

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

PROVIDER FORM

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SECTION 1. SERVICE PROVIDER INFORMATION

1. Provider Address: (Edit)

a.	Street:	1000 Street Avenue
b.	City:	Some City
c.	State:	XX
d.	ZIP Code:	11111

2. Contact information: (Edit)

a.	Name:	Jonathan Doe
b.	Title:	Data Manager
c.	Phone #:	(800) 555-1234
d.	Fax #:	(800) 555-1235
e.	Email:	jdoe@fakemail.org

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. 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):

\$

that best describes the organization. After
will be pre-populated in subsequent data

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

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

tion received Minority AIDS Initiative
reporting period.

in White Program funds expended on oral
reporting period

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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

Close Window and Return to Contracts Page

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

ADMINISTRATIVE SERVICES

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

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 type="checkbox"/>	<input 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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Medical case management (including treatment adherence)
<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse services-outpatient

SUPPORT SERVICES

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

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

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.

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ADMINISTRATIVE SERVICES		
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).

CORE MEDICAL SERVICES		
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 type="checkbox"/>	<input 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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Medical case management (including treatment adherence)
<input type="checkbox"/>	<input type="checkbox"/>	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
<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

- 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
<input type="checkbox"/>	<input type="checkbox"/>	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 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.

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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.

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

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:

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
- Previously established quality management program
- Previously established program with new quality standards added this reporting period
- Not applicable

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

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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