Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0281. Public reporting burden for this collection of information is estimated to average .06 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857.

HRSA AIDS Education and Training Centers Participant Information Form (PIF)

Instructions: This form should be completed or updated at least once every 12 months by participants.

1. Ple	Unique ase cons	D num istently	ber: En / use th	iter an e nis ema	email a il addre	ddress ess for	as a po registe	ersona ring fo	dentifier. iuture programs or notify the AIDS Education and Training Center of	
cha	ange.									
2.	2. Today's date:									
	M	М	D	D	Υ	Υ	Υ	Υ		
3.	Vour Primary Profession/Discipline (Select one) Dentist Other Dental Professional Nurse Practitioner/Nurse Professional (Prescriber) Nurse Professional (Non-Prescriber) Pharmacist Physician Physician Physician or Nutritionist Mental/Behavioral Health Professional Substance Use Disorder Professional Social Worker or Case Manager Community Health Worker (Includes Peer Educator Or Navigator) Clergy or Faith-Based Professional Practice Administrator or Leader (i.e., Chief Executive Officer, Nurse Administrator) Other Allied Health Professional Other Public Health Professional									
4.	0 (Other Chiropra	actor, A	Iternativ	ve Medi	cine Sp			s Specialist, Etc.i.e.,(Professional Clinical	
	Your Primary Functional Role (Select one) Administrator Agency Board Member Care Provider/Clinician – Prescribes HIV Treatment Case Provider/Clinician – Does Not Prescribe HIV Treatment Case Manager HIV Tester Client/Patient Educator (Includes Navigator) Clinical/Medical Assistant Health Care Organization Non-Clinical Staff (i.e., Front Desk) Intern/Resident Researcher/Evaluator Student/Graduate Student Teacher/Faculty City, Local, State Government Employee Federal Government Employee Other (Specify):									
5.	Are you	-			•					
	OY	es]	No Cho	ose No	t to Disc	close			
6.	What is	-		ckgrou n / Alas			that ap	oply.		

O Black or African American

O Native Hawaiian or Other Pacific Islander

	O White									
	O Choose Not to Disclose									
	OOther, Please Specify:									
7.	What best describes your gender identity? Select one.									
	O Female O									
	Male									
	O Transgender Man									
	O Transgender Woman									
	O Other Gender Identity									
	OChoose Not to Disclose									
8.	Which of the following characteristics best describe your principal employment setting? (Select one) O Academic Health Center									
	O Correctional Facility									
	O Dental Health Facility									
	O Emergency Department									
	O Federally Qualified Health Center									
	O Family Planning Clinic									
	O HIV or Infectious Diseases Clinic									
	O HMO/Managed Care Organization									
	O Hospital-Based Clinic O Indian Health Services/Tribal Clinic									
	O Long-Term Nursing Facility									
	O Maternal /Child Health Clinic									
	O Mental Health Clinic									
	O STD Clinic									
	O Substance Use Treatment Center									
	Student Health Clinic Other Community-Based Organization									
	O Pharmacy									
	O Military or Veterans' Health Facility									
	O Other Federal Health Facility									
	O Private Practice									
	O State or Local Health Department									
	O Other Primary Care Setting									
	 Principal Employment Setting Does Not Involve Direct Provision of Care or Services (Stop Here, I Am Not Working (Stop Here. You Are Done With This Form.) 									
	O TAIL NOT WORKING (Stop Fiele. Tou Are Dolle With This Form.)									
9.	List the ZIP codes (up to three) where you provide care and services to clients:									
10.	Do you provide HIV prevention counseling and/or testing services to clients?									
	OYes ∏No									
11.	Do you prescribe HIV pre-exposure prophylaxis (PrEP) to clients?									
	OYes ∏No									
	O les Livo									
12	Do you prescribe antiretroviral therapy (ART) to clients?									
12.										
	OYes □No									
12	Does your principal employment setting receive Ryan White HIV/AIDS Program funding?									
13.										
	OYes No Not sure									
1.4	In LIIV care and treatment provided by your principal completement actting?									
14.	Is HIV care and treatment provided by your principal employment setting?									
	OYes □No									
15.	Do you have direct interaction with clients?									
	OYes ☐No (Stop here. You are done with this form.)									
	- · · · · · · · · · · · · · · · · · · ·									
16.	Do you provide services directly to <u>clients with HIV?</u>									
	OYes ☐No (Stop here. You are done with this form.)									

17.	How many <u>YEARS</u> have you been providing services directly to clients with HIV? Round up to the nearest whole year. If less than one year, write "01".						
18.	Estimate the <u>NUMBER</u> of clients with HIV to whom you provided direct services in the past YEAR:						
19.	Which of the following best describes the way you provide services to clients with HIV: O Behavioral or Support Services, but not Antiretroviral Therapy (I.E. Case Management, Counseling, Cognitive Behavioral						
	Therapy, Transportation, Legal)						
	O Clinical Services To People With HIV, but not Antiretroviral Therapy (I.E. Nutrition, Physical Therapy, Psychiatry, General Primary Care)						
	O Basić HIV Care and Treatment (Novice)						
	O Intermediate HIV Care and Treatment O Advanced HIV Care and Treatment						
	O Expert HIV Care and Treatment, including Training Others and/or Clinical Consultation						
Fo	YEAR. past the in with HIV clients your of percentage estimate the 22, through 20 questions						
20.	. Estimate the PERCENTAGE of your clients with HIV in the past YEAR who are racial and ethnic minorities:						
	O None O 1-24%						
	O 25-49%						
	O 50-74% O ≥75%						
21.	Estimate the PERCENTAGE of your clients with HIV in the past YEAR with hepatitis B or hepatitis C:						
	○ None○ 1-24%						
	O 25-49% O 50-74%						
	O ≥75%						
22.	Estimate the PERCENTAGE of your clients with HIV in the past YEAR who are receiving antiretroviral therapy:						
	O None O 1-24%						
	O 25-49%						
	O 50-74% O ≥75%						