**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. **Unique ID number: Enter an email address as a personal identifier.**

**Please consistently use this email address for registering for future programs or notify the AIDS Education and Training Center of change.**

1. **Today’s date:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| **M** | **M** | **D** | **D** | **Y** | **Y** | **Y** | **Y** |

1. **Your Primary Profession/Discipline (Select one)**
   * Dentist
   * Other Dental Professional
   * Nurse Practitioner/Nurse Professional (Prescriber)
   * Nurse Professional (Non-Prescriber)
   * Midwife
   * Pharmacist
   * Physician
   * Physician Assistant
   * Dietitian 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 (Specify, i.e., Medical Assistant, Physical Therapist-- Specify): \_\_\_\_\_\_\_\_\_\_\_
   * Other Public Health Professional
   * Other Non-Clinical Professional (i.e., Front Desk Staff, Grant Writer -- Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_
   * Other Specify): -- Podiatry, Chiropractor, Alternative Medicine Specialist, Wellness Specialist, Etc.i.e.,( Professional Clinical

# Your Primary Functional Role (Select one)

* + Administrator
  + Agency Board Member
  + Care Provider/Clinician – Prescribes HIV Treatment
  + Care 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): \_\_\_\_\_\_\_\_\_

# Are you of Hispanic or LatinX origin?

* + Yes No Choose Not to Disclose

# What is your racial background? Select all that apply.

* + American Indian / Alaska Native
  + Asian
  + Black or African American
  + Native Hawaiian or Other Pacific Islander
  + White
  + Choose Not to Disclose
  + Other, Please Specify: \_\_\_\_\_\_\_\_\_\_\_

# What best describes your gender identity? Select one.

* + Female

O

Male

* + Transgender Man
  + Transgender Woman
  + Other Gender Identity
  + Choose Not to Disclose

# Which of the following characteristics best describe your principal employment setting? (Select one)

* + Academic Health Center
  + Correctional Facility
  + Dental Health Facility
  + Emergency Department
  + Federally Qualified Health Center
  + Family Planning Clinic
  + HIV or Infectious Diseases Clinic
  + HMO/Managed Care Organization
  + Hospital-Based Clinic
  + Indian Health Services/Tribal Clinic
  + Long-Term Nursing Facility
  + Maternal /Child Health Clinic
  + Mental Health Clinic
  + STD Clinic
  + Substance Use Treatment Center
  + Student Health Clinic
  + Other Community-Based Organization
  + Pharmacy
  + Military or Veterans’ Health Facility
  + Other Federal Health Facility
  + Private Practice
  + State or Local Health Department
  + 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.)

# List the ZIP codes (up to three) where you provide care and services to clients:

1. **Do you provide HIV prevention counseling and/or testing services to clients?**
   * Yes No

# Do you prescribe HIV pre-exposure prophylaxis (PrEP) to clients?

* + Yes No

# Do you prescribe antiretroviral therapy (ART) to clients?

* + Yes No

# Does your principal employment setting receive Ryan White HIV/AIDS Program funding?

* + Yes No Not sure

# Is HIV care and treatment provided by your principal employment setting?

* + Yes No

# Do you have direct interaction with clients?

* + Yes No (Stop here. You are done with this form.)

# Do you provide services directly to clients with HIV?

* + Yes No (Stop here. You are done with this form.)

1. **How many YEARS have you been providing services directly to clients with HIV? Round up to the nearest whole year. If less than one year, write “01”.**
2. **Estimate the NUMBER of clients with HIV to whom you provided direct services in the past YEAR:**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

1. **Which of the following best describes the way you provide services to clients with HIV:**
   * Behavioral or Support Services, but not Antiretroviral Therapy (I.E. Case Management, Counseling, Cognitive Behavioral Therapy, Transportation, Legal)
   * Clinical Services To People With HIV, but not Antiretroviral Therapy (I.E. Nutrition, Physical Therapy, Psychiatry, General Primary Care)
   * Basic HIV Care and Treatment (Novice)
   * Intermediate HIV Care and Treatment
   * Advanced HIV Care and Treatment
   * Expert HIV Care and Treatment, including Training Others and/or Clinical Consultation

**ForYEAR. past the in with HIV clients your of percentage estimate the 22, through 20 questions**

# Estimate the PERCENTAGE of your clients with HIV in the past YEAR who are racial and ethnic minorities:

* + None
  + 1-24%
  + 25-49%
  + 50-74%
  + ≥75%

# Estimate the PERCENTAGE of your clients with HIV in the past YEAR with hepatitis B or hepatitis C:

* + None
  + 1-24%
  + 25-49%
  + 50-74%
  + ≥75%

# Estimate the PERCENTAGE of your clients with HIV in the past YEAR who are receiving antiretroviral therapy:

* + None
  + 1-24%
  + 25-49%
  + 50-74%
  + ≥75%