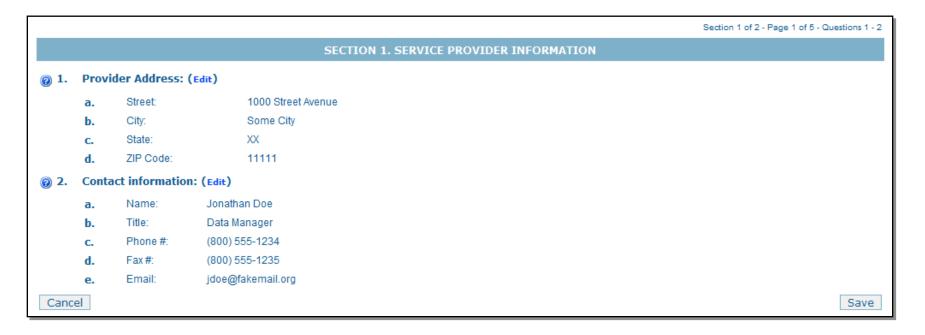
## **PROVIDER FORM**



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

## **PROVIDER FORM**

	Section 1 of 2 - Page 2 of 5 - Questions 3	
	SECTION 1. SERVICE PROVIDER INFORMATION (Continued)	that best descri
@ 3.	Provider type:	vill be pre-pop
<b>8</b> 3.	C Hospital or university-based clinic	
	Publicly funded community health center (go to Item 4)	tion received f
	Publicly funded community mental health center	ring the given
	C Other community-based service organization (CBO)	
	C Health Department	est describes
	C Substance abuse treatment center	profit" is selec
	C Solo/group private medical practice	III.*
	C Agency reporting for multiple fee-for-service providers	is item will be
	C PLWHA coalition	
	C VA facility	tion received N
	C Other provider type (Specify:	orting period.
		n White Progr
<b>②</b> 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)?	rting period
	© Yes C No C Unknown	
<b>②</b> 5.	Ownership status:	1
	a. Type of ownership:	
	© Public/local	
	C Public/state	
	C Public/federal	
	C Private, nonprofit (go to Item 5b)	
	C Private, for-profit	
	C Unincorporated	
	Other (Specify: )	1
		1
	b. For private, nonprofit organizations only: is your organization faith-based?	
	C Yes C No	
<b>@</b> 6.	During this reporting period, did your organization receive Minority AIDS Initiative (MAI) funds?	1
	C Yes   ● No C Unknown	1
<b>②</b> 7.		
	dollar):	1
	\$	
Cance	el Save	

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

ion received funding under Section 330 of fing the given reporting period.

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

ion received Minority AIDS Initiative orting period.

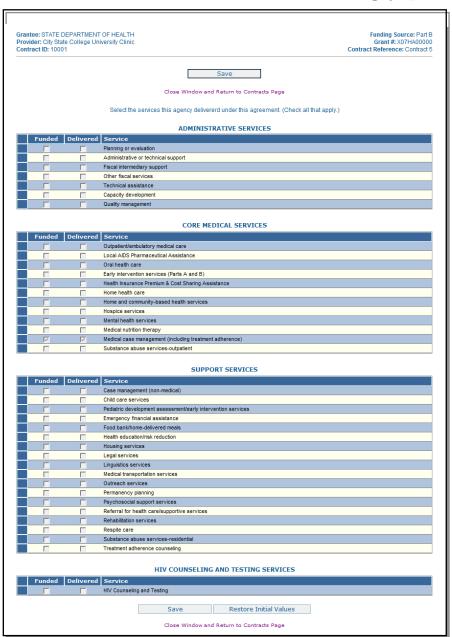
White Program funds expended on oral ting period

#### PROVIDER FORM

Section 1 of 2 - Page 3 of 5 - Question 8 SECTION 1. SERVICE PROVIDER INFORMATION (Continued) 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. Grantee Name **Funding Source Grant Number** Start Date STATE HEALTH SERVICES, DEPARTMENT OF 77245 Part B X00HA0000 BY12-13 Part B 09/01/2012 08/31/2013 Services (5) 233,433 (Funded through Regional Administrative Agent) STATE HEALTH SERVICES, DEPARTMENT OF 77284 Part B X00HA00000 BY13-14 Part B 09/01/2013 08/31/2014 Services (6) (Funded through Regional Administrative Agent) 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).

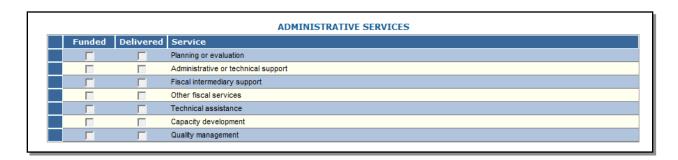
#### **PROVIDER FORM**



 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.

#### **PROVIDER FORM**

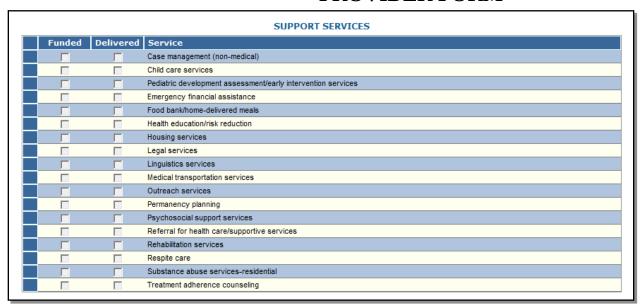


• Please select the administrative services delivered under this agreement during the given reporting period (check all that apply).

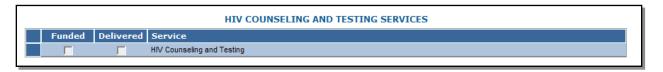


Please select the core medical services delivered under this agreement during the given reporting period (check all that apply).

#### **PROVIDER FORM**



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 <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.

## **PROVIDER FORM**

	Section 1 of 2 - Page 4 of 5 - Questions 9 - 11				
	SECTION 1. SERVICE PROVIDER INFORMATION (Continued)				
	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 ou are NOT required to submit client data records.				
<b>@</b> 9.	Which of the following categories describes your agency? (Check all that apply.)				
	An agency in which racial/ethnic minority group members make up more than 50% of the agency's board members				
	Racial/ethnic minority group members make up more than 50% of the agency's professional staff members in HIV direct services				
	☐ Solo or group private health care practice in which more than 50% of the clinicians are racial/ethnic minority group members				
	☐ Other "traditional" provider that has historically served racial/ethnic minority clients but does not meet any of the criteria above				
	☐ Other type of agency or facility				
② 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:					
	2.00				
11. Please select the status of your agency's clinical quality management program for assessing HIV health services. (Select only one)					
	Clinical quality management program introduced this reporting period				
	C Previously established quality management program				
	C Previously established program with new quality standards added this reporting period				
	C Not applicable				
Cance	Save				

**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)			
<b>@</b> _12.	Number of individuals tested for HIV:			
	1000			
<b>@</b> _13.	. Of those tested (#12 above), number who tested NEGATIVE:			
	995			
<b>@</b> _14.	. Number who tested NEGATIVE (#13 above) <u>and</u> received posttest counseling:			
	990			
<b>@</b> _15.	Of those tested (#12 above), number who tested POSITIVE:			
	5			
<b>@</b> _16.	Number who tested POSITIVE (#15 above) and received posttest counseling:			
	5			
<b>@</b> _17.	. Of those tested POSITIVE (#15 above), number referred to HIV medical care:			
	5			
End of Report. Upload client-level data if required.				
Cancel				

**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