

Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program Client-Level Data Report

PROVIDER FORM

Provider Information	Provider Information (continued)	HIV Counseling & Testing	Imports
Provider Name		<i>Reporting period: January 1, 2009 through June 30, 2009</i>	
<p>1. Provider address:</p> <p>a. Street: 123 5th Avenue, Suite 10000</p> <p>b. City: New York</p> <p>c. State: NY</p> <p>d. ZIP Code: 10020-1234</p> <p>2. Contact information for person completing this form:</p> <p>a. Name: Contact Name</p> <p>b. Title: Grantee Data Submitter</p> <p>c. Phone: (301) 555-1212 Extension: 12345</p> <p>d. Fax: (301) 555-1212</p> <p>e. Email: person@company.com</p> <p>3. Provider type: (Select only one.)</p> <p><input type="radio"/> Hospital or university-based clinic</p> <p><input type="radio"/> Publicly funded community health center</p> <p><input type="radio"/> Publicly funded community mental health center</p> <p><input type="radio"/> Other community-based service organization (CBO)</p> <p><input type="radio"/> Health department</p> <p><input type="radio"/> Substance abuse treatment center</p> <p><input type="radio"/> Solo/group private medical practice</p> <p><input type="radio"/> Agency reporting for multiple fee-for-service providers</p> <p><input type="radio"/> PLWHA coalition</p> <p><input type="radio"/> VA facility</p> <p><input type="radio"/> Other provider type</p> <p>Specify other provider type: <input style="width: 80px;" type="text"/></p>	<p>4. During this reporting period, did your organization receive funding under Section 330 of the Public Health Service Act (funds Community Health Centers, Migrant Health Centers, and Health Care for the Homeless)?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Unknown</p> <p>5. Ownership status:</p> <p>a. Type of ownership: (Select only one.)</p> <p><input type="radio"/> Public/local</p> <p><input type="radio"/> Public/state</p> <p><input type="radio"/> Public/federal</p> <p><input type="radio"/> Private, nonprofit (Go to Item 5b)</p> <p><input type="radio"/> Private, for-profit</p> <p><input type="radio"/> Unincorporated</p> <p><input type="radio"/> Other</p> <p>Specify other ownership status: <input style="width: 80px;" type="text"/></p> <p>b. For private, nonprofit organizations only: Is your organization faith-based?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p>6. During this reporting period, did your organization receive Minority AIDS Initiative funds?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Unknown</p> <p>7. Enter the amount of Part A, B, C or D funds that were expended on oral health care during this reporting period (rounded to the nearest dollar).</p> <p><input style="width: 80px;" type="text"/></p>	<input type="button" value="Next"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>	

Items 1 – 2 (display only): These items contain information saved in the Ryan White Client-level Data System (CLDS). To edit this information, providers must update their organization and user profiles in the CLDS.

Item 3: Select the provider type that best describes the organization. After the initial submission, this item will be pre-populated in subsequent data reports.

Item 4: Indicate if your organization received funding under Section 330 of the Public Health Service Act during the given reporting period.

Item 5: Select the category that best describes your organization's ownership status. If "Private, nonprofit" is selected, you must answer Item 5b. After the initial submission, this item will be pre-populated in subsequent data reports.

Item 6: Indicate if your organization received Minority AIDS Initiative (MAI) funds during the given reporting period.

Item 7: Enter the amount of Ryan White Program funds expended on oral health care during the given reporting period.

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Provider Information	Provider Information (continued)	HIV Counseling & Testing	Imports		
Provider Name: <i>Testing</i>		Reporting Period: <i>July 01, 2007 through December 31, 2007</i>			
8. Please indicate if your organization expended Ryan White HIV/AIDS Program funds to provide services to the grantees listed in the table below.					
Grantee Name^	Funding Source	Grant Number	Contract Reference	Services	Funded
New York, NY	Part A	H89HA00015		Services	\$100
Totals					\$100
9. Which of the following categories describes your agency? (Check all that apply.) <ul style="list-style-type: none"> <input type="checkbox"/> An agency in which racial/ethnic minority group members make up more than 50% of the agency's board members <input type="checkbox"/> Racial/ethnic minority group members make up more than 50% of the agency's professional staff members in direct HIV services <input type="checkbox"/> Solo or group private health care practice in which more than 50% of the clinicians are racial/ethnic minority group members <input type="checkbox"/> Other provider that has historically served racial/ethnic minority clients but does not meet any of the criteria above <input type="checkbox"/> Other type of agency or facility 			10. Report the number of paid staff, in full-time equivalents (FTEs) in up to two decimal places, that were funded by the Ryan White HIV/AIDS Program during this reporting period: <input style="width: 80px;" type="text"/>		
			11. Please select the status of your agency's clinical quality management program for assessing HIV health services. (Select only one.) <ul style="list-style-type: none"> <input checked="" type="radio"/> Clinical quality management program introduced this reporting period <input type="radio"/> Previously established clinical quality management program <input type="radio"/> Previously established clinical quality management program with new quality standards added this reporting period <input type="radio"/> Not applicable 		
		<input type="button" value="Previous"/>	<input type="button" value="Next"/>	<input type="button" value="Save"/>	<input type="button" value="Cancel"/>

Item 8: Grantee/contract information: This list of contracts is populated with information provided by Ryan White HIV/AIDS Program grantees. The contract reference, if specified, will help you report the data associated with a particular contract. (**Note:** For the purposes of the Ryan White Data Report, “contracts” include formal contracts, memorandum of understanding, and other agreements.)

Services: This link opens another screen (see pages 5 – 8). Select the services delivered under each agreement during the given reporting period.

Item 9: Select the categories that best describe your organization.

Item 10: Report the number of paid staff, in full-time equivalents (FTEs), funded by the Ryan White HIV/AIDS Program during the given reporting period.

Item 11: Select the status of your agency’s clinical quality management program.

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PROVIDER FORM

Provider Information	Provider Information (continued)	HIV Counseling & Testing	Imports
<i>Provider Name: Testing</i>		<i>Reporting Period: July 01, 2007 through December 31, 2007</i>	
<p>Please report the following for your organization during this reporting period:</p> <p>12. Number of individuals tested for HIV antibodies: <input style="width: 100px;" type="text"/></p> <p>13. Of those tested (#12 above), number who tested NEGATIVE: <input style="width: 100px;" type="text"/></p> <p>14. Number who tested NEGATIVE (#13 above) <u>and</u> received posttest counseling: <input style="width: 100px;" type="text"/></p>		<p>15. Of those tested (#12 above), number who tested POSITIVE: <input style="width: 100px;" type="text"/></p> <p>16. Number who tested POSITIVE (#15 above) <u>and</u> received posttest counseling: <input style="width: 100px;" type="text"/></p> <p>17. Of those tested POSITIVE (#15 above), number referred to HIV medical care: <input style="width: 100px;" type="text"/></p>	
		<input type="button" value="Previous"/>	<input type="button" value="Next"/>
		<input type="button" value="Save"/>	<input type="button" value="Cancel"/>

Items 12–17: If a grantee indicates that your organization was contracted to provide HIV counseling and testing services during the given reporting period, your organization must complete this section.

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Provider Information	Provider Information (continued)	HIV Counseling & Testing	Imports
<i>Provider Name: Testing</i>		<i>Reporting Period: July 01, 2007 through December 31, 2007</i>	
<input type="button" value="Import XML Provider File"/>		Imported on June 29, 2009 4:59 PM	
<input type="button" value="Import XML Client File"/>		Imported 625 clients on June 29, 2009 5:59 PM	
		<input type="button" value="Previous"/>	<input type="button" value="Save"/> <input type="button" value="Cancel"/>

Grantees and/or providers have the option of importing provider data into the CLDS from their local system. The XML provider file includes:

- Provider organizational data (Items 3 – 7 and 9 – 11)
- Services provided with Ryan White funds under each agreement (Item 8)
- HIV counseling and testing data (Item 12 – 17)

In order to complete their submission, grantees must ensure that their providers' client-level data, if appropriate, are imported into the CLDS. The XML client file includes the proposed client-level data fields.

**Health Resources and Services Administration (HRSA)
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PROVIDER FORM— SERVICES

Administrative & Technical Services	Core Medical Services	Support Services	HIV Counseling & Testing
[Grantee Name]		Reporting period: January 1, 2009 through June 30, 2009	
[Contract 1 of n - Contract Reference]			
Please select the services delivered under this agreement during the given reporting period. (Check all that apply.)			
ID^	Delivered	Service	
1	<input type="checkbox"/>	Planning or evaluation	
2	<input type="checkbox"/>	Administrative or technical support	
3	<input type="checkbox"/>	Fiscal intermediary support	
4	<input type="checkbox"/>	Other fiscal services	
5	<input type="checkbox"/>	Technical assistance	
6	<input type="checkbox"/>	Capacity development	
7	<input type="checkbox"/>	Quality management	
<input type="checkbox"/> Check this box if administrative and technical services are the only contracted services.			
		Next	Save
		Cancel	

Please select administrative and technical services delivered under this agreement during the given reporting period (check all that apply).

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Administrative & Technical Services	Core Medical Services	Support Services	HIV Counseling & Testing
[Grantee Name]		Reporting period: January 1, 2009 through June 30, 2009	
[Contract 1 of n - Contract Reference]			
Please select the services delivered under this agreement during the given reporting period. (Check all that apply.)			
ID^	Delivered	Service	
1	<input type="checkbox"/>	Outpatient/ambulatory medical care	
2	<input type="checkbox"/>	Local AIDS Pharmaceutical Assistance (not ADAP)	
3	<input type="checkbox"/>	Oral health care	
4	<input type="checkbox"/>	Early intervention services (Parts A and B)	
5	<input type="checkbox"/>	Health Insurance Premium & Cost Sharing Assistance	
6	<input type="checkbox"/>	Home health care	
7	<input type="checkbox"/>	Home and community-based health services	
8	<input type="checkbox"/>	Hospice services	
9	<input type="checkbox"/>	Mental health services	
10	<input type="checkbox"/>	Medical nutrition therapy	
11	<input type="checkbox"/>	Medical case management (including treatment adherence)	
12	<input type="checkbox"/>	Substance abuse services-outpatient	
		<input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>	

Please select the core medical services delivered under this agreement during the given reporting period (check all that apply).

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PROVIDER FORM— SERVICES

Administrative & Technical Services	Core Medical Services	Support Services	HIV Counseling & Testing
[Grantee Name]		Reporting period: January 1, 2009 through June 30, 2009	
[Contract 1 of n - Contract Reference]			
Please select the services delivered under this agreement during the given reporting period. (Check all that apply.)			
ID^	Delivered	Service	
1	<input type="checkbox"/>	Case management (non-medical)	
2	<input type="checkbox"/>	Child care services	
3	<input type="checkbox"/>	Pediatric development assessment/early intervention services	
4	<input type="checkbox"/>	Emergency financial assistance	
5	<input type="checkbox"/>	Food bank/home-delivered meals	
6	<input type="checkbox"/>	Health education/risk reduction	
7	<input type="checkbox"/>	Housing services	
8	<input type="checkbox"/>	Legal services	
9	<input type="checkbox"/>	Linguistic services	
10	<input type="checkbox"/>	Medical transportation services	
11	<input type="checkbox"/>	Outreach services	
12	<input type="checkbox"/>	Permanency planning	
13	<input type="checkbox"/>	Psychosocial support services	
14	<input type="checkbox"/>	Referral for health care/supportive services	
15	<input type="checkbox"/>	Rehabilitation services	
16	<input type="checkbox"/>	Respite care	
17	<input type="checkbox"/>	Substance abuse services-residential	
18	<input type="checkbox"/>	Treatment adherence counseling	
			<input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>

Please select the support services delivered under this agreement during the given reporting period (check all that apply).

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PROVIDER FORM— SERVICES

Administrative & Technical Services	Core Medical Services	Support Services	HIV Counseling & Testing
[Grantee Name]		Reporting period: January 1, 2009 through June 30, 2009	
[Contract 1 of n - Contract Reference]			
Please select the services delivered under this agreement during the given reporting period. (Check all that apply.)			
ID^	Delivered	Service	
1	<input type="checkbox"/>	HIV Counseling and Testing	
		<input type="button" value="Previous"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>	

Please indicate if you delivered HIV counseling and testing services under this agreement during the given reporting period.