**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%