**INDIANA WIC PROGRAM CLINIC SITE**

State Form 54145 (10-09)
Indiana State Department of Health

THIS FORM IS POSTED TO SHAREPOINT UNDER THE CLINIC SERVICE'S SECTION. PLEASE USE THAT FORM.

*INSTRUCTIONS:* *1. Complete this form online via the Indiana WIC Program SharePoint site.*
*2. Submit via SharePoint to Indiana WIC Program.*

| **Your Name:** | **Local Agency:** |
|---|---|
| **Date *(month, day, year)*:** | **Anticipated Date of Move *(month, day, year)*:** |

## I. BASIC SITE INFORMATION

**A. Clinic or site number to be moved:**
1) Address of the proposed site:

**B. Is this a:** ☐ New Site? ☐ Relocation?

**C: Caseload to be served at this site:**

**D. Proposed days and hours of operation:**

New telephone number? ☐ Yes ☐ No Telephone:

**E. Is this to be a shared site?** ☐ Yes ☐ No

If yes, with whom?

*If yes, attach a cost allocation plan detailing how costs for rent, utilities, liability insurance, etc. will be divided.*

**F. Total square feet:**

**G. Cost per square feet:** *(Annual rent cost divided by the total number of square feet.)*

## II. ADEQUACY

**A. Does the layout allow for confidentiality during:**

Intake? ☐ Yes ☐ No
Screening? ☐ Yes ☐ No
Counseling? ☐ Yes ☐ No

*If no, detail how confidentiality safety will be improved in Section III B.*

**B. Are the facility/restrooms accessible to handicapped individuals?** ☐ Yes ☐ No

**C. Is the facility safe for small children (e.g., no exposed heating elements or accessible glass fixtures that can be broken, etc.)?**

Inside? ☐ Yes ☐ No
Outside? ☐ Yes ☐ No

*If no, detail how safety will be improved in Section III B.*

**D. Is a sink available in the screening area?** ☐ Yes ☐ No

**E. Is there room for caseload expansion?** ☐ Yes ☐ No

**F. Is adequate/free/adjacent parking available?** ☐ Yes ☐ No

**G. If public transportation is available in the service area, does it provide transportation service close to the site?**

☐ Yes ☐ No ☐ Not Available

## III. Design

**A. Provide (fax) a detailed floor plan of the clinic, including doorways, walls, sinks, etc.**

1. Note what each room will be used for (waiting, intake, check issuance, measurements, certification, counseling, classes, restrooms, storage, or other).
2. Describe the clinic flow.
3. If this is a shared site, indicate which space will be WIC only, shared, or other.

**B. Facility Changes**

1. Are there any changes/repairs to the facility necessary prior to renting the space?
   ☐ Yes ☐ No *(If no, skip to Section V.)*

2. Are the changes:

   Permanent (such as walls or sinks) ☐ Yes ☐ No
   Temporary (such as partitions) ☐ Yes ☐ No

3. Is the landlord willing to make these changes? ☐ Yes ☐ No

   If no, is the landlord willing to prorate the cost as part of the rent? ☐ Yes ☐ No
   If not, please explain under Additional Information at the end of this form.

4. Describe the changes.

## IV. Lease

Does the lease meet State Policy (escape clause, no taxes/insurance, lease between local agency & landlord, aligns with federal/fiscal year)? ☐ Yes ☐ No

## V. Budget

Estimated or actual cost may be submitted. If estimates are provided, then actual costs for everything except utilities must be submitted before final approval can be given.

| Item | Current Costs/month | New Costs/month | One Time Cost |
|---|---|---|---|
| **A. Space Costs** | | | |
| 1. Phones: | | | |
| a. Number of lines needed: | | | |
| b. Installation | | | |
| c. Monthly service | | | |
| d. Long distance | | | |
| 2. Internet ☐ Dial-up ☐ DSL ☐ Same | | | |
| 3. Janitorial Services | | | |
| 4. Moving Expenses | | | |
| 5. Security | | | |
| 6. Insurance | | | |
| 7. Trash | | | |
| 8. Utilities: | | | |
| a. Gas | | | |
| b. Water | | | |
| c. Electric | | | |
| d. Sewage | | | |
| 9. Rent: ☐ Increase ☐ Decrease ☐ Same | | | |

| | | | |
|---|---|---|---|
| **B. Facility Changes/Repairs:** | | | |
| **C. Equipment** *(list items)* | | | |
| **D. Other** *(list items)* | | | |
| **Total** | | | |

**E. Requesting additional funds?** ☐ Yes ☐ No
*If yes, please submit RBC.*
If yes, how much?

Additional Information: