

___ Quarterly ___ Biannual FOA (RFA)#: _____ Cohort: _____ Multi-year funded: ___

Reporting Period: _____ to _____	Grant Year: ___	No-cost ext.: ___, # months: ___	Grantee Federal Identification #: TI _____
Date: _____	Project Name: _____	Grantee Name: _____	
Completed by: _____	Title: _____	Telephone: _____	CSAT Project Officer: _____

I. Key Staff Personnel

Key Staff	Name	Address	Email	Telephone
Project Director				
Project Evaluator				
Other:				

II. Changes in Staffing Personnel (this reporting period)

A. Staff Updates – Please complete the below table with any staff changes

*Note: Project Director, Evaluator, and Program Manager/Coordinator (e.g., Clinical Supervisor) require **prior** CSAT approval*

Name (for new hires)	Position/Title	Email	Telephone	Date Hired
Name (for changed roles)	Position/Title (old position)	Position/Title (new position)	Old position vacant? If so, why	

B. Other Staff Matters – Fully staffed? ___Yes ___No *if No, please describe staffing challenges (e.g., recruitment, retention)*

III. Knowledge-building Activity (this reporting period)

Name	Position	Training Activity	Licensing		Technical Assistance (TA) request/need
			Yes	No	

IV. Project Information (this reporting period)

A. Annual Target and Goal(s)

*Any change to annual targets and/or goals require **prior** CSAT approval*

1. What are your Annual Targets? Intake _____ Follow-up _____

Current / Existing Goals	
New Goals	Approved By (SAMHSA official)

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2. Please explain any changes in your annual targets and/or goals, *if applicable*.

B. Financial Data

Federal Funds Authorized (Annual)		Q1	Q2	1 st half	Q3	Q4	2 nd half	TOTAL
Forecasted Cash Needs (Budgeted)								
Federal Share Spent (Expended)								
a. Substance Use Disorder (SUD) Services								
SUD Treatment								
Recovery Support								
<i>Other federal funding:</i>								
<i>Other state funding:</i>								
<i>Funding from other sources:</i>								
b. HIV Services								
<i>Other federal funding:</i>								
<i>Other state funding:</i>								
<i>Funding from other sources:</i>								
c. Hepatitis Services								
<i>Other federal funding:</i>								
<i>Other state funding:</i>								
<i>Funding from other sources:</i>								
d. Contract Services								
Obligated Funds								
Unliquidated obligation (ULO) Funds								
Unobligated (UO) Funds								
Carryover Funds								

C. Care Coordination (*Linkages & Referral Services*)

List all organizations to which clients were referred to by your organization for additional services

Organization (Referred To)	Location	Referred Services (Type)	# Referrals	Outcome of Referral(s)	MOU / MOA

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Organization (Referred To)	Location	Referred Services (Type)	# Referrals	Outcome of Referral(s)	MOU / MOA

List all organizations which referred clients to your agency (if applicable)

Organization (Referred From)	Referral Source (e.g. Hospital)	Referred Services (Type)	# Referrals	Outcome of Referral(s)	MOU / MOA

D. Client Information

1. Substance Use Disorder (SUD) Reporting

	Q1	Q2	1 st half	Q3	Q4	2 nd half	TOTAL
# clients served							
# intakes/admissions planned (your targets)							
# intake/admissions completed							
# clients completed assessment but received no treatment							
# clients completed six (6) month follow-up assessment							
# clients discharged <i>prior</i> to program completion*							
# clients successfully completed treatment/program							

* clients who left the program for any reason without completing their treatment plan

2. Substance Use Disorder (SUD) / Co-occurring Disorder (COD) Treatment Reporting

Target Population	SUD				COD			
	Screening tool used	# screened	# referred	Services provided	Screening tool used	# screened	# referred	Services provided
Minority Women				Individual / Group Counseling Treatment Medication Peer Services Recovery Services				Individual / Group Counseling Treatment Medication Peer Services Recovery Services
Minority Men				Individual / Group Counseling Treatment Medication Peer Services Recovery Services				Individual / Group Counseling Treatment Medication Peer Services Recovery Services

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Target Population	SUD				COD			
	Screening tool used	# screened	# referred	Services provided	Screening tool used	# screened	# referred	Services provided
Heterosexual				Individual / Group Counseling Treatment Medication Peer Services Recovery Services				Individual / Group Counseling Treatment Medication Peer Services Recovery Services
Transgender				Individual / Group Counseling Treatment Medication Peer Services Recovery Services				Individual / Group Counseling Treatment Medication Peer Services Recovery Services
Bisexual				Individual / Group Counseling Treatment Medication Peer Services Recovery Services				Individual / Group Counseling Treatment Medication Peer Services Recovery Services
Lesbian				Individual / Group Counseling Treatment Medication Peer Services Recovery Services				Individual / Group Counseling Treatment Medication Peer Services Recovery Services
MSM				Individual / Group Counseling Treatment Medication Peer Services Recovery Services				Individual / Group Counseling Treatment Medication Peer Services Recovery Services
YMSM				Individual / Group Counseling Treatment Medication Peer Services Recovery Services				Individual / Group Counseling Treatment Medication Peer Services Recovery Services

- a. Please enter the number (#) of Screening, Brief Intervention, and Referral to Treatment (SBIRT) conducted: _____
- b. Please list and/or **update** currently used evidence-based interventions / practices (EBIs / EBPs)

EBIs / EBPs	SUD	COD	HIV	Hepatitis	EBIs / EBPs	SUD	COD	HIV	Hepatitis

3. HIV Testing Reporting

	Q1	Q2	1 st half	Q3	Q4	2 nd half	TOTAL
HIV Testing							
# staff trained on HIV testing							
# HIV test kits purchased							
# HIV tests planned							
# HIV tests completed							
HIV Positivity							
# positive test results							
# negative test results							
# tests conducted solely to verify HIV-positive status							
# tests with missing or invalid values							
HIV Knowledge-status							
# HIV-positive clients knowing their HIV status in 12 month period							
# HIV-positive tests in 12 month period							
Late HIV Diagnosis							
# clients diagnosed with Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection in 12 month period							
# clients with an HIV diagnosis in 12 month period							
Linkage to HIV Medical Care							
# clients who attended a HIV care visit within 3 months of diagnosis							
# clients with an HIV diagnosis in 12 month period							
Retention in HIV Medical Care							
# clients with HIV diagnosis and had at least one HIV medical care visit in each 6 month period (of 24 month period)							
# clients who attended at least one HIV medical care visit in the first 6 month period (of 24 month period)							

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Antiretroviral Therapy (ART) <i>(if applicable)</i>							
# clients prescribed ART in 12 month period							
# clients with HIV diagnosis and had at least one HIV medical care visit in 12 month period							
Viral Load Suppression <i>(if applicable)</i>							
# clients who have maintained a viral load <200 copies/mL at last test in 12 month period							
# clients with HIV diagnosis and had at least one HIV medical care visit in 12 month period							
Housing Status							
# clients with an HIV diagnosis who were homeless or unstably housed in 12 month period							
# clients with HIV diagnosis receiving HIV services in last 12 months							

4. **Hepatitis Testing Reporting: (IF APPLICABLE)**

	Q1	Q2	1 st half	Q3	Q4	2 nd half	TOTAL
Hepatitis Testing							
# staff trained on Hepatitis testing							
# HBV test kits purchased							
# HBV tests planned							
# HBV tests completed							
# HCV test kits purchased							
# HCV tests planned							
# HCV tests completed							
Hepatitis B (HBV)							
# Positives							
# Negatives							
# HBV tests with missing or invalid values							
Hepatitis C (HCV)							
# Positives							
# Negatives							
# HCV tests with missing or invalid values							
Referral/Linkage to Care							
# referrals issued for Hepatitis testing at your facility							
# referrals issued for Hepatitis testing outside of your facility							
# referrals issued for follow up (confirmatory) testing							
# referrals issued for treatment, post-confirmatory testing							
# clients who completed referral to Hepatitis medical care							
Retention in Care							
# clients attending routine Hepatitis medical care within 3 months of diagnosis							
# clients who attended at least one Hepatitis medical care visit in the last 6 months, if not receiving routine Hepatitis care							
Hepatitis Treatment							
# clients receiving HBV treatment							
# clients receiving HCV treatment							
Immunization Efforts							
# clients vaccinated for HAV							
# clients vaccinated for HBV							
# clients vaccinated for HAV and HBV							

5. **Outreach & Engagement Reporting**

a. Please enter the # of individuals contacted during outreach (educational, pre-counseling, not enrolled in treatment)

	Q1	Q2	1 st half	Q3	Q4	2 nd half	TOTAL
Comprehensive (Comp.) **							
SUD/COD/Trauma							
SUD/COD							
HIV							
Hepatitis							
Trauma							

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** An inclusive event that incorporates SUD, COD, Trauma, HIV, and/or Hepatitis (if applicable) together

b. Please enter the # of visits to the following venues during this reporting period

Activity	Target Population							Venue												Program			
	Minority Women	Minority Men	Heterosexual	Transgender	Bisexual	Lesbian	MSM	YMSM	Community Center	Public Spaces	Beauty / Hair shop	“The Corner” / block	Church, Mosque, etc.	Primary Care	Restaurant / Coffee House	Nightclub / Bar	Social Media	Cyberspace	College Campus		Greek (e.g., frat) House	Other:	
Health & wellness fairs																							Comp.**
																							SUD/COD
																							HIV
																							Hepatitis
Other fair types																							Trauma
																							Comp.**
																							SUD/COD
																							HIV
Health clinic days																							Hepatitis
																							Trauma
																							Comp.**
																							SUD/COD
Mobile clinic days																							HIV
																							Hepatitis
																							Trauma
																							Comp.**
Day-specific (e.g., World AIDS Day) events																							SUD/COD
																							HIV
																							Hepatitis
																							Trauma
Structured socialization																							Comp.**
																							SUD/COD
																							HIV
																							Hepatitis
Other:																							Trauma
																							Comp.**
																							SUD/COD
																							HIV

c. Please enter the average # of health promotion items distributed during this reporting period

Health Promotion Item	Location	Minority Women	Minority Men	Heterosexual	Transgender	Bisexual	Lesbian	MSM	YMSM
Health Information Flyers	On-site								
	Off-site								
Safer Sex Brochures	On-site								
	Off-site								
Condoms	On-site								
	Off-site								
Hot Line Information	On-site								
	Off-site								
Other:	On-site								
	Off-site								

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6. Trauma Reporting: (IF APPLICABLE)

a. Please complete the below table to capture your trauma-informed approach (TIA) / trauma-informed care (TIC) activities

Target Group	Screening tool used (e.g., HITS, PCL-C, STaT, PSSR)	# screened	# referred to Trauma-informed care (TIC)		# treated	# referred to Ancillary Services												
						TIC Treatment (e.g., ATRIUM, Seeking Safety, TREM)	Domestic Shelter	Transportation	Legal / Legal Aide	Medical Care	Advocacy	Court / Judicial	Law Enforcement	Family Counseling	Faith-based	Support Group	Traditional Healers	
Minority Women			Internal															
			External															
Minority Men			Internal															
			External															
Trans-gender			Internal															
			External															
Hetero-sexual			Internal															
			External															
Bisexual			Internal															
			External															
Lesbian			Internal															
			External															
MSM			Internal															
			External															
YMSM			Internal															
			External															

b. Please complete the below table to capture referral system performance data [Mandatory for VITEL Grantees, optional for all others] → Intimate Partner Violence (IPV) and the Referral System

Indicator	Numerator / Denominator	IPV # clients		Trauma (all forms) # clients	
Referral Initiation	# clients referred from your agency				
	# clients seen at your agency				
Referral Compliance	# referred clients seen at receiving agency				
	# clients referred from your agency				
Counter-referral Compliance	# clients seen at your agency after being counter-referred				
	# referred clients seen at receiving agency				

7. Disparities Impact Statement (DIS) Reporting: (please submit an updated DIS, if applicable)

Demographics for this period	Planned	Actual		Planned	Actual		Planned	Actual
By Race:			By Gender:			By Sexual Identity:		
Black / African American			Male (M)			Heterosexual		
American Indian / Alaskan Native			Female (F)			Lesbian		
Asian			Transgender (M)			Gay		
Native Hawaiian / Pacific Islander			Transgender (F)			Bisexual		
White								
Multi-racial								
By Ethnicity:								
Hispanic / Latino								

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- a. What have been your successes and challenges in implementing your DIS strategy?

8. **Additional Information or Data Grantee May Wish to Provide**

**** Don't forget to include your Evaluation Report (if available) ****

V. Project Summary (*this reporting period*)

Project Narrative - Provide a summary that includes, but not limited to, the following:

Guidance for developing and writing the narrative

1. Describe progress and challenge(s) towards achieving your project goals, objectives and targets (new, revised, and/or changed). Detail strategies (presently and/or to be) implemented to overcome those challenges.
2. Describe the successes and challenges associated with conducting intake and/or follow-up.
3. Describe the successes and challenges you have been experiencing in operating your referral/transition tracking system. What are you doing to maintain/expand your successes and/or to overcome your challenges?
4. Explain any differences between the number of planned and actual clients seen **and** between the number of clients served and the number of intakes. Discuss how the project will meet the annual goal for the number of clients served.
5. Describe any efforts to expand the project's capacity to serve the target population(s).
6. Note **any** changes in or concerns about your financial status that may affect the implementation or operation of the grant.
7. Provide copies of any information disseminated to others about the project (e.g., newspaper article; TV or radio coverage; public presentations including those at local, state, or national conferences; publications).

