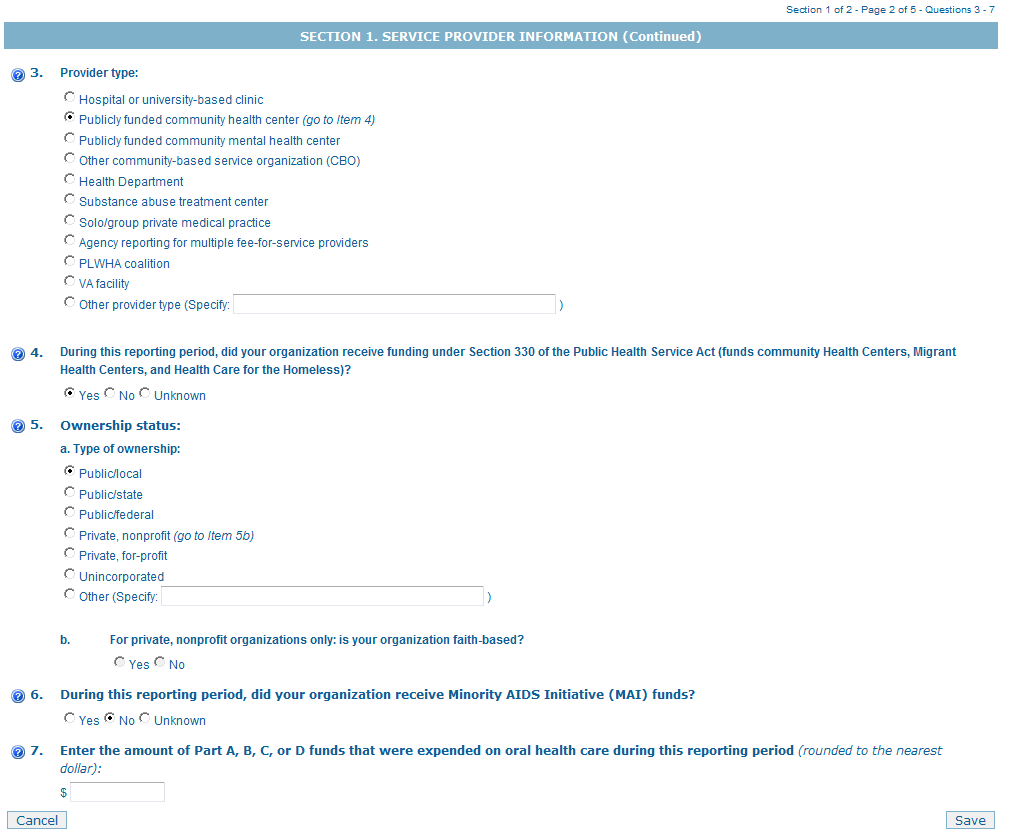


**Items 1 – 2:** If the information in Item 1 or Item 2 is incorrect, it must be corrected. Providers may edit the information by selecting the “edit” link next to the Item.



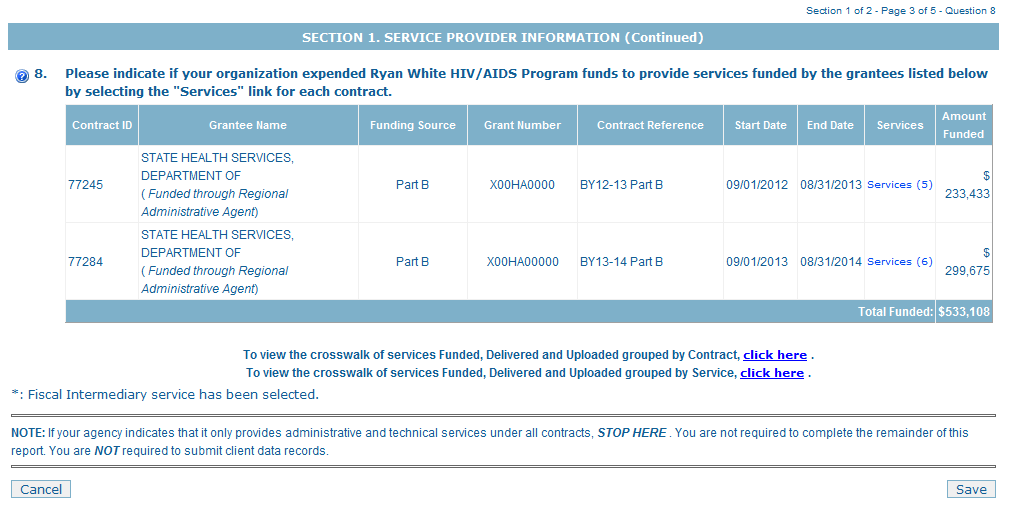
**Item 3**: Select the provider type that best describes the organization. After the initial submission, this item will be pre-populated in subsequent data reports.

**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



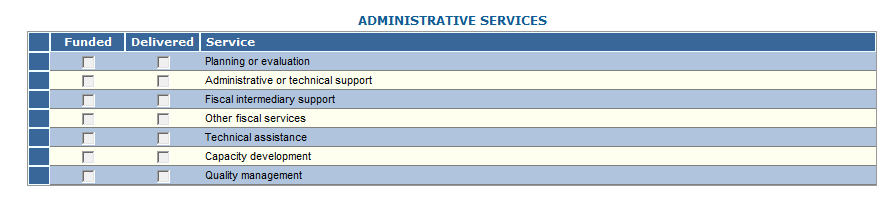
**Item 8: Grantee/contract information:** This list of contracts is populated with information provided by Ryan White HIV/AIDS Program grantees. The contract reference, if specified, will help you report the data associated with a particular contract. (**Note**: For the purposes of the Ryan White Data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

**Services:** This link opens another screen (see page 3).

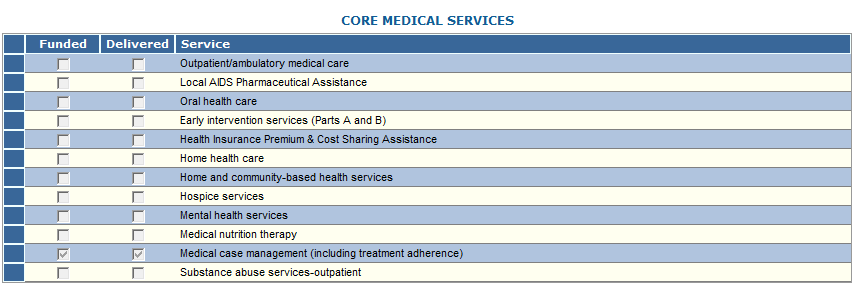


* Select the services delivered under each agreement during the given reporting period.

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



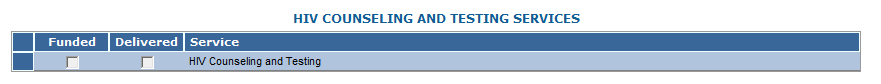
* Please select the administrative services delivered under this agreement during the given reporting period (check all that apply).



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



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



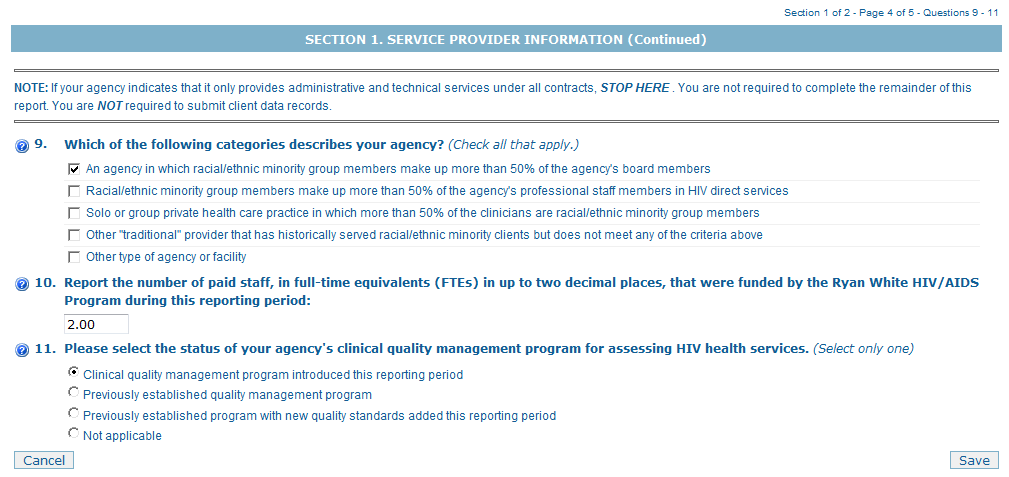
* Please check the box if this agency delivered HIV Counseling and Testing Services during the given reporting period.

**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.

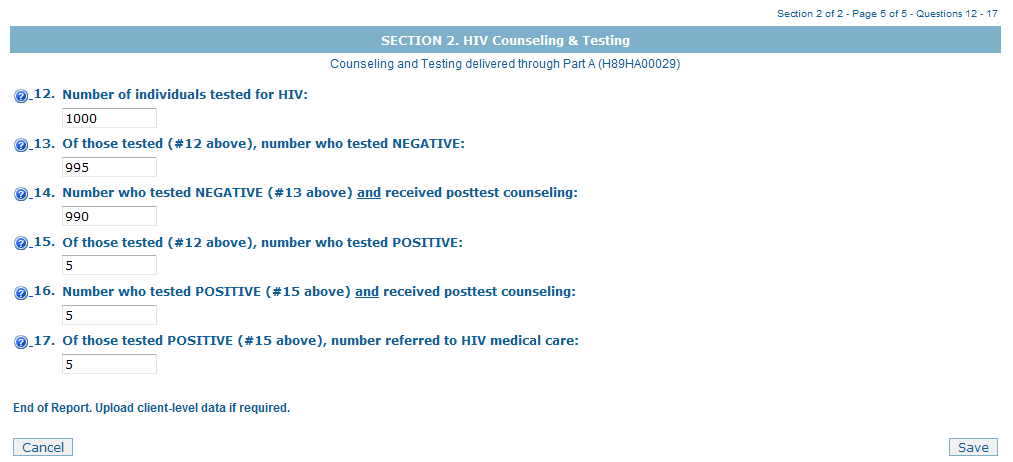
Conversely, if you indicated that you did deliver “Core Medical Services,” then Items 9 through 11 will be required.



**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.

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



**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

**Item 16 –** Number of Test Results Positive & Received Counseling

**Item 17 –** Number of Test Results Positive and Referred