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.

2. **Today's date:**

M	**M**	**D**	**D**	**Y**	**Y**	**Y**	**Y**

3. **Your Primary Profession/Discipline (Select one)**
   - O Dentist
   - O Other Dental Professional
   - O Nurse Practitioner/Nurse Professional (Prescriber)
   - O Nurse Professional (Non-Prescriber)
   - O Midwife
   - O Pharmacist
   - O Physician
   - O Physician Assistant
   - O Dietitian or Nutritionist
   - O Mental/Behavioral Health Professional
   - O Substance Use Disorder Professional
   - O Social Worker or Case Manager
   - O Community Health Worker (Includes Peer Educator Or Navigator)
   - O Clergy or Faith-Based Professional
   - O Practice Administrator or Leader (i.e., Chief Executive Officer, Nurse Administrator)
   - O Other Allied Health Professional (Specify, i.e., Medical Assistant, Physical Therapist-- Specify): _____
   - O Other Public Health Professional
   - O Other Non-Clinical Professional (i.e., Front Desk Staff, Grant Writer -- Specify): _____
   - O Other_____ Specify): -- Podiatry, Chiropractor, Alternative Medicine Specialist, Wellness Specialist, Etc.i.e.,(Professional Clinical

4. **Your Primary Functional Role (Select one)**
   - O Administrator
   - O Agency Board Member
   - O Care Provider/Clinician – Prescribes HIV Treatment
   - O Care Provider/Clinician – Does Not Prescribe HIV Treatment
   - O Case Manager
   - O HIV Tester
   - O Client/Patient Educator (Includes Navigator)
   - O Clinical/Medical Assistant
   - O Health Care Organization Non-Clinical Staff (i.e., Front Desk)
   - O Intern/Resident
   - O Researcher/Evaluator
   - O Student/Graduate Student
   - O Teacher/Faculty
   - O City, Local, State Government Employee
   - O Federal Government Employee
   - O Other (Specify): _____

5. **Are you of Hispanic or LatinX origin?**
   - O Yes No Choose Not to Disclose

6. **What is your racial background? Select all that apply.**
   - O American Indian / Alaska Native
   - O Asian
   - O Black or African American
   - O Native Hawaiian or Other Pacific Islander

O White
OChoose 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
O Student Health Clinic
O 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
O Principal Employment Setting Does Not Involve Direct Provision of Care or Services (Stop Here,
O I Am Not Working (Stop Here. You Are Done 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

12. **Do you prescribe antiretroviral therapy (ART) to clients?**

OYes □No

13. **Does your principal employment setting receive Ryan White HIV/AIDS Program funding?**

OYes □No □Not sure

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 Basic 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

ForYEAR. 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:**
    - O None
    - O 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%