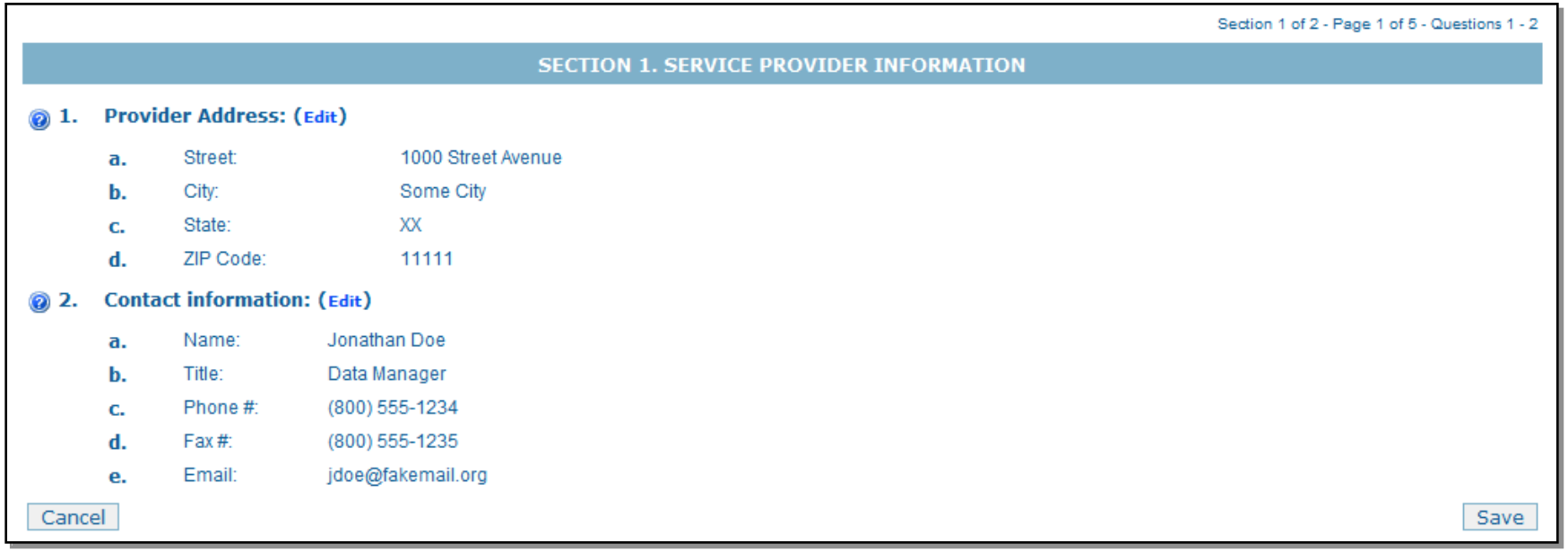
Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program Ryan White Services Report (RSR)

PROVIDER FORM



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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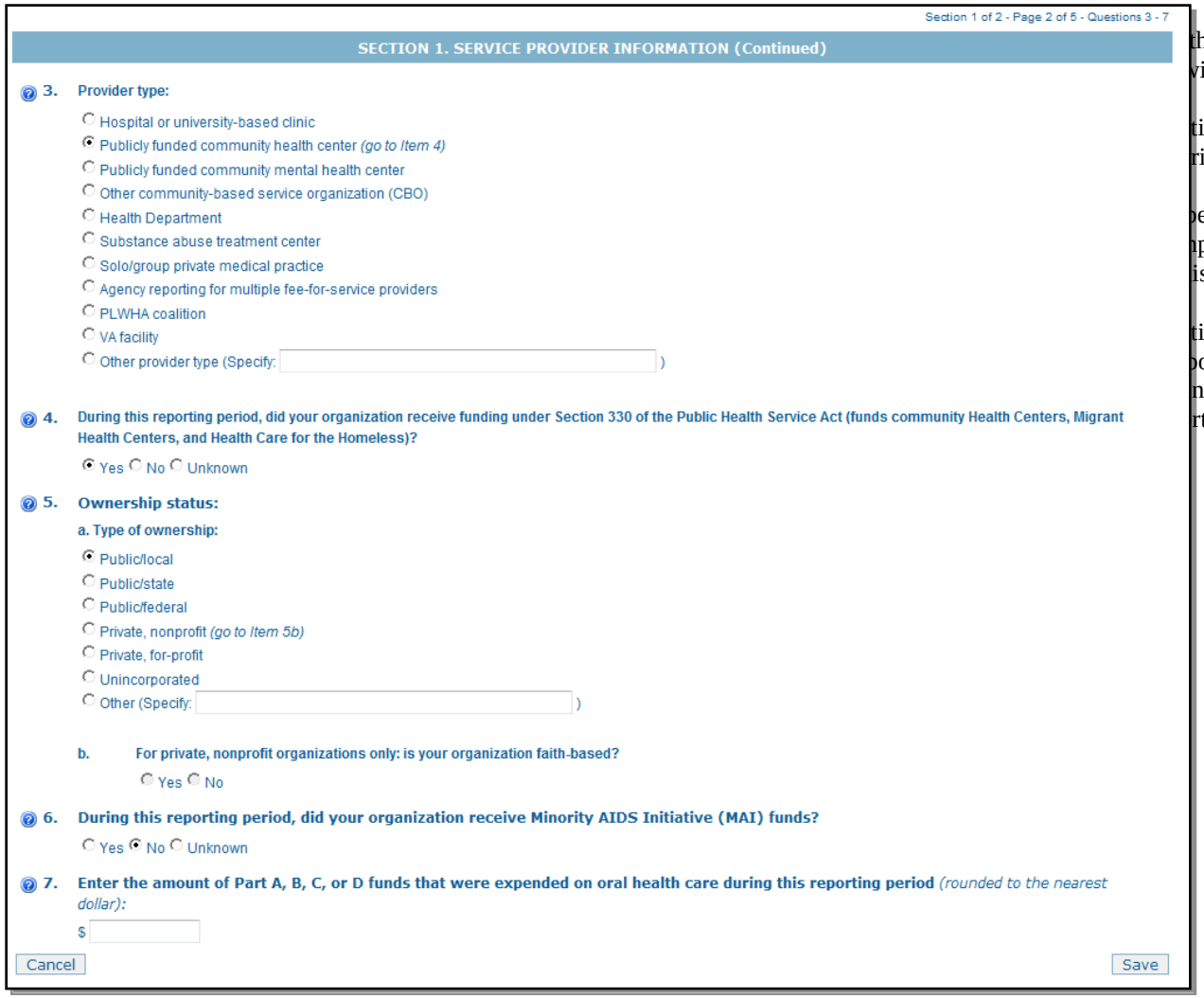


Section 1 of 2 - Page 2 of 5 - Questions 3 - 7

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)?

◉ 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?

○ 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):*

$

Cancel Save

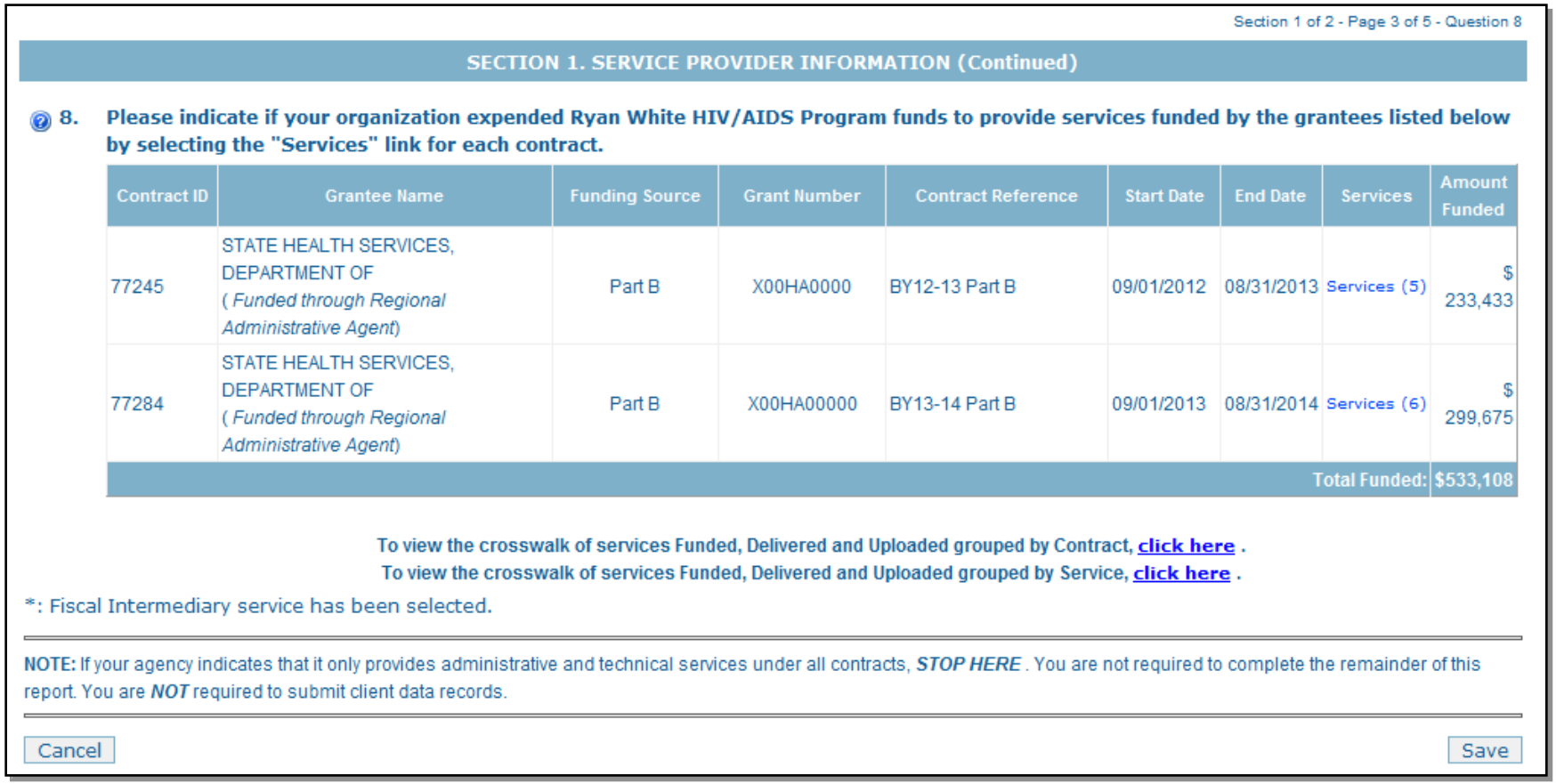
hat best describes the organization. After
ill be pre-populated in subsequent data

tion received funding under Section 330 of
ring the given reporting period.

est describes your organization's
nprofit" is selected, you must answer Item
is item will be pre-populated in subsequent

tion received Minority AIDS Initiative
orting period.
n White Program funds expended on oral
rting period

PROVIDER FORM



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

SECTION 1. SERVICE PROVIDER INFORMATION (Continued)

8. Please indicate if your organization expended Ryan White HIV/AIDS Program funds to provide services funded by the grantees listed 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
77245	STATE HEALTH SERVICES, DEPARTMENT OF *(Funded through Regional Administrative Agent)*	Part B	X00HA0000	BY12-13 Part B	09/01/2012	08/31/2013	Services (5)	$ 233,433
77284	STATE HEALTH SERVICES, DEPARTMENT OF *(Funded through Regional Administrative Agent)*	Part B	X00HA00000	BY13-14 Part B	09/01/2013	08/31/2014	Services (6)	$ 299,675
							Total Funded:	$533,108

To view the crosswalk of services Funded, Delivered and Uploaded grouped by Contract, click here .
To view the crosswalk of services Funded, Delivered and Uploaded grouped 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.

Cancel Save

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).

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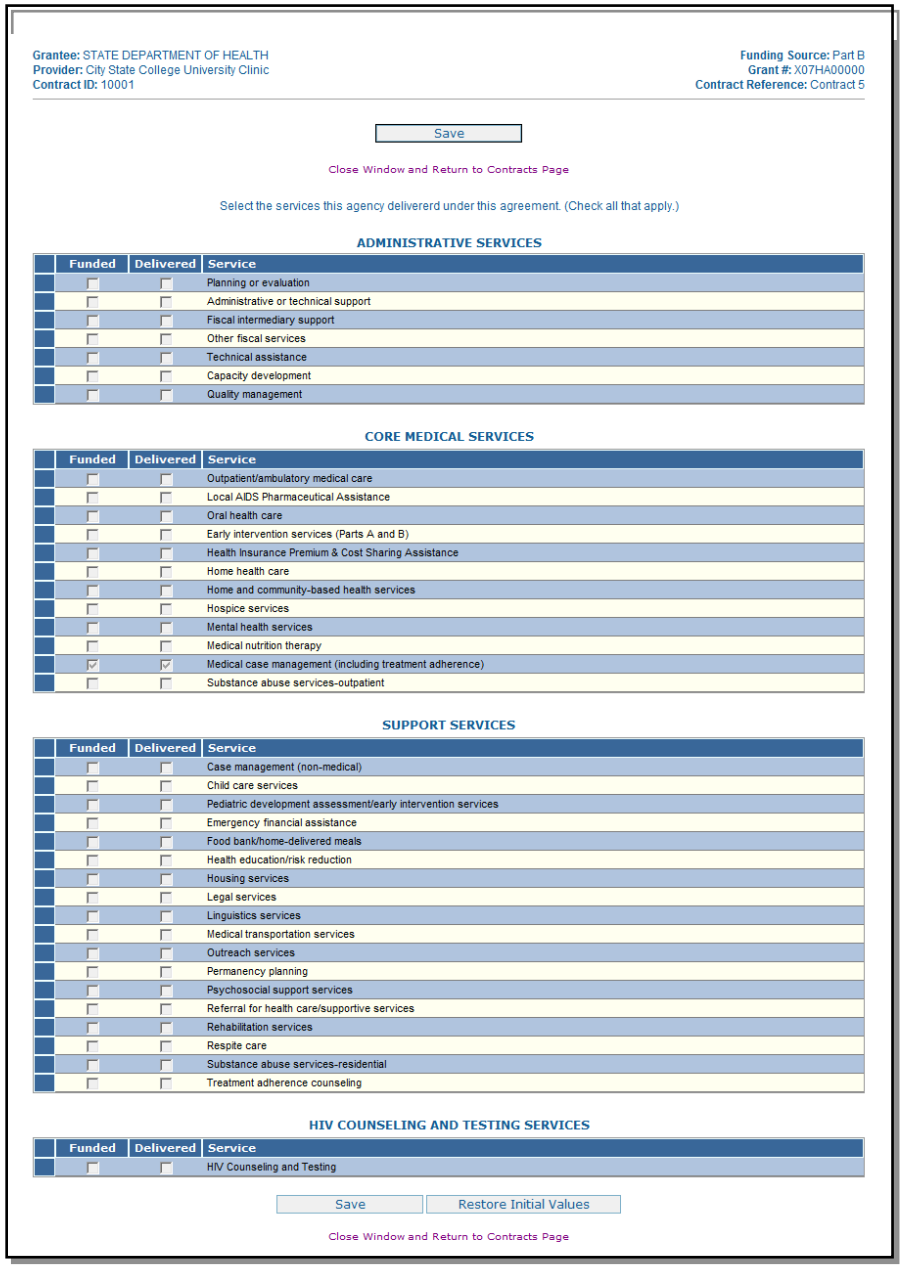

Grantee: STATE DEPARTMENT OF HEALTH
Provider: City State College University Clinic
Contract ID: 10001

Funding Source: Part B
Grant #: X07HA00000
Contract Reference: Contract 5

Save

Close Window and Return to Contracts Page

Select the services this agency delivererd under this agreement. (Check all that apply.)

ADMINISTRATIVE SERVICES

Funded	Delivered	Service
☐	☐	Planning or evaluation
☐	☐	Administrative or technical support
☐	☐	Fiscal intermediary support
☐	☐	Other fiscal services
☐	☐	Technical assistance
☐	☐	Capacity development
☐	☐	Quality management

CORE MEDICAL SERVICES

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

SUPPORT SERVICES

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

HIV COUNSELING AND TESTING SERVICES

Funded	Delivered	Service
☐	☐	HIV Counseling and Testing

Save | Restore Initial Values

Close Window and Return to Contracts Page

- 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)
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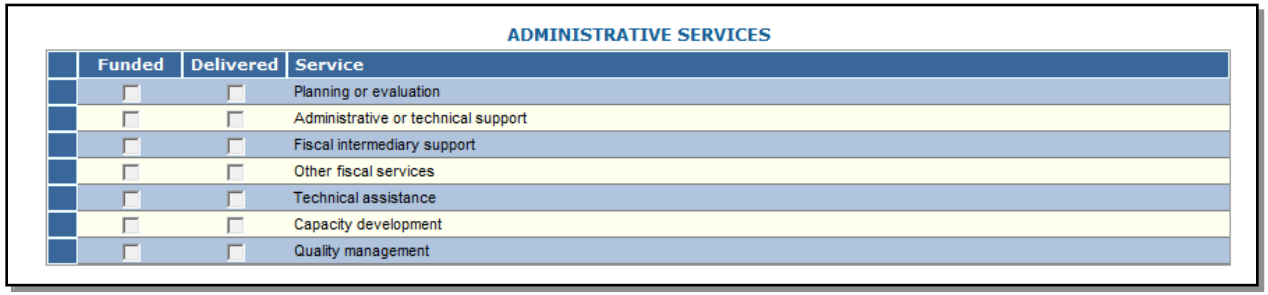
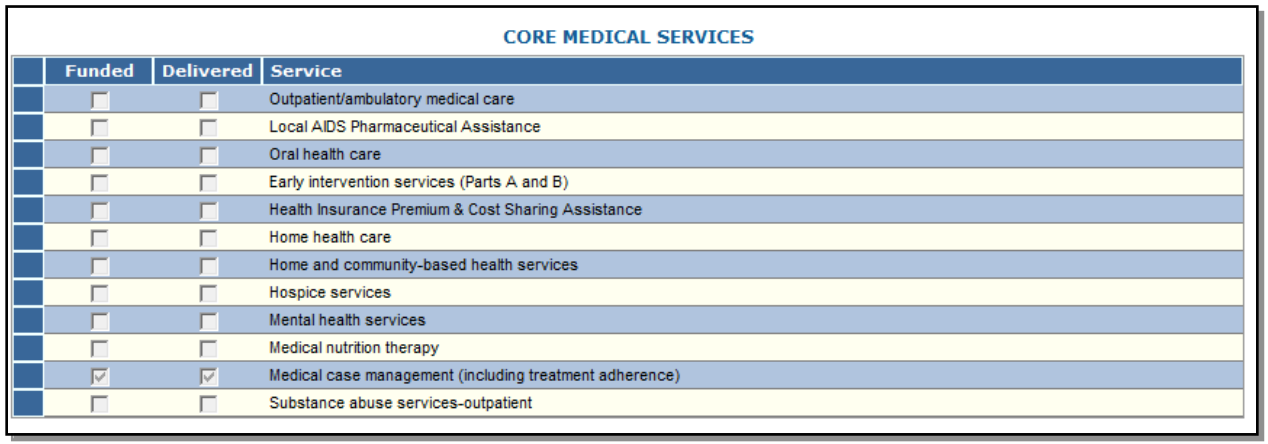
PROVIDER FORM



ADMINISTRATIVE SERVICES

	Funded	Delivered	Service
	☐	☐	Planning or evaluation
	☐	☐	Administrative or technical support
	☐	☐	Fiscal intermediary support
	☐	☐	Other fiscal services
	☐	☐	Technical assistance
	☐	☐	Capacity development
	☐	☐	Quality management

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



CORE MEDICAL SERVICES

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

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

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SUPPORT SERVICES

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

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

HIV COUNSELING AND TESTING SERVICES

Funded	Delivered	Service
☐	☐	HIV Counseling and Testing

- 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 <u>not</u> required.
You will STOP here.
Conversely, if you indicated that you did deliver "Core Medical Services," then Items 9 through 11 will be required.

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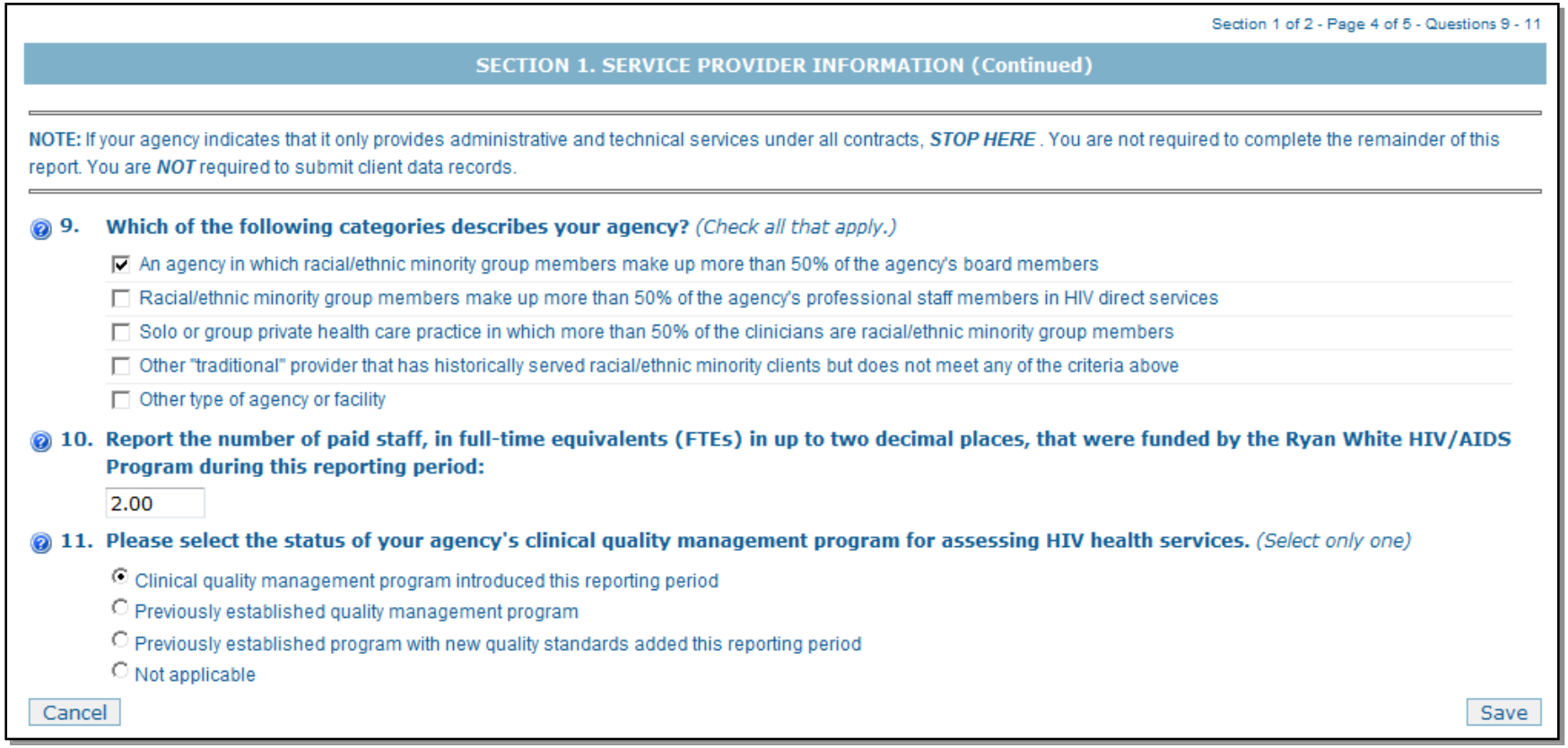
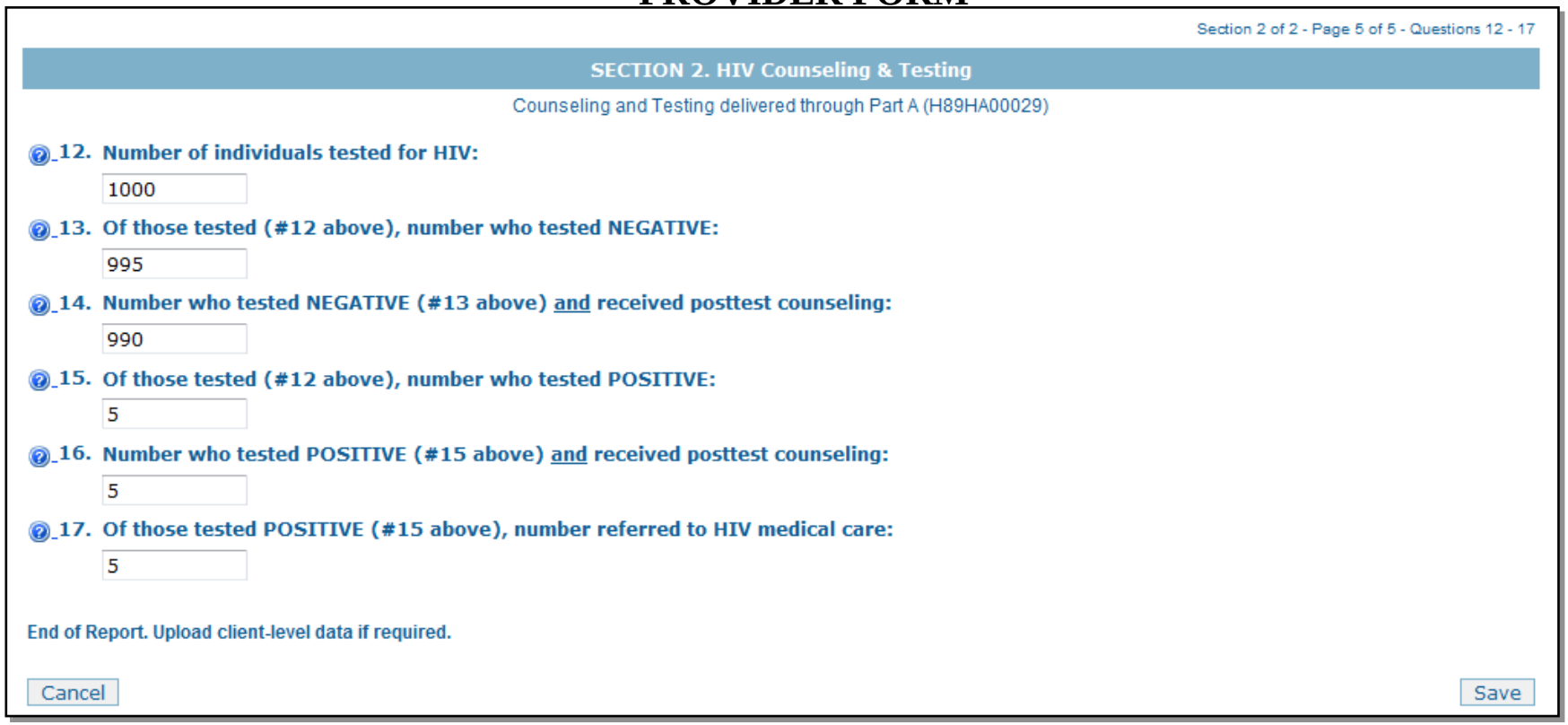
PROVIDER FORM



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

PROVIDER FORM



Section 2 of 2 - Page 5 of 5 - Questions 12 - 17

SECTION 2. HIV Counseling & Testing

Counseling and Testing delivered through Part A (H89HA00029)

12. Number of individuals tested for HIV:
1000

13. Of those tested (#12 above), number who tested NEGATIVE:
995

14. Number who tested NEGATIVE (#13 above) and received posttest counseling:
990

15. Of those tested (#12 above), number who tested POSITIVE:
5

16. Number who tested POSITIVE (#15 above) and received posttest counseling:
5

17. Of those tested POSITIVE (#15 above), number referred to HIV medical care:
5

End of Report. Upload client-level data if required.

Cancel Save

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