

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

PROVIDER FORM

The deadline to submit the RSR to your grantee is April 26, 2011 06:00 PM EDT The grantee deadline for returning RSRs is May 29, 2011 06:00 PM EDT The grantee deadline for accepting RSRs is April 26, 2011 06:00 PM EDT	Number of clients uploaded: 1				
Owned by: Provider Name					
Access Mode: edit - Data can be edited by: None only - RSR Status: working					
Section 1 of 2 - Page 1 of 5 - Questions 1 - 2					
Provider Name: Provider Name	Reporting Period: 1 January 2010 through 31 December 2010				
SECTION 1. SERVICE PROVIDER INFORMATION					
1. Provider Address: (Edit)					
a. Street:	7737 Lueders Avenue				
b. City:	Jacksonville				
c. State:	FL				
d. ZIP Code:	32208				
2. Contact information: (Edit)					
a. Name:	Lisa C				
b. Title:	Project Ofcr				
c. Phone #:	301-230-4703				
d. Fax #:					
e. Email:	lisa.e.craun@saic.com				
<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="padding: 2px 10px;">< Previous Page</td><td style="padding: 2px 10px;">Next Page ></td><td style="padding: 2px 10px;">Save</td><td style="padding: 2px 10px;">Restore Initial Values</td></tr></table>		< Previous Page	Next Page >	Save	Restore Initial Values
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Items 1 – 2: If the information in Item 1 or Item 2 is incorrect, it must be corrected. Providers may edit the information by selecting the “edit” link next to the Item.

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Number of clients uploaded: 1

Owned by: CITY OF JACKSONVILLE
Access Mode: edit - Data can be edited by: None only - RSR Status: working

Section 1 of 2 - Page 2 of 5 - Questions 3 - 7

Provider Name: A.H.P. Home Health Care Reporting Period: 1 January 2010 through 31 December 2010

SECTION 1. SERVICE PROVIDER INFORMATION (Continued)

3. Provider type:

- Hospital or university-based clinic
- Publicly funded community health center (go to Item 4)
- Publicly funded community mental health center
- Other community-based service organization (CBO)
- Health Department
- Substance abuse treatment center
- Solo/group private medical practice
- Agency reporting for multiple fee-for-service providers
- PLWHA coalition
- VA facility
- Other provider type (Specify:)

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)? (Clear my answer)

Yes No Unknown

5. Ownership status:

a. Type of ownership:

- Public/local
- Public/state
- Public/federal
- Private, nonprofit (go to Item 5b)
- Private, for-profit
- Unincorporated
- Other (Specify:)

b. For private, nonprofit organizations only: is your organization faith-based? (Clear my answer)

Yes No

6. During this reporting period, did your organization receive Minority AIDS Initiative (MAI) funds?

Yes No Unknown

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):

\$

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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 b. 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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Number of clients uploaded: 1

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Access Mode: edit - Data can be edited by: None only - RSR Status: working

Section 1 of 2 - Page 3 of 5 - Question 8

Provider Name: Provider Name

Reporting Period: 1 January 2010 through 31 December 2010

SECTION 1. SERVICE PROVIDER INFORMATION (Continued)

8. Please indicate if your organization expended Ryan White HIV/AIDS Program funds to provide services to the grantees listed in the table below by selecting the "Services" link for each contract.

Contract ID	Grantee Name	Funding Source	Grant Number	Contract Reference	Start Date	End Date	Services	Amount Funded
Contract ID	Grantee Name	Part(s)	Grant Number		01/01/2010	12/31/2010	Services	\$ 0
Contract ID	Grantee Name	Part(s)	Grant Number		01/01/2010	06/30/2010	Services	\$ 0
Total Funded:								\$0

To view the crosswalk of services Funded, Delivered and Uploaded, click here .
 To view the crosswalk of services Funded, Delivered and Uploaded group by Service, click here .

*: Fiscal Intermediary service has been selected.

NOTE: If your agency indicates that it only provides administrative and technical services under all contracts, **STOP HERE** . You are not required to complete the remainder of this report. You are **NOT** required to submit client data records.

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 page 3).

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

PROVIDER FORM

Grantee: Grantee Name		Funding Source: Part
Provider: Provider Name		Grant #: Grant Number
Contract ID: Contract ID		Contract Reference: Contract Reference

ADMINISTRATIVE SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
<input type="checkbox"/>	<input type="checkbox"/>	Planning or evaluation
<input type="checkbox"/>	<input type="checkbox"/>	Administrative or technical support
<input type="checkbox"/>	<input type="checkbox"/>	Fiscal intermediary support
<input type="checkbox"/>	<input type="checkbox"/>	Other fiscal services
<input type="checkbox"/>	<input type="checkbox"/>	Technical assistance
<input type="checkbox"/>	<input type="checkbox"/>	Capacity development
<input type="checkbox"/>	<input type="checkbox"/>	Quality management

CORE MEDICAL SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
<input type="checkbox"/>	<input type="checkbox"/>	Outpatient/ambulatory medical care
<input type="checkbox"/>	<input type="checkbox"/>	Local AIDS Pharmaceutical Assistance
<input type="checkbox"/>	<input type="checkbox"/>	Oral health care
<input type="checkbox"/>	<input type="checkbox"/>	Early intervention services (Parts A and B)
<input type="checkbox"/>	<input type="checkbox"/>	Health Insurance Premium & Cost Sharing Assistance
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Home health care
<input type="checkbox"/>	<input type="checkbox"/>	Home and community-based health services
<input type="checkbox"/>	<input type="checkbox"/>	Hospice services
<input type="checkbox"/>	<input type="checkbox"/>	Mental health services
<input type="checkbox"/>	<input type="checkbox"/>	Medical nutrition therapy
<input type="checkbox"/>	<input type="checkbox"/>	Medical case management (including treatment adherence)
<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse services-outpatient

SUPPORT SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
<input type="checkbox"/>	<input type="checkbox"/>	Case management (non-medical)
<input type="checkbox"/>	<input type="checkbox"/>	Child care services
<input type="checkbox"/>	<input type="checkbox"/>	Pediatric development assessment/early intervention services
<input type="checkbox"/>	<input type="checkbox"/>	Emergency financial assistance
<input type="checkbox"/>	<input type="checkbox"/>	Food bank/home-delivered meals
<input type="checkbox"/>	<input type="checkbox"/>	Health education/risk reduction
<input type="checkbox"/>	<input type="checkbox"/>	Housing services
<input type="checkbox"/>	<input type="checkbox"/>	Legal services
<input type="checkbox"/>	<input type="checkbox"/>	Linguistics services
<input type="checkbox"/>	<input type="checkbox"/>	Medical transportation services
<input type="checkbox"/>	<input type="checkbox"/>	Outreach services
<input type="checkbox"/>	<input type="checkbox"/>	Permanency planning
<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial support services
<input type="checkbox"/>	<input type="checkbox"/>	Referral for health care/supportive services
<input type="checkbox"/>	<input type="checkbox"/>	Rehabilitation services
<input type="checkbox"/>	<input type="checkbox"/>	Respite care
<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse services-residential
<input type="checkbox"/>	<input type="checkbox"/>	Treatment adherence counseling

HIV COUNSELING AND TESTING SERVICES

Check the box if this agency was funded to provide HIV Counseling and Testing services under this agreement.

Funded	Delivered	Service
<input type="checkbox"/>	<input type="checkbox"/>	HIV Counseling and Testing

- Select the services delivered under each agreement during the given reporting period.

Please see the following pages (pgs. 5-6) for magnified views of each service section.

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

PROVIDER FORM

Grantee: Grantee Name
 Provider: Provider Name
 Contract ID: Contract ID

Funding Source: Part
 Grant #: Grant Number
 Contract Reference: Contract Reference

ADMINISTRATIVE SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
<input type="checkbox"/>	<input type="checkbox"/>	Planning or evaluation
<input type="checkbox"/>	<input type="checkbox"/>	Administrative or technical support
<input type="checkbox"/>	<input type="checkbox"/>	Fiscal intermediary support
<input type="checkbox"/>	<input type="checkbox"/>	Other fiscal services
<input type="checkbox"/>	<input type="checkbox"/>	Technical assistance
<input type="checkbox"/>	<input type="checkbox"/>	Capacity development
<input type="checkbox"/>	<input type="checkbox"/>	Quality management

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

<input type="checkbox"/>	<input type="checkbox"/>	Quality management
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CORE MEDICAL SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
<input type="checkbox"/>	<input type="checkbox"/>	Outpatient/ambulatory medical care
<input type="checkbox"/>	<input type="checkbox"/>	Local AIDS Pharmaceutical Assistance
<input type="checkbox"/>	<input type="checkbox"/>	Oral health care
<input type="checkbox"/>	<input type="checkbox"/>	Early intervention services (Parts A and B)
<input type="checkbox"/>	<input type="checkbox"/>	Health Insurance Premium & Cost Sharing Assistance
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Home health care
<input type="checkbox"/>	<input type="checkbox"/>	Home and community-based health services
<input type="checkbox"/>	<input type="checkbox"/>	Hospice services
<input type="checkbox"/>	<input type="checkbox"/>	Mental health services
<input type="checkbox"/>	<input type="checkbox"/>	Medical nutrition therapy
<input type="checkbox"/>	<input type="checkbox"/>	Medical case management (including treatment adherence)
<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse services-outpatient

SUPPORT SERVICES

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

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

PROVIDER FORM

SUPPORT SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
<input type="checkbox"/>	<input type="checkbox"/>	Case management (non-medical)
<input type="checkbox"/>	<input type="checkbox"/>	Child care services
<input type="checkbox"/>	<input type="checkbox"/>	Pediatric development assessment/early intervention services
<input type="checkbox"/>	<input type="checkbox"/>	Emergency financial assistance
<input type="checkbox"/>	<input type="checkbox"/>	Food bank/home-delivered meals
<input type="checkbox"/>	<input type="checkbox"/>	Health education/risk reduction
<input type="checkbox"/>	<input type="checkbox"/>	Housing services
<input type="checkbox"/>	<input type="checkbox"/>	Legal services
<input type="checkbox"/>	<input type="checkbox"/>	Linguistics services
<input type="checkbox"/>	<input type="checkbox"/>	Medical transportation services
<input type="checkbox"/>	<input type="checkbox"/>	Outreach services
<input type="checkbox"/>	<input type="checkbox"/>	Permanency planning
<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial support services
<input type="checkbox"/>	<input type="checkbox"/>	Referral for health care/supportive services
<input type="checkbox"/>	<input type="checkbox"/>	Rehabilitation services
<input type="checkbox"/>	<input type="checkbox"/>	Respite care
<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse services-residential
<input type="checkbox"/>	<input type="checkbox"/>	Treatment adherence counseling

HIV COUNSELING AND TESTING SERVICES

Check the box if this agency was funded to provide HIV Counseling and Testing services under this agreement.

Funded	Delivered	Service
<input type="checkbox"/>	<input type="checkbox"/>	HIV Counseling and Testing

- Please select the support services delivered under this agreement during the given reporting period (check all that apply).
- Please check the box if this agency delivered HIV Counseling and Testing Services during the given reporting period.

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Owned by: Report Owner Organization Name Access Mode: edit - Data can be edited by: None only - RSR Status: working	Section 1 of 2 - Page 4 of 5 - Questions 9 - 11
Provider Name: Provider Name	Reporting Period: 1 January 2010 through 31 December 2010
SECTION 1. SERVICE PROVIDER INFORMATION (Continued)	
NOTE: If your agency indicates that it only provides administrative and technical services under all contracts, STOP HERE . You are not required to complete the remainder of this report. You are NOT required to submit client data records.	
<p>9. Which of the following categories describes your agency? (Check all that apply.)</p> <p><input type="checkbox"/> An agency in which racial/ethnic minority group members make up more than 50% of the agency's board members</p> <p><input type="checkbox"/> Racial/ethnic minority group members make up more than 50% of the agency's professional staff members in HIV direct services</p> <p><input type="checkbox"/> Solo or group private health care practice in which more than 50% of the clinicians are racial/ethnic minority group members</p> <p><input type="checkbox"/> Other "traditional" provider that has historically served racial/ethnic minority clients but does not meet any of the criteria above</p> <p><input type="checkbox"/> Other type of agency or facility</p> <p>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:</p> <input type="text"/>	
<p>11. Please select the status of your agency's clinical quality management program for assessing HIV health services. (Select only one)(Clear my answer)</p> <p><input type="radio"/> Clinical quality management program introduced this reporting period</p> <p><input type="radio"/> Previously established quality management program</p> <p><input type="radio"/> Previously established program with new quality standards added this reporting period</p> <p><input type="radio"/> Not applicable</p>	
<p>< Previous Page Next Page > Save Restore Initial Values</p>	

Items 9 through 11 – Core Medical Services

If you indicated in Item 8 (services delivered), that you delivered ONLY “Administrative Services” and/or “Support Services,” then Items 9 through 17 are not required.

You will STOP here.

Conversely, if you indicated that you did deliver “Core Medical Services,” then Items 9 through 11 will be required.

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.

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PROVIDER FORM

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

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Owned by: Report Owner Organization Name		
Access Mode: edit - Data can be edited by: None only - RSR Status: working		Section 2 of 2 - Page 5 of 5 - Questions 12 - 17
Provider Name: Provider Name		Reporting Period: 1 January 2010 through 31 December 2010
SECTION 2. HIV Counseling & Testing		
12. Number of individuals tested for HIV:	<input type="text"/>	
13. Of those tested (#12 above), number who tested NEGATIVE:	<input type="text"/>	
14. Number who tested NEGATIVE (#13 above) <u>and</u> received posttest counseling:	<input type="text"/>	
15. Of those tested (#12 above), number who tested POSITIVE:	<input type="text"/>	
16. Number who tested POSITIVE (#15 above) <u>and</u> received posttest counseling:	<input type="text"/>	
17. Of those tested POSITIVE (#15 above), number referred to HIV medical care:	<input type="text"/>	
End of Report. Upload client-level data if required.		
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Items 12–17: If a grantee indicates in **Item 8** that your organization was contracted to provide HIV counseling and testing services during the given reporting period, your organization then **Items 12 through 17** ARE required.

Conversely, if you indicated that you did NOT deliver “HIV Counseling and Testing”, then Items 12 through 17 will be disabled.

Item 12 – Number Tested for HIV

Item 13 – Number of Test Results Negative

Item 14 – Number of Results Negative & Received Counseling

Item 15 – Number of Test Results Positive

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

PROVIDER FORM

Item 16 – Number of Test Results Positive & Received Counseling

Item 17 – Number of Test Results Positive and Referred