:

C. Outreach, Advertising, Awareness Promotion:
Please provide information on your facility's outreach and awareness promotional efforts to inform the community of services available at your facility.

1. How does your facility promote awareness of services to the public?

☐Social media (Facebook, Twitter etc)
☐TV/Radio
☐Podcasts, Blogs
☐Newspapers
☐Community events and participation
☐Search Engine advertisements (Google Ads etc)
☐Billboards

Please provide information on other platforms used to increase awareness:

2. When conducting outreach and promoting awareness of services (through your website, or in person events, etc),
   a. Do you present your facility as a medical facility?
   ☐Yes ☐No
   b. Do you present your facility as an entity providing comprehensive, all-options pregnancy counseling?
   ☐Yes ☐No

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Thank you for completing the survey. If you have any questions regarding this survey, you can contact us at: LSPC.Queries@health.ny.gov