

## 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)**

- 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

**4. 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): \_\_\_\_\_

**5. Are you of Hispanic or LatinX origin?**

- Yes       No Choose Not to Disclose

**6. 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: \_\_\_\_\_

**7. What best describes your gender identity? Select one.**

- Female
- Male
- Transgender Man
- Transgender Woman
- Other Gender Identity
- Choose Not to Disclose

**8. 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.)

**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?**

- Yes
- No

**11. Do you prescribe HIV pre-exposure prophylaxis (PrEP) to clients?**

- Yes
- No

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

- Yes
- No

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

- Yes
- No
- Not sure

**14. Is HIV care and treatment provided by your principal employment setting?**

- Yes
- No

**15. Do you have direct interaction with clients?**

- Yes
- No (Stop here. You are done with this form.)

**16. Do you provide services directly to clients with HIV?**

- Yes
- No (Stop here. You are done with this form.)

17. 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".

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

18. Estimate the NUMBER 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:

- 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

For 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:

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

21. 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%

22. 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%