INSTRUCTIONS FOR COMPLETING THE 2008 RYAN WHITE HIV/AIDS PROGRAM ANNUAL DATA REPORT

EFFECTIVE DATE: NOVEMBER 12, 2008

HIV/AIDS Bureau
Division of Science and Policy
Health Resources and Services Administration
5600 Fishers Lane, Room 7-90
Rockville, MD 20857

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INTRODUCTION

WHO COMPLETES THE RYAN WHITE HIV/AIDS PROGRAM DATA REPORT?

The Ryan White HIV/AIDS Program Data Report should be completed by all Ryan White HIV/AIDS Program Part A, Part B, Part C, Part D, including the Adolescent Initiative, and Part F (MAI) funded grantees, service providers, and Part B consortia.

Grantee of record is the official Ryan White HIV/AIDS Program grantee that receives Federal funding directly from the Health Resources and Services Administration (HRSA). This agency may be the same as the provider agency or may be the agency through which the provider agency is subcontracted.

The *service provider* is the agency that provides direct services to clients and their families and is funded by the Ryan White HIV/AIDS Program. Services may be directly funded by one or more Parts of the Ryan White HIV/AIDS Program or through subcontract(s) with official Ryan White HIV/AIDS Program grantees of record.

If the only services you provided during this reporting period were (1) planning or evaluation, (2) administrative or technical support, (3) fiscal intermediary services, (4) technical assistance, (5) capacity development, or (6) quality management, please complete Section 1, Items 1–16 only.

Providers who receive funds under more than one Part should complete this form ONLY once. Include information from all Parts under which you are funded.

WHICH CLIENTS SHOULD BE INCLUDED IN THE RYAN WHITE HIV/AIDS PROGRAM DATA REPORT?

Providers should report data on all clients who received services **eligible** for the Ryan White HIV/AIDS Program Parts A, B, C, D, including Adolescent Initiative funding, and/or Part F (MAI) regardless of the actual funding source used to pay for those services.

Grantees and providers that choose to report only on the subset of clients who received funded services from any Part of the Ryan White HIV/AIDS Program must have special permission

from their HRSA Project Officer (See Section 1.2: Reporting scope for more information).

SECTIONS OF THE RYAN WHITE HIV/AIDS PROGRAM DATA REPORT

The Ryan White HIV/AIDS Program Data Report is divided into seven sections. Not everyone is required to respond to each section; some sections are specific to Parts C and D. Only programs administering a Health Insurance Program (HIP) should complete Section 7.

Who Completes Each Section?

Part	A	B	C	D	F (MAI)
Section 1. Service Provider Information	✓	✓	✓	✓	✓
Section 2. Client Information	✓	✓	✓	✓	✓
Section 3. Service Information	✓	✓	✓	✓	✓
Section 4. HIV Counseling and Testing	✓	✓	✓	✓	✓
Section 5. Medical Information	✓	✓	✓	✓	✓
Section 6. Demographic Tables/ Part-Specific Data for Parts C and D					
Section 6.1. Part C Information			✓		
Section 6.2. Part D Information				✓	
Section 7. Health Insurance Program Information	✓	✓	✓		✓

Section 1. Service Provider Information

Section 1.1. Provider and Agency Contact Information

This section includes contact information of the person responsible for the Ryan White HIV/AIDS Program Data Report as well as the name, address, and taxpayer ID number for the agency.

Section1.2. Reporting and Program Information

This section includes dates of the reporting period for the data in the report, reporting scope, provider type, ownership status, source of Ryan White HIV/AIDS Program funding, target population, funding expended, and staffing.

Section 2. Client Information

This section includes the total number of clients receiving services during the reporting period, new clients, gender, age, race/ethnicity, household income, living/housing arrangements, insurance, HIV/AIDS status, and vital/enrollment status.

Section 3. Service Information

This section includes services offered and total number of clients receiving those services.

Section 4. HIV Counseling and Testing

This section includes the number of clients who received HIV counseling and testing, posttest counseling, number of clients who tested positive for HIV antibodies, and partner notification.

Section 5. Medical Information

This section includes risk factors, testing and treatment, opportunistic infections, and pregnancy.

Section 6. Demographic Tables / Part-Specific Data for Parts C and D, including the Adolescent Initiative

Section 6.1. Part C Information

This section includes demographic tables of clients who were HIV-positive and who received at least one primary health care service with Part C funds by race/ethnicity, gender, age, and HIV exposure category, costs, sources of income, and available services.

Section 6.2. Part D including the Adolescent Initiative Information

This section includes demographic tables of clients who are HIV-positive as well as affected partner/family member(s) by gender, race/ethnicity, age, and HIV exposure category.

Section 7. Health Insurance Program (HIP) Information

This section includes annual expenditures, number of unduplicated clients receiving HIP, and funding received from Eligible Metropolitan Areas (EMAs)/Transitional Grant Areas (TGAs) and other sources.

QUALITY ASSURANCE CHECKLIST

We highly recommend that you use the following checklist to ensure the quality and reliability of the data that you report in the Ryan White HIV/AIDS Program Annual Data Report.

☐ This report includes information on all clients served and services delivered between January 1 and December 31 of the reporting year (not based on your fiscal calendar).

☐ The **full name** of the agency was given in Item 1. If an acronym is commonly used for the agency name, the definition of the acronym was provided.

☐ A valid nine-digit taxpayer ID was reported in Item 2d.

☐ If this report was prepared using the *eligible reporting scope "01"* (Item 6), it includes all clients receiving services eligible to be paid for with Ryan White HIV/AIDS Program funds, regardless of whether Ryan White HIV/AIDS Program funds were actually used to pay for the services. If this report was prepared using the *funded-only reporting scope "02"* (Item 6), it **only** includes clients receiving services funded by the Ryan White HIV/AIDS Program.

☐ An association exists between the provider and grantee of record for each source of funding reported in Item 10. (To restate, the provider listed in Item 1 appears on the provider list for the funding agency reported in Item 10.)

☐ **All** sources of Ryan White HIV/AIDS Program funding were reported in Item 10. For each source of funding reported, the actual amount of funding *expended* was reported in Items 11-14.

☐ Full-time equivalents were reported in Items 21 and 22 for paid and volunteer staff, **not** the actual number of staff members.

☐ The funding information reported in Items 11-14 is annualized to reflect the calendar year, **not** the agency's fiscal year.

☐ The total number of new clients reported in Item 24 is **less than or equal to** the total number of clients reported in Item 23.

   NOTE: The total number of new clients in Item 24 should **only** be equal to the total number of clients in Item 23 if the agency is newly funded by the Ryan White HIV/AIDS Program, in which case all of the clients are new to the agency.

☐ All client totals in Section 2, Items 25-32 must be **equal to** the total number of unduplicated clients reported in Item 23.

☐ The number of clients seen for any given service, as reported in each row of Item 33, does **not exceed** the total number of unduplicated clients reported in Item 23. If the number of clients that were seen for a given service is unknown, column 3b in Item 33 is checked.

☐ The number of visits for any given service reported in column 4a of Item 33 is **greater than or equal to** the number of clients reported for that service in column 3a. If the number of visits for a given service is unknown, column 4b in Item 33 is checked.

☐ If counseling and testing services were reported in Section 4: Item 38 is **less than or equal to** Item 37, Item 39 is **less than or equal to** Item 37, and Item 40 is **less than or equal to** Item 38.

☐ **All clients who are HIV-positive** reported in Section 3, Item 33a: Outpatient/ambulatory medical care have also been reported in Section 5, Item 42 (To restate, the total number of clients reported in Item 42 is **equal to** the total number of clients reported in Item 33a).

☐ If Section 5 was completed, the total number of clients reported in Item 43 is **equal to** the total number of clients reported in Item 42.

☐ If the agency provided primary health care services with Part C funding, Section 6.1 is completed. The total number of clients reported in Items 55-61 must be **equal**. In addition, the total number of clients reported in Items 55-61 must be **less than or equal to** the total number of clients reported in Item 23. Finally, subtotal data reported in Items 59, 60, and 61 must match across all tables.

☐ If the agency receives Part D including Adolescent Initiative funding, Section 6.2 is completed. The total number of clients reported in Items 66-73 must be **equal**. In addition, the total number of clients reported in each item must be **less than or equal to** the total number of clients reported in Item 23.

SECTION 1. SERVICE PROVIDER INFORMATION

This section should be completed by all service providers and/or grantees funded through the Ryan White HIV/AIDS Program Parts A, B, C, D, and F (MAI).

Section 1.1. Provider and Agency Contact Information

1. Provider name

Give the name of the service provider for whom this data report is being completed. If an acronym is used for an agency's name, please include the definition of the acronym.

Items 2 through 3e refer to the provider agency listed in Item 1.

2. Provider address

a. Street

Enter the street address of the provider listed in Item 1 (where service is provided).

b. City and state

Enter the city and state of the provider listed in Item 1.

c. ZIP Code

Enter the ZIP Code of the provider listed in Item 1.

d. Taxpayer ID #

Give the unique nine-digit taxpayer ID number (also called an EIN) of the provider agency. This number, issued by the Internal Revenue Service, serves as an organization's or agency's taxpayer identification number, upon application, for use in connection with filing requirements. Self employed individuals who serve as providers should use their Social Security Number.

3. Contact information

a. Name

Enter the name of the contact person at the provider agency listed in Item 1 who is responsible for completing the data in this report.

b. Title

Enter the title of the person listed in Item 3a.

c. Phone #

Enter the telephone number, including area code, of the person listed in Item 3a.

d. Fax #

Enter the fax number, including area code, of the person listed in Item 3a.

e. E-mail

Enter the e-mail address of the person listed in Item 3a.

4. Person completing this form

a. Name

Enter the name of the person completing the form at the provider agency, as defined in Item 1.

b. Phone #

Enter the telephone number, including area code, of the person listed in Item 4a.

c. E-mail

Enter the e-mail address of the person listed in Item 4a.

Section 1.2. Reporting and Program Information

5. Reporting period

Enter the start and end dates of the reporting period for the provider agency.

Reporting period is a calendar year, January 1 through December 31. The data are reported to HRSA by the following March 15.

All information reported on clients and service delivery should reflect the calendar year reporting period.

The reporting period may be shorter than a year if a provider agency did not receive Ryan White HIV/AIDS Program funding for an entire calendar year. In this case, the beginning or end dates of the reporting period should reflect the exact time period in the calendar year during which services were delivered to clients. For example, the reporting period for a provider whose contract began on April 1 would be April 1–December 31. Similarly, the reporting period for a provider whose contract was effective on January 1 but discontinued on June 30 would be January 1–June 30.

6. Reporting scope

Indicate the reporting scope for the collection of the data in this report Select only one response.

Scope 01: ALL clients receiving a service ELIGIBLE under the Part for which the grantee is funded (which varies by Part A, B, C, D, and F (MAI) funding).

Explanation: Reporting scope for providers reporting ELIGIBLE services. Data are based on all services that are eligible for funding from the Ryan White HIV/AIDS Program Parts A, B, C, D, and F (MAI).

Please refer to Section 3, Item 33 for a complete list of ELIGIBLE service categories.

Under the ELIGIBLE reporting scope, clients receiving any service eligible for Ryan White Part A, B, C, D, or F (MAI) funding are included in the report even if the service was not paid for with Ryan White Part A, B, C, D, or F (MAI) funds.

Scope 02: ONLY clients receiving a Part A, B, C, D, or F (MAI) FUNDED service.

Explanation: Reporting scope for providers reporting FUNDED clients. Data are based on clients whose services are paid for by the Ryan White HIV/AIDS Program Parts A, B, C, D, and/or F (MAI).

Under the FUNDED scope, only clients receiving services paid for exclusively with Ryan White HIV/AIDS Program Parts A, B, C, D, and/or F (MAI) funds are included in the report. Typically, this is a subset of the eligible reporting scope. Providers using the funded-only reporting scope must:

- Have an adequate mechanism for tracking clients and services by funding stream;

- Have secured prior approval from their grantee in consultation with their HRSA project officer; and

- Report actual numbers of clients and services not estimates.

7. Provider type

Using the provider types listed below, select the type of provider that best describes the agency completing this data report. **Check only one.**

a. Provider types:

Hospital or university-based clinic includes outpatient/ambulatory care departments/outpatient medical care or clinics, emergency rooms, rehabilitation facilities (physical, occupational, speech), hospice programs, substance abuse treatment programs, STD clinics, HIV/AIDS clinics, and inpatient case management service programs.

Publicly funded community health center includes community health centers, migrant health centers, rural health centers, and homeless health care centers. If you select this answer, you must answer Item 7b.

Publicly funded community mental health center is a community-based agency, funded by local, state, or Federal funds, that provides mental health services to low income people.

Other community-based service organization (CBO) includes non-hospital-based organizations, HIV/AIDS service and volunteer organizations, private nonprofit social service and mental health organizations, hospice programs (home and residential), home health care agencies, rehabilitation programs, substance abuse treatment programs, case management agencies, and mental health care providers.

Health department includes State or local health departments.

Substance abuse treatment center is an agency that focuses on the delivery of substance abuse treatment services.

Solo/group private medical practice includes all health and health-related private practitioners and practice groups.

Agency reporting for multiple fee-for-service providers is an agency that reports data for more than one fee-for-service provider (e.g., State operating a reimbursement pool).

*PLWHA (*People Living with HIV/AIDS) *coalition* includes organizations that provide support services to individuals and families infected with and/or affected by HIV and AIDS.

VA facility is a facility funded through the Veterans Administration.

Other facility includes facilities other than those listed above.

b. Section 330 of PHSA funding

Check whether you received funding under Section 330 of the Public Health Service Act (PHSA) during the reporting period. Section 330 is a section of the PHSA that funds community health centers, migrant health centers, and health care for the homeless. If you checked "publicly funded community health center," you must answer 7b.

Section 330 of PHSA supports the development and operation of community health centers, migrant health centers, and health care for the homeless that provide preventive and primary health care services, supplemental health and support services, and environmental health services to medically underserved areas/populations.

8. Ownership status

Using the categories defined below; check the box that best describes the provider's status of incorporation. **Check only one**.

a. Types of ownership status:

Public/local ownership indicates that an organization is funded and operated by a local government entity. An example is a city health department.

Public/State ownership indicates that an organization is funded and operated by a State government entity. An example is a State health department.

Public/Federal indicates that an organization is funded and operated by the Federal Government. An example is a Federal agency.

Private, nonprofit indicates that an organization is owned and operated by a private, not-for-profit entity, such as a nonprofit health clinic. If you select this answer, you must answer Item 8b.

Private, for-profit ownership indicates that an organization is owned and operated by a private entity, even though the organization may receive government funding. A privately owned hospital is an example of a private, for-profit organization.

Unincorporated indicates that an agency is not incorporated.

Other indicates an agency is owned by someone other than those listed above.

b. Faith-based organization

If you selected "private, nonprofit" for ownership status, indicate whether or not the agency receiving funding is a faith-based organization.

Faith-based organization indicates that the organization is owned and operated by a religiously affiliated entity, such as a Catholic hospital.

9. Minority AIDS Initiative (MAI) funding

Indicate whether or not the organization received MAI funds during the reporting period.

MAI is a national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and to improve health outcomes for people living with HIV disease within communities of color. This initiative was enacted to address the disproportionate impact of the disease in such communities. It was formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

10. Source of funding

Check the provider agency's source(s) of funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F (MAI). **Check all that apply**. This item includes funding that is received directly from the Federal Government (grantee), through a subcontract with a Ryan White HIV/AIDS Program grantee (service provider), through Part B funding to a consortium, or through Part F (MAI) funds distributed by a Part A or Part B grantee. For Part F (MAI) funds, check the Part A or B grantee from which the provider received MAI funds. For each source of funding checked, please also indicate the name of each grantee from whom funding was received. If you are the grantee of record please

enter the name of your agency next to the appropriate funding source.

Data Quality Check

An association between the provider and grantee of record should exist for each source of funding reported in Item 10.

For each source of funding checked in Item 10, the amount of funding expended must be reported in Items 11–14.

Part A of the Ryan White HIV/AIDS Program provides direct financial assistance to designated Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). The purpose of these funds is to deliver or enhance HIV-related core medical services, including medical case management, pharmaceutical assistance, and home health care; and support services, including non-medical case management, outreach, testing, respite care, and referrals. Seventy-five percent of funds must support core medical services.

Part B of the Ryan White HIV/AIDS Program authorizes the distribution of Federal funds to States and Territories to improve the quality, availability, and organization of health care and support services for individuals with HIV disease and their families. It also funds AIDS Drug Assistance Program (ADAP) grants, and Emerging Community (EC) grants. The Ryan White HIV/AIDS Program emphasizes that such care and support be part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated. The funds are distributed to States and Territories. Seventy-five percent of funds must support core medical services.

Part C EIS of the Ryan White HIV/AIDS Program provides support for early intervention services, including preventive, diagnostic, and therapeutic services for HIV/AIDS clients. This specifically includes a continuum of comprehensive primary health care, referrals for specialty care, counseling and testing, outreach, case management and eligibility assistance. Seventy-five percent of funds must support core medical services.

Part D of the Ryan White HIV/AIDS Program supports coordinated services for women, infants, children, and youth with HIV disease

and their affected family members. The Adolescent Initiative is a separate grant under the Part D program that is aimed at identifying adolescents who are HIV-positive and enrolling them in care.

Item 10 is pre-populated in the online form. The sources of funding listed are based on the associations reported by grantees during Provider List Verification. If you received funding from a Ryan White Program that is not listed, please contact your grantee of record and ask them to add your agency to its provider list. Likewise, if your agency is NOT funded by a Ryan White Program shown in Item 10, contact the grantee and ask them to remove your agency from its provider list.

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11. Part A funding

a. Part A funding expended

Indicate the total dollar amount of Part A (EMA/TGA) funds EXPENDED (rounded to the nearest dollar) by your agency during the reporting period.

Expended means the amount of money spent providing services directly to clients and on any other grant-related activities.

b. Part A MAI funding

Of the amount of Part A funding (indicated on the line above), provide the amount received from the MAI. If you do not know or do not receive funding from the MAI, report "0."

12. Part B funding

a. Part B funding expended

Indicate the total dollar amount of Part B (State/consortium) funds EXPENDED (rounded to the nearest dollar) by your agency during the reporting period.

Expended means the amount of money spent providing services directly to clients and on any other grant-related activities.

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b. Part B MAI funding

Of the amount of Part B funding (indicated on the line above), provide the amount received from the MAI. If you do not know or do not receive funding from the MAI, report "0."

13. Part C EIS funding

a. Part C EIS funding expended

Indicate the total dollar amount of Part C EIS funds EXPENDED (rounded to the nearest dollar) by your agency during the reporting period.

Expended means the amount of money spent providing services directly to clients and on any other grant-related activities.

b. Part C EIS MAI funding

Of the amount of Part C EIS funding (indicated on the line above), provide the amount received from the MAI. If you do not know or do not receive funding from the MAI, report "0."

14. Part D funding

a. Part D funding expended

Indicate the total dollar amount of Part D funds EXPENDED (rounded to the nearest dollar) by your agency during the reporting period. Include Adolescent Initiative funding.

Expended means the amount of money spent providing services directly to clients and on any other grant-related activities.

b. Part D MAI funding

Of the amount of Part D funding (indicated on the line above), provide the amount received from the MAI. If you do not know or do not receive funding from the MAI, report "0."

Data Quality Check
For each amount of funding reported in Items 11-14, the corresponding funding source must be checked in Item 10.

NOTE: The amount of money spent during the calendar year (January 1 – December 31) should be reported, regardless of the timing of the fiscal year(s). **Ideally, report the actual amount spent during the calendar year.**

If you are unable to report the actual amount, it is acceptable to annualize the funding spent. See the following example.

15. Oral health care expenditures

Indicate the total amount of Ryan White HIV/AIDS Program funds **EXPENDED** (rounded to the nearest dollar) on oral health care during the reporting period. If no funds were spent, report "0" in the space provided. Do not include Part F (Dental Reimbursement or Community Based Dental Partnership) oral health expenditures here. These data are included in a separate report.

16. Service provided to grantee of record

For each of the six services listed, indicate whether the service was provided to the grantee of record by the service provider by checking "Yes" or "No" for each item. If the grantee of record is the service provider, indicate whether the service was provided by checking "Yes" or "No" for each item.

NOTE: If any of these services were the *only* services provided with Ryan White HIV/AIDS Program funding, **STOP HERE** and do not complete the remainder of this form. Third-party administrators who process fee-for-service reimbursements to providers of eligible services should continue with Item 17a.

Planning or evaluation is the systematic (orderly) collection of information about the characteristics, activities, and outcomes of services or programs to assess the extent to which objectives have been achieved, to identify needed improvements, and/or to make future programming decisions.

Administrative or technical support is the provision of qualitative and responsive "support services" to an organization. Services may include human resources, financial management, and administrative services (e.g., property management, warehousing, printing/publications, libraries, claims, medical supplies, and conference/training facilities).

Fiscal intermediary services include reimbursements received or collected on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts.

Technical assistance (TA) is the identification of need for, and delivery of, practical program and technical support to the Ryan White HIV/AIDS Program community. TA should assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating Ryan White HIV/AIDS Program-supported planning and primary care service delivery systems.

Capacity development is a set of core competencies that contribute to an organization's ability to develop effective HIV health care services, including the quality, quantity, and cost-effectiveness of such services. These competencies also sustain the infrastructure and resource base necessary to develop and support these services. Core competencies include: management of program finances; effective HIV service delivery, including quality assurance; personnel management and board development; resource development, including preparation of grant applications to obtain resources and purchase of supplies/equipment; service evaluation; and cultural competency development.

Quality management is a systematic process with identified leadership, accountability, and dedicated resources, that uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs should also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change. The process is continuous and should fit within the framework of other program quality assurance and quality improvement activities, such as JCAHO and Medicaid. Data collected as part of this process should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized.

17. a. ADAP or other APA program

Indicate whether the provider agency administered an AIDS Drug Assistance Program (ADAP), administered an AIDS Pharmaceutical Assistance (APA) program during the reporting period. If your answer is "Yes," continue with Item 17b. If your answer is "No," skip to Item 18.

ADAP is typically a centrally administered program operated at the State level that receives Ryan White HIV/AIDS Program Part B ADAP-earmarked and Part B base funds. The State ADAP may also receive contributions from other Ryan White HIV/AIDS Programs. Other AIDS Pharmaceutical Assistance programs typically operate at the local EMA/TGA) or consortia level. Funds for these programs may come from a variety of sources that are not federally earmarked for AIDS medications. These may include Part A and private sources.

ADAP is a State-administered program authorized under Part B of the Ryan White HIV/AIDS Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

Local APA program is a local pharmacy assistance program implemented by Part A, B, or C. The Part B grantee consortium or Part A planning council contracts with one or more organizations to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., primary care, case management) to the clients that they serve through a Ryan White HIV/AIDS Program contract with their grantee or other funding sources.

Programs are considered a Local APA if they provide HIV/AIDS medications to clients and meet *all* of the criteria listed below:

- Have a client enrollment process;
- Have uniform benefits for all enrolled clients;
- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are *not* local APAs if they dispense medications in one of the following situations:

- Medications are dispensed to a client as a result or as a component of a primary medical visit;
- Medications are dispensed to a client on an emergency basis (an emergency basis is defined as a single occurrence of short duration); or
- Money or cash vouchers are given to a client to procure medications.

b. Type of pharmaceutical program

If your agency administered an ADAP, administered another APA program, or dispensed pharmaceuticals to clients, specify the program type:

- State ADAP; or
- Local APA program.

If the only program you administered was a State ADAP, **STOP HERE**. If you administered a Local APA continue to complete the data report.

> **Data Quality Check**
> If Local APA program is checked in Item 17b, Item 33b, Local AIDS Pharmaceutical Assistance must also be checked.

18. Health Insurance Program (HIP) assistance

Indicate whether or not you provided health insurance through HIP (with Ryan White HIV/AIDS Program funds) during the reporting period. If this was the *only* service you provided with Ryan White HIV/AIDS Program funding, skip to Section 7. Health insurance paid for with ADAP funds is not considered HIP.

HIP is a program that makes premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to keep his or her private health insurance active.

> **Data Quality Check**
> If HIP is checked in Item 18, Item 33e, Health Insurance Premium & Cost Sharing Assistance, must also be checked and Section 7 must be completed.

19. Target population

Check the box next to each population group that the program specifically targeted (i.e., set as a goal to achieve and directly allocated funds to support) for outreach efforts or service delivery during the reporting period. The program caseload of clients who are HIV-positive may not be entirely representative of the target populations indicated. If other populations that are not listed here were targeted, check "Other."

Target population is a population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

20. Minority group membership of agency

Check the categories that best describe your agency. **Check all that apply.**

21. Total paid staff

Report the number of paid staff, in full-time equivalents (FTEs) that were funded by the Ryan White HIV/AIDS Program during this reporting period. See the text box on the following page for information on how to calculate FTEs.

22. Total volunteer staff

Report the total number of volunteer staff (at all sites within your overall program) in full-time equivalent positions dedicated to HIV care during the reporting period. See the text box on this page for information on how to calculate FTEs.

> **How to calculate FTEs**
>
> *Step One:* Count each staff member who works full-time (generally 35–40 hours per week) on HIV/AIDS care as one FTE. Full-time employees who regularly work overtime should not be counted as more than one FTE.
>
> If a percentage of each staff member's time is being funded by Parts A, B, C, D, and/or F (MAI), simply add the percentages to calculate the total. For example: Physician .50 FTE, Nurse Practitioner 1.0 FTE, Dentist .20 FTE, Case Manager .75 FTE, Counseling & Testing 1.0 FTE = 3.45 FTEs.
>
> *Step Two:* Identify the staff members who do not work full-time on HIV/AIDS care (e.g., part-time employees or full-time employees who spend only a portion of their time in HIV/AIDS care), and sum the weekly hours they spend in HIV/AIDS care. Divide this number by your agency's definition of full-time (e.g., 40 hours per week).
>
> *Step Three:* Add the FTEs calculated in steps one and two. This sum is the number of FTEs you should report.

SECTION 2. CLIENT INFORMATION

This section should be completed by all agencies that provide services directly to clients and are funded through the Ryan White HIV/AIDS Program Parts A, B, C, D, and F (MAI). Record numbers separately for infected and affected clients served during the reporting period.

Clients in this section include your infected and affected population, whether receiving core or support services.

*Infected client*s include individuals who were HIV-positive and who received at least one Ryan White HIV/AIDS Program-eligible service during the reporting period.

Indeterminate clients include children under age 2, born to mothers who were HIV-infected, and whose HIV status is not yet definite.

Affected clients include individuals who were HIV-negative as well as those with unknown HIV status. *An affected client* is a family member or partner who received at least one Ryan White HIV/AIDS Program support service during the reporting period. **This individual must be linked to an infected client who is currently receiving services from your agency.**

Family members include children, partners, biological parents, adoptive parents, foster parents, grandparents, other caregivers, and siblings (who may or may not be living with HIV).

In Section 2, and all other sections of the Data Report, check "Unknown" boxes or report "Unknown" counts only when necessary. If you report more than 10 percent of your clients with an unknown age, race/ethnicity, or HIV status (medical providers), you should examine your data collection system to determine how it can be improved to reduce this percentage.

Remember your reporting scope. If you chose reporting scope "01" on page 1, Item 6, provide information on all clients who received services eligible for Ryan White HIV/AIDS Program funding, whether funded by a Ryan White HIV/AIDS Program grant or other funding source. If you chose reporting scope "02" on page 1, Item 6, (with the permission of the HRSA Project Officer) include only those clients who received services funded by Parts A, B, C, D, and/or F (MAI).

23. Total number of unduplicated clients

In each respective category report the total number of individuals receiving at least one Ryan White HIV/AIDS Program-eligible service during the reporting period. To obtain an unduplicated client count, an individual receiving multiple units of service must be counted only once. Anonymous clients should ***not*** be reflected in this total.

Unduplicated client count is an accounting of clients in which a single individual is counted only once. For providers with multiple sites, a client is only counted once, even if he or she receives services at more than one of the provider's sites.

24. Total number of new clients

Report the number of unduplicated clients whose first receipt of services from the provider agency occurred during this reporting period. Clients served anonymously should not be considered new clients and should not be reported in this item.

New client is an individual who received services from a provider for the first time ever during this reporting period. Individuals who return for care after an extended absence are not considered new unless past records of their care are not available.

Data Quality Check

The total number of new clients reported in Item 24 must be less than or equal to the total number of clients reported in Item 23 by category.

NOTE: The total number of new clients reported in Item 23 should only be equal to the total number of clients in Item 24 if the agency is newly funded by the Ryan White HIV/AIDS Program.

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25. Gender of clients

Report the actual unduplicated numbers of male, female, and transgender clients (this item should be based on the self-report of the client), and the number of clients for whom gender is unknown or unreported. Include infants under the age of 2 whose HIV status is indeterminate in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

Transgender is an individual who exhibits the appearance and behavioral characteristics of the opposite sex and is based on self-report by that individual.

26. Age of clients

Report the actual unduplicated number of clients in each age group using client ages at the end of the reporting period. Include infants under the age of 2, whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

27. Race and ethnicity of clients

Based on the client's self-report, report the number of unduplicated clients by race and ethnicity, Hispanic (27a) or non-Hispanic (27b).

If clients report race, but not ethnicity, report them in the appropriate race category in the non-Hispanic table (27b). Similarly, if clients report their ethnicity as Hispanic, but do not report race, report them in the "Not reported" race category in the Hispanic table (27a). Clients who report neither race nor ethnicity should be included in the "Not reported" race category and in the non-Hispanic table (27b). Do not include any anonymous clients in these counts. All clients who identify with more than one race should be included in the "More than one race" category and in either the Hispanic (27a) or non-Hispanic (27b) table.

The following racial category descriptions, defined in October 1997, are required for all Federal reporting, as mandated by the Office of Management and Budget. For more information go to:

http://www.whitehouse.gov/omb/fedreg/1997standards.html).

Race and ethnicity categories:

American Indian or Alaska Native is an individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian is an individual having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American is an individual having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander is an individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White is an individual having origins in any of the original peoples of Europe, the Middle East, or North Africa.

More than one race is an individual who identifies with more than one race.

Not reported is an individual who did not self-report either race or ethnicity.

Hispanic (or Latino) is an individual of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

a. Hispanic clients

Report the number of unduplicated Hispanic clients by race.

b. Non-Hispanic clients

Report the number of unduplicated non-Hispanic clients by race.

28. Household income

Report the annual household income category of the client **at the end of the reporting period**, or report the most recent data available within the reporting period. Income is defined in ranges relative to the Federal poverty guidelines. Include infants under the age of 2, whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

> **Data Quality Check**
> The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 28 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

Household includes all people who occupy a house, an apartment, a mobile home, a group of rooms, or a single room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of related or unrelated people who **share** living arrangements.

Household income is the sum of money received in the previous calendar year by all household members, ages 15 years and older, including household members not related to the householder and people living alone.

Families and individuals are classified as below poverty level if their total family income or unrelated individual income was less than the poverty threshold specified for the applicable family size, age of householder, and number of related children under 18 present. Poverty status is determined for all families (and, by implication, all family members).

For individuals not in families, poverty status is determined by their income in relation to the appropriate poverty threshold. Thus, two unrelated individuals living together may not have the same poverty status. The poverty thresholds are updated each year to reflect changes in the Consumer Price Index. See Poverty Guidelines, Research, and Measurement at http://aspe.hhs.gov/poverty/.

Household income categories:

*Equal to or below the Federal poverty level i*ndicate that the client's annual household income is the same as or below the Federal poverty level.

Within 101–200% of the Federal poverty level indicates that the client's income is equal to or no more than double the Federal poverty level.

Within 201–300% of the Federal poverty level indicates that the client's income is double or no more than triple the Federal poverty level.

More than 300% of the Federal poverty level indicates that the client's income is triple or more above the Federal poverty level.

Unknown/unreported indicates that the client's income is unknown or was not reported.

29. Housing arrangement categories

Report the number of clients according to their regular place of residence **at the end of the reporting period**, or most recent data available within the reporting period, using the categories defined below. Include infants, under the age of 2 whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

> **Data Quality Check**
> The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 29 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

Housing/living arrangements:

Permanently housed includes clients who reside in apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited.

Non-permanently housed includes clients who are homeless, as well as those living in transient or transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for living. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program.

Institution includes residential, health care, and correctional facilities. Residential facility includes supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and

hospices. Correctional facility includes jails, prisons, and correctional halfway houses.

Other includes other housing/living arrangements not listed above.

Unknown/unreported indicates that housing/living arrangements were not reported.

30. Primary source of medical insurance

Report the number of clients receiving each type of medical insurance **at the end of the reporting period**, or the most recent data available for the reporting period.

Select only one form of insurance for each client. Report the medical insurance that provides the most reimbursement if a client has more than one source of insurance at the end of the reporting period. If a client's only means of covering the costs of services is Ryan White HIV/AIDS Program funds, report the client in the "no insurance" category. Include infants under the age of 2 whose HIV status is indeterminate in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

Data Quality Check
The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 30 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

Private includes health insurance plans such as BlueCross/BlueShield, Kaiser Permanente, and Aetna.

Medicare is a health insurance program for people ages 65 years and older, people with disabilities under age 65, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Medicaid is a jointly funded, Federal-State health insurance program for people with low incomes.

Other public includes other Federal, State, and/or local government programs providing a broad array of benefits for eligible individuals. Examples include State-funded insurance plans, military health care (TRICARE), State Children's Insurance Program (SCHIP), Indian

Health Services, and Veterans Health Administration.

No insurance indicates that the client has no insurance to cover the cost of services (i.e. self-pays).

Other indicates that the client has an insurance type other than those listed above.

Unknown/unreported indicates that the primary source of medical insurance is unknown and not documented.

31. HIV/AIDS status

Report the total number of clients by their HIV/AIDS status at the end of the reporting period.

Data Quality Check
The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 31 must equal the total number of HIV-positive, HIV-indeterminate, and HIV-affected clients reported in Item 23.

HIV-positive, not AIDS clients have tested positive for and been diagnosed with HIV, but have not advanced to AIDS.

HIV-positive, AIDS status unknown clients have tested positive for and been diagnosed with HIV. It is unknown whether or not the client has advanced to AIDS.

CDC-defined AIDS clients have advanced to and been diagnosed with CDC-defined AIDS.

HIV-indeterminate clients are children under age 2, born to mothers who were HIV-infected, and whose HIV status is not yet definite.

HIV-negative (affected) clients have tested negative for HIV and are an affected partner or family member of an individual who is HIV-positive.

Unknown (affected) indicates the HIV/AIDS status of the client is unknown and not documented.

NOTE: Once a client has been diagnosed with AIDS, s/he is always counted in the CDC-defined AIDS category regardless of disease indicators (i.e., CD4 counts).

32. Vital/enrollment status categories

Report the number of clients with each vital/enrollment status *at the end of the reporting period*.

Active client, new to the program is an individual whose first point of contact with the program occurred during this reporting period.

Active client, continuing in program is an individual who was a client when the period started and continued in the program.

Deceased clients have died sometime during this reporting period.

Inactive includes, for example, clients who have moved or were lost to follow-up.

Unknown/unreported indicates that the vital/enrollment status is unknown or not reported.

SECTION 3. SERVICE INFORMATION

Service providers funded under all Parts should complete this section. If you offered a particular service, check the box in column 2 and list the number of clients and the total number of visits for the appropriate service categories. If you offered a particular service but do not know the number of clients or visits during the reporting period, check the "Unknown" box in the appropriate column. Include HIV-indeterminate clients in the HIV+ column. Core services for affected clients are not eligible for Ryan White HIV/AIDS Program funding.

NOTE: This question lists all services eligible under the Ryan White HIV/AIDS Program. However some services cannot be funded under some Parts. Check your notice of grant award or call your Project Officer to determine services eligible to be funded under your Part(s). For additional information please visit http://hab.hrsa.gov/treatmentmodernization/.

33. **Services offered, number of clients served, and the total number of visits**

    For each of the following services:

    - Place a check mark in column 2 if the service was offered by your organization, either directly or via a contractual arrangement with another service provider that does not complete its own Ryan White HIV/AIDS Program Data Report.

    - For all services that you offer, as indicated with a check mark in column 2, report the total number of unduplicated clients who received the service and the total number of visits made by those clients during the reporting period.

    - If your program offers a particular service but did not see any clients for that service, enter a check mark in column 2 and report "0" in columns 3 and 4.

    - Do not leave the columns blank.

    - Do not include any anonymous/drop-in clients or visits in columns 3 and 4.

Core services to affected clients are not eligible for Ryan White funding. [Prior to reauthorization of the Ryan White HIV/AIDS Program, Part D programs were allowed to provide core services to affected clients.]

NOTE: A client may only have one visit for each service category per day.

Service categories:

CORE SERVICES

Outpatient/ambulatory medical care includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).

Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
NOTE: Early Intervention Services provided by Ryan White Part C and Part D programs should be reported under *Outpatient/ambulatory medical care.*

AIDS pharmaceutical assistance (local) /*dispense pharmaceuticals* includes local pharmacy assistance programs implemented by Part A, B, and/or C grantees that provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds, Part B base award funds, and/or Part C grant funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding.

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Early intervention services (Parts A and B) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
NOTE: EIS provided by Ryan White Part C and Part D Programs should NOT be reported under this service category. Part C and Part D EIS should be included under *Outpatient/ambulatory medical care*.

Health Insurance Premium & Cost Sharing Assistance is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Home health care includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Home and community-based health services include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.

Hospice services include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Mental health services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Medical nutrition therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment

adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Substance abuse services - outpatien is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

SUPPORT SERVICES

Case management (non-medical**)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Child care services are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training. **NOTE:** This does not include child care while a client is at work.

Pediatric developmental assessment and early intervention services are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or a child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services.

It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational

settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

NOTE: Only Part D programs are eligible to provide Pediatric developmental assessment and early intervention services.

Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

NOTE: Part A and Part B programs must allocate, track, and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02).

Food bank/home-delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. This includes vouchers to purchase food.

Health education/risk reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Housing services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

Legal services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including

discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Linguistics services include the provision of interpretation and translation services.

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status (i.e., case finding) so that they may become aware of, and may be enrolled in, care and treatment services. Outreach services do not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Permanency planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Referral for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by

professional case managers, informally through support staff, or as part of an outreach program.

Rehabilitation services are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Respite care is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

Substance abuse services - residential is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

NOTE: Part C programs are not eligible to provide Substance abuse services **-** residential**.**

Treatment adherence counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical settings.

Data Quality Check

If Item 33a Outpatient/ambulatory medical care; Item 33c Oral health care; Item 33i Mental health services; Item 33j Medical nutritian therapy; Item 33k Medical case management; or Item 33l Substance abuse services, is checked then "*Yes, within the EIS program*" **must be checked** for the corresponding service in Item 64.

SECTION 4. HIV COUNSELING AND TESTING

Part A, B, C, D, and F (MAI) grantees/service providers who selected the eligible reporting scope "01", and provide HIV antibody counseling and testing, must report on all Items in Section 4. Those who selected the funded reporting scope "02", and provide HIV antibody counseling and testing, but do not use Ryan White HIV/AIDS Program funds can answer "Yes" to Item 34 in this section, "No" to Item 35, and skip to Section 5, Item 42.

NOTE: HIV counseling and testing are funded as components of Early Intervention Services for Parts A and B. HIV counseling and testing are required components of a Part C program. Part D funds may be used to support these services.

Report the number of individuals who received HIV counseling and testing during the reporting period, regardless of where these services were provided (i.e. at your outpatient facilities or at another site within your program). This number should include **ALL** individuals who received HIV counseling and testing in your program, whether or not they were reported as clients in Section 2. This is the ONLY section of the Data Report where individuals who are not considered clients may be reported.

34. a. HIV counseling and testing services

Indicate whether HIV counseling and testing were provided as part of your outpatient system of care during the reporting period, either in your facilities or by procuring or subsidizing these services provided by other programs. If HIV counseling and testing services were provided, continue to Item 34b. If HIV counseling and testing services were not provided during the reporting period, do not complete Items 34b through 41 in this section, but skip to Section 5.

Agencies that provide HIV testing based on the CDC's revised recommendations for HIV testing should answer "Yes" to Item 34 and continue to complete Section 4. For more information about the CDC's recommendations, refer to:

http://www.cdc.gov/hiv/topics/testing/guideline.htm

NOTE: If HIV counseling and testing were the ONLY services you provided, complete only Sections 1 and 4.

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b. Infant testing

If HIV counseling and testing services were provided, indicate the total number of infants (under 2 years old) tested during this reporting period.

35. Funding source for HIV counseling and testing services

Indicate whether Ryan White HIV/AIDS Program funds were used to support HIV counseling and testing services during the reporting period, regardless of where these services were provided (i.e., at your outpatient facilities or at another site within your program).

36. HIV pretest counseling

Indicate the number of individuals who received each type of HIV pretest counseling (counseling before testing for HIV antibodies) by an individual qualified to provide such counseling, during the reporting period.

Confidential indicates that information such as name, gender, age, etc., is collected about the individual, and the individual is reassured that no identifying information will be shared or passed on to anyone.

Anonymous indicates that no identifying information is collected from the individual.

If the answer to both confidential and anonymous pretest counseling is "0," skip to Item 41a.

37. HIV testing

Indicate the number of individuals who were tested for HIV using an FDA approved test during the reporting period.

38. Positive results

Indicate the number of individuals who tested positive for HIV during the reporting period.

> **Data Quality Check**
> The total number of individuals reported in Item 38 must be less than or equal to the total number of individuals reported in Item 37.

39. HIV posttest counseling

Indicate the number of individuals who, after being tested for HIV, returned for HIV posttest counseling from an individual qualified to provide such counseling, during the reporting period, regardless of their test results. This includes every individual

tested for HIV, whether the test result was positive, negative, or indeterminate.

> **Data Quality Check**
> The total number of individuals reported in Item 39 must be less than or equal to the total number of individuals reported in Item 37.

40. Did not return for HIV posttest counseling

Indicate the number of individuals who had a positive HIV test result and did not return for HIV posttest counseling, during the reporting period.

> **Data Quality Check**
> The total number of clients reported in Item 40 must be less than or equal to the total number of clients reported in Item 38.

41. a. Partner notification

Indicate by checking "Yes" if you offered partner notification services during the reporting period. If partner notification was offered through referral to another organization, or it is not offered, check "No" and then skip to Section 5. This includes notification of both sex partners and injection drug use partners.

Partner notification is when a clinician in your program notifies the partner of a client of possible exposure to HIV. (Check State and local laws for specific requirements of partner notification programs.) It is not the number of individuals who tested positive for HIV antibodies and offered partners' names for notification, nor is it the number of individuals who came to your program because of a referral by a partner notification service.

b. At-risk partner notification

Indicate the number of at-risk partners who were directly contacted by a provider to discuss their possible exposure to HIV. Do not count the number of individuals counseled on disclosure issues. Do not count the number of individuals who were referred to an agency that provided partner notification services. If partner notification services were provided but no partners were notified during the reporting period, report "0."

> **Data Quality Check**
> If '"Yes" was checked in Item 41a, a number must be reported in Item 41b.

SECTION 5. MEDICAL INFORMATION

*This section should be completed by medical service providers funded through the Ryan White HIV/AIDS Program Parts A, B, C, D, and F (MAI) for clients who are HIV-positive/indeterminate and had at least one outpatient/ambulatory medical care visit during the reporting period. Other individuals who have authorized access to medical information should **NOT** complete this section. Providers who report under scope 01 should report all medical services even if those services were not funded by the Ryan White HIV/AIDS Program. A medical service provider is any service provider who provided outpatient/ambulatory medical care (Item 33, service category "a"). It is expected that grantees who contract with multiple fee for service medical providers will report the medical information for all providers who do not complete a Data Report.*

42. Gender

Report the number of unduplicated clients in each gender category.

> **Data Quality Check**
> The total number of clients reported in Item 42 must be less than or equal to the total number of HIV-positive and HIV-indeterminate clients reported in Item 23. The number of clients reported in each gender category in Item 42 must be less than or equal to the number of clients reported in each gender category in Item 25. In addition, **all** HIV+/indeterminate clients reported in Item 33a **must** be included in Section 5.

43. Outpatient/ambulatory medical care visits

Report the number of unduplicated clients in each of the listed categories of number of outpatient/ambulatory medical care visits.

44. HIV exposure category

Report the number of unduplicated clients in each of the HIV exposure categories.

Clients with more than one reported mode of exposure to HIV are counted in the exposure category listed first in the hierarchy, except for males with a history of both sex with men and injection drug use. They are counted in a separate category.

> **Data Quality Check**
> The total number of clients reported in Item 44 must be equal to the total number of clients reported in Item 42.

Men who have sex with men (MSM) cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).

Injection drug user (IDU) cases include clients who report use of drugs intravenously or through skin-popping.

MSM and IDU cases include men who report sexual contact with men and use of drugs intravenously or through skin-popping.

Hemophilia/coagulation disorder cases include clients with delayed clotting of the blood.

Heterosexual contact cases include clients who report specific heterosexual contact with an individual with, or at increased risk for, HIV infection (e.g., an injection drug user).

Receipt of transfusion of blood, blood components, or tissue cases include transmission through receipt of infected blood or tissue products given for medical care.

Mother with/at risk for HIV infection (perinatal transmission) cases include transmission from mother to child during pregnancy. This category is exclusively for infants and children infected by mothers who are HIV-positive or at risk.

Other indicates the client's exposure category is known, but not listed above.

Undetermined/unknown, risk not reported or identified indicates the client's exposure category is unknown or not reported for data collection.

45. New clients

Indicate the number of unduplicated clients who received HIV outpatient/ambulatory medical care from your agency for the first time during this reporting period.

46. New clients receiving CD4 and viral load counts

Indicate the number of new clients from Item 45 who received at least one CD4 count or one viral load test during the reporting period.

> **Data Quality Check**
> The total number of clients reported in each category in Item 46 must be less than or equal to the total number of new clients reported in Item 45.

47. Latent tuberculosis (TB) testing

For more information about TB, refer to the Guidelines for Prevention of OIs for persons Infected with HIV:

http://aidsinfo.nih.gov/contentfiles/OIpreventionGL.pdf

a. Number of clients for whom a latent TB test (skin or blood) was indicated

Indicate the number of clients for whom a latent tuberculosis test was medically indicated during this reporting period. Do not include clients if they have had a positive TB test, if they have been treated for active tuberculosis, or if they received treatment of latent TB infection (LTBI) in a prior reporting period.

b. Receipt of TB test

Indicate the number of clients reported in Item 47a who actually received a PPD skin or QFT-G blood test.

c. Results of TB test

Indicate the number of clients who received a TB test (skin or blood) in Item 47b who had a positive, negative, indeterminate, or unknown result.

d. Started treatment of latent TB infection (LTBI) or active TB

Indicate the number of clients who received a positive TB test (skin or blood) and started treatment of LTBI, or received treatment for active TB, or were lost to follow-up.

e. TB treatment status

Indicate the number of clients who received a positive TB test (skin or blood) and who completed or are currently undergoing treatment of LTBI or active TB respectively, as well as those who did not complete the full treatment or were lost to follow-up.

> **Data Quality Check**
> The number of clients reported in Item 47a must be less than or equal to the total number of clients in Item 42. The number in Item 47b must be less than or equal to the number in Item 47a. The number in Item 47c must be equal to the number in Item 47b. The number in Item 47d must be equal to the number of HIV-positive clients in Item 47c. Item 47e must be equal to the number of clients who received Treatment of LTBI and for active TB in Item 47d.

48. Screening/Testing services

Report the total number of clients who received each of the screening/testing services listed at any time during the reporting period. Report one answer for each of the services.

> **Data Quality Check**
> The total number of clients in any single category in Item 48 must be less than or equal to the total number of clients reported in Item 42.

49. AIDS diagnoses

Report the number of clients who were diagnosed as having AIDS during the reporting period.

AIDS is the most severe manifestation of infection with HIV. CDC lists numerous opportunistic infections and cancers that, in the presence of HIV infection, constitute an AIDS diagnosis. In 1993, CDC expanded the criteria for an AIDS diagnosis in adults and adolescents to include CD4+ cell counts at or below 200 cells per microliter in the presence of HIV infection. AIDS defining conditions include: pneumocystis carinii pneumonia (PCP), Mycobacterium avium complex (MAC), Mycobacterium tuberculosis, cytomegalovirus disease, toxoplasmosis, cervical cancer, and others. See http://aidsinfo.nih.gov for more information on AIDS diagnosis, opportunistic infections, and cell counts.

> **Data Quality Check**
> The total number of clients reported in Item 49 must be less than or equal to the total number of clients reported in Item 42.

50. Deceased clients

Of the clients reported in Item 42, indicate the number of HIV positive clients who were known to have died during the reporting period.

51. Antiretroviral therapy type

Indicate the number of clients receiving each type of antiretroviral therapy. Count each client only once.

HAART (Highly Active Antiretroviral Therapy) is an aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV, whose purpose is to reduce viral load to undetectable levels.

Monotherapy refers to the use of only one antiretroviral drug.

Dual Therapy refers to the use of only two antiretrovirals.

Unknown/unreported indicates the client's therapy is unknown.

For more information on treatment guidelines visit http://www.aidsinfo.nih.gov/guidelines.

52. Gynecological exams

Report the total number of women (female clients) who received a pelvic exam and cervical Pap test during the reporting period.

> **Data Quality Check**
> The total number of women reported in Item 52 must be less than or equal to the total number of women (female clients) reported in Item 42.

53. Pregnant women

a. Number of pregnant women

Report the number of women who were HIV-positive and who were pregnant at any time during the reporting period, regardless of the outcome of their pregnancies.

b. Trimester of first visit for prenatal care

Of the number of pregnant women reported in Item 53a, list the number who entered prenatal care in each trimester of pregnancy (or at delivery).

c. Antiretroviral medications received by pregnant women

Report the total number of pregnant women, reported in Item 53a, who received antiretroviral medications during the reporting period.

> **Data Quality Check**
> The total number of women reported in Item 53a must be less than or equal to the number of women (female clients) reported in Item 42. The total number of women reported in Item 53b must be less than or equal to Item 53a. Item 53c must be less than or equal to Item 53a.

d. Infants delivered

Report the total number of infants delivered (live births) to pregnant women during the reporting period.

e. HIV/AIDS status of infants

Of the infants delivered (Item 53d), report the number in each category at the end of the reporting period.

> **Data Quality Check**
> The total number of infants reported in Item 53e must be equal to the total number of infants reported in Item 53d.

54. Quality management program

Indicate whether your agency has a program to manage the quality of Ryan White HIV/AIDS Program services. Also indicate whether the program has been recently introduced or updated with new standards. For further information on quality management of the Ryan White HIV/AIDS Program, refer to the Technical Assistance Manual available from http://hab.hrsa.gov/tools.htm.

SECTION 6. DEMOGRAPHIC TABLES/PART-SPECIFIC DATA FOR PARTS C AND D

This section should be completed by Part C and D grantees/service providers. All others should skip to Section 7. Part 6.1 is specific to Part C. Part 6.2 is specific to Part D including the Adolescent Initiative.

Section 6.1 Part C Information

Part 6.1 should be completed only by Part C grantees/service providers that provide primary health care services with Part C funds. Include all of your Part C Early Intervention Service (EIS) clients in this table. These are clients who are HIV-positive or HIV-indeterminate and have received at least one primary health care service during the reporting period, regardless of the funding source for that service.

Each grantee defines the clients who are in the EIS program. At the very least, your definition must reflect the program you described in your last competing grant application.

Part C defines "regardless of funding source" to mean that Part C eligible services can be funded from Part C or any other funding sources.

Primary health care service is any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client who is HIV-positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, medical case management, and pharmacy services; radiology, laboratory and other tests used for diagnosis and treatment planning; HIV counseling and testing; and the cost of making and tracking referrals for medical care.

The number of clients reported in this section must be less than or equal to the number of clients in Section 2. If the number of clients reported in this section is equal to the number in Section 2 (including the demographic breakdowns), check the box and skip to Item 59.

> **Data Quality Check**
> If the box is checked, the number of clients reported throughout Section 6.1 must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported in Section 2. All data quality checks will compare Section 2 data with Section 6.1 data.

55. Unduplicated client count

a. HIV-positive and indeterminate clients

Indicate the number of clients included in this section who received at least one service and are HIV-positive or HIV-indeterminate (children under age 2 only).

b. New clients

Of the clients in Item 55a, indicate how many were newly enrolled during this reporting period. This number must be less than the number of clients reported in Item 55a.

> **Data Quality Check**
> The total number of clients reported in Item 55a must be less than or equal to the total number of HIV+/indeterminate clients reported in Item 23. In addition, the number of clients reported in Item 55b must be less than or equal to the number of HIV+/indeterminate clients reported in Item 24 as well as the total number of clients reported in item 55a.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported in Items 23 and 24.

56. Gender

Report the actual unduplicated numbers of male, female, and transgender HIV-positive/indeterminate clients (this item should be based on the self-report of the client), and the number of clients for whom gender is unknown or unreported. Do not include any anonymous clients in these counts.

> **Data Quality Check**
> The number of clients reported on each line in Item 56 must be less than or equal to the number of clients reported on the corresponding line in Item 25.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported on the corresponding line in Item 25.

57. Age

Report the actual unduplicated number of HIV-positive/indeterminate clients in each age group using client ages at the end of the reporting period. Do not include any anonymous clients in these counts.

> **Data Quality Check**
>
> The number of clients reported on each line in Item 57 must be less than or equal to the number of clients reported on the corresponding line in Item 26.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported on the corresponding line in Item 26.

58. Race and ethnicity

Report the number of HIV-positive/indeterminate clients by race and ethnicity, based on the self-report of the client. If clients report race, but not ethnicity, report them in the appropriate category in the non-Hispanic column. Similarly, if clients report their ethnicity as Hispanic, but do not report race, report them in the "Not reported" race category in the Hispanic column. Clients who do not report race or ethnicity should be included in the "Not reported" category and in the non-Hispanic column. Do not include any anonymous clients in these counts. All clients who identify with more than one race should be included in the "More than one race" category and in the Hispanic or non-Hispanic column.

> **Data Quality Check**
>
> The number of Hispanic clients reported on each line in Item 58 must be less than or equal to the number of HIV-positive/indeterminate Hispanic clients reported on the corresponding line in Item 27a. The number of non-Hispanic clients reported on each line in Item 58 must be less than or equal to the number of HIV-positive/indeterminate non-Hispanic clients reported on the corresponding line in Item 27b.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of unduplicated HIV+/indeterminate clients reported on the corresponding line in Items 27a and 27b.

59. Race, ethnicity, gender, and age

This two part question requests the number of HIV-positive or indeterminate clients who received at least one primary health care service during the

reporting period by race, ethnicity, gender and age. In Item 59a report the number of Hispanic clients and in 59b, report the non-Hispanic clients.

> **Data Quality Check**
>
> The total number of clients who are HIV+/indeterminate reported in Items 59a and 59b must equal the number of clients reported in Item 55a. Furthermore, the total number of clients reported in each category in Items 59a and 59b must be equal to the number of clients in the corresponding categories in Items 56 to 58; the subtotal of clients by race, ethnicity, and gender in Items 60a and 60b; and the subtotal of clients by gender and age in Item 61.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Items 25 to 27.

60. HIV exposure category, gender, race, and ethnicity

This two part question requests the number of HIV-positive or indeterminate clients who received at least one primary health care service during the reporting period by HIV exposure category, gender, race, and ethnicity. In Item 60a report the number of Hispanic clients and in 60b, report the non-Hispanic clients.

> **Data Quality Check**
>
> The total number of clients who are HIV+/indeterminate reported in Items 60a and 60b must equal the number of clients reported in Item 55a. Furthermore, the total number of clients reported in each category in Items 60a and 60b must be equal to the number of clients in the corresponding categories in Items 56 and 58; the subtotal of clients by race, ethnicity and gender in Items 59a and 59b; and the subtotal of clients by gender and HIV exposure category in Item 61.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Items 25 and 27.

61. HIV exposure category, gender, and age

Report the number of clients who are HIV-positive or indeterminate who received primary health care services during the reporting period by exposure category, gender, and age.

---

62. Cost and revenue

Your response to each of the following items will indicate the cost of or revenue for providing "Primary health care" and "Other program" services as defined below.

Primary health care is any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client who is HIV-positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, medical case management, and pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; HIV counseling and testing; and the cost of making and tracking referrals for medical care.

Other program, for Part C reporting purposes, refers to optional services that are eligible for Part C funds. Examples include non-medical case management, eligibility assistance, social work, outreach, CME, etc. Check the line-item budget on your last approved application for clarity. Do NOT include any administrative costs, expenditures, or revenues. Include any Part C eligible service, even if it is not being *funded* under your grant.

a. Total cost of providing service

Indicate the total cost (personnel, supplies, rent, etc.) to the EIS program of providing each category of service during the reporting period. Each dollar figure should be representative of the amount of money it takes to provide the service as part of the EIS program.

These amounts are independent of funding sources and will give some indication of what it costs to provide HIV-related care. Do not leave any line blank.

b. Part C grant funds expended

Indicate the amount of the Part C funds expended to support each category of service during the reporting period. This is the amount of Part C monies used to cover part of the total cost of providing each service. If Part C money was not used to support a particular service, report "0." Do not leave any line blank.

c. Direct collections from clients

Indicate the amount of money collected directly from clients as payment for services provided during the reporting period. This would include any out-of-pocket payment from clients such as co-payments, deductibles, nominal per-visit fees, etc. This is the amount of money received from clients that is used to cover part of the total cost of providing each service. If direct collections from clients are not received or used to support a particular service, report "0." Do not leave any line blank.

d. Reimbursements

Indicate the amount of reimbursements received from third-party payers (public and private) as payment for services provided during the reporting period. This includes reimbursements from Medicaid, private insurance, VA benefits, etc. This is the amount of money that is used from third-party payers to cover part of the cost of providing each service. If third-party money is not used to support a service, report "0." Do not leave any line blank.

e. Other sources of income

Indicate the amount of other sources of income or revenue (other than the Ryan White HIV/AIDS Program Part C, direct collections from clients, and reimbursements received from third-party payers, as reported in Item 62c, and Item 62d) that was used during the reporting period to support services in your EIS program. This is the amount of money that was used from other sources of income to cover part of the cost of providing each service. Other sources may be from city, county, or State agencies; academic institutions, foundations, and corporations; and fundraising activities, bequests, and donations. Include any other Ryan White HIV/AIDS Program funding, such as Parts A, B, and D, and any other Federal agency funding (CDC,

SAMHSA, BPHC, etc.) used to support any category of service. If these other sources of income did not provide money to support EIS services, report "0." Do not leave any line blank.

Data Quality Check

Funds reported in Item 62b, c, d, and e for the categories of "Primary care" and "Other program" should not exceed the cost of providing services in the corresponding categories in Item 62a.

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63. Early Intervention Services sites

a. Early Intervention Services sites

Check whether or not the grantee organization provided Early Intervention Services (EIS) , that is, Part C-eligible services, at more than one site during the reporting period.

b. Number of EIS sites

If you answered "Yes" to Item 63a, indicate the number of sites at which EIS were provided during the reporting period.

64. Available services

Check whether each primary health care service was available to clients who are HIV-positive, within the EIS program and/or through referral to providers outside of the EIS program, during the reporting period.

EIS program encompasses the care supported by the Part C legislation and is made available by the grantee organization and its subcontractors. Subcontractors render care to clients referred to them by the grantee organization and are reimbursed for their services or otherwise have a remunerative relationship with the grantee for the referred service.

Outside the EIS Program is a referral made to a provider that (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Part C grantee or its parent organization.

It is not necessary to indicate how many clients received each service or how many client visits were made to obtain each service. All the services you have indicated may not have been utilized during the reporting period. However, the services you have indicated should have been available if a client had required them within the EIS program

and/or through referral. If services other than those listed here were available, check "Other services." See list below for description of services.

Description of services:

Outpatient/ambulatory medical care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Outpatient/ambulatory medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Dermatology refers to care related to the skin.

Dispensing of pharmaceuticals is the provision of prescription drugs to prolong life or prevent deterioration of health.

Gastroenterology refers to the care related to the stomach and intestines.

Medical case management is a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of

treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Medical nutrition therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Mental health services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Neurology refers to care related to the nervous system.

Obstetrics/gynecology refers to care related to the female reproductive organs as well as pregnancy.

Optometry/ophthalmology refers to care related to the eye.

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Substance abuse services include the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Other services include other Part C-eligible, primary health care services not listed above.

65. Referrals outside the EIS program

Report the total number of unduplicated clients who are HIV-positive and were referred outside of the EIS program for any primary health care service not available within the EIS program during the reporting period. This number should be a subset of all clients who received at least one primary health care service in the program during the reporting period. If no clients were referred outside the program during the reporting period, report "0." Do not leave the line blank.

Section 6.2 Part D Information

*Section 6.2 should be completed only by Part D including Adolescent Initiative grantees/service providers. Report only on the Part D clients who are **HIV-positive, HIV-indeterminate, and HIV-affected** (a family member or partner of a client who is HIV-positive). The number of clients reported in this section must be less than or equal to the number reported in Section 2. If the number of clients reported in this section is equal to the number in Section 2 (including the demographic breakdowns), you may check the box and skip to Item 71.*

Data Quality Check
If the box is checked, the number of clients reported in Section 6.2 must be **EQUAL** to the number of clients reported in Section 2. All data quality checks will compare Section 2 data with Section 6.2 data.

Part D programs are designed to provide family-centered care and services to women, infants, children, and youth with HIV disease and their affected family members.

If your Part D project works with partners that provide care and services to many different individuals with HIV/AIDS, report ONLY those clients who received Part D services in Section 6.2.

66. Unduplicated client count

Provide the unduplicated number of Part D clients who are HIV-positive, HIV-indeterminate, or HIV-negative/unknown. Children under age 2 with undetermined status should be listed as "indeterminate."

> **Data Quality Check**
>
> The total number of clients reported in Item 66 must be less than or equal to the number of clients in each of the corresponding categories in Item 23.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Item 23.

67. New clients

Of the clients reported in the question above, indicate the number in each category who were enrolled for the first time during this reporting period.

> **Data Quality Check**
>
> The total number of clients reported in Item 67 must be less than or equal to the number of clients reported in each of the corresponding categories in Items 24 and 66.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Item 24.

68. Gender

Report the actual unduplicated numbers of male, female, and transgender clients (this item should be based on the self-report of the client), and the number of clients for whom gender is unknown or unreported for HIV-positive and HIV-negative/unknown clients. Do not include any anonymous clients in these counts.

> **Data Quality Check**
>
> The total number of clients reported in Item 68 must be less than or equal to the number of clients reported in each of the corresponding categories in Item 25.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Item 25.

69. Age

Report the actual unduplicated numbers of clients in each group and the number of clients for whom age is unknown or unreported for HIV-positive/indeterminate and HIV-negative/unknown clients. Do not include any anonymous clients in these counts.

> **Data Quality Check**
>
> The total number of clients reported in Item 69 must be less than or equal to the number of clients reported in each of the corresponding categories in Item 26.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Item 26.

70. Race and ethnicity

Based on the client's self-report, report the number of unduplicated clients by race and ethnicity, Hispanic (70a) or non-Hispanic (70b).

If clients report race, but not ethnicity, report them in the appropriate race category in the non-Hispanic (70b) table. Similarly, if clients report their ethnicity as Hispanic, but do not report race, report them in the "Not reported" race category in the Hispanic (70a) table. Clients who report neither race nor ethnicity should be included in the "Not reported" race category and in the non-Hispanic (70b) table. Do not include any anonymous clients in these counts. All clients who identify with more than one race should be included in the "More than one race" category and in either the Hispanic (70a) or non-Hispanic (70b) table.

a. Hispanic clients

Report the number of unduplicated Hispanic clients by race.

> **Data Quality Check**
>
> The total number of Hispanic clients reported in Item 70a must be less than or equal to the number of Hispanic clients reported in each of the corresponding categories in Item 27a.
>
> If the box is checked, the number of Hispanic clients reported must be **EQUAL** to the number of Hispanic clients reported in each of the corresponding categories in Item 27a.

b. Non-Hispanic clients

Report the unduplicated number of non-Hispanic clients by race.

> **Data Quality Check**
> The total number of non-Hispanic clients reported in Item 70b must be less than or equal to the number of non-Hispanic clients reported in each of the corresponding categories in Item 27b.
>
> If the box is checked, the number of non-Hispanic clients reported must be **EQUAL** to the number of non-Hispanic clients reported in each of the corresponding categories in Item 27b.

71. Gender, HIV status, and age

Report the number of clients during the reporting period by gender, HIV status, and age.

> **Data Quality Check**
> The total number of clients reported in Item 71 must be equal to the total number of clients reported in Item 66. In addition, the total number of clients reported in each gender and age category in Item 71 must be equal to the number of clients reported in each of the corresponding categories in Items 68 and 69.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Items 25 and 26.

72. Race, ethnicity, HIV status, and age

This two part question requests the number of HIV-positive or indeterminate clients who received at least one Part D service during the reporting period by race, ethnicity, HIV status, and age. In Item 72a report the number of Hispanic clients and in 72b, report the non-Hispanic clients.

> **Data Quality Check**
> The total number of clients reported in Items 72a and 72b must be equal to the total number of clients reported in Item 66. In addition, the total number of clients reported in each race and age category in Items 72a and 72b must be equal to the number of clients reported in each of the corresponding categories in Items 69, 70a, and 70b.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of clients reported in each of the corresponding categories in Items 26, 27a and 27b.

73. Exposure category by age

Report the number of clients who are HIV-positive/indeterminate by exposure category and age.

> **Data Quality Check**
> The total number of clients reported in Item 73 must be equal to the total number of clients who are HIV+/indeterminate reported in Item 66. In addition, the total number of clients reported in each age category in Item 73 must be equal to the number of clients who are HIV+/indeterminate reported in Item 69.
>
> If the box is checked, the number of clients reported must be **EQUAL** to the number of HIV+/indeterminate clients reported in each of the corresponding categories in Item 26.

SECTION 7. HEALTH INSURANCE PROGRAM (HIP) INFORMATION

This section should be completed by the state agency and other entities that used Ryan White HIV/AIDS Program funds, except funds from ADAP, to pay for or supplement a client's health insurance. This section should not be completed by Ryan White HIV/AIDS Program grantees providing funding to another HIP, or by service providers that only provide vouchers for health insurance. **Data on health insurance programs funded through ADAP should be reported in the ADAP Quarterly Reports.**

A Health Insurance Program is a program authorized and primarily funded under Part A or Part B of the Ryan White HIV/AIDS Program that makes premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to maintain his/her health insurance coverage.

74. Total number of unduplicated clients

Report the total number of unique clients for whom the HIP made at least one premium payment, deductible payment, co-payment, or risk pool payment during the reporting period. Do not include any anonymous clients in this count. In an unduplicated client count, an individual receiving multiple services must be counted only once. *Client counts should be unduplicated across multiple provider sites. Unduplicated client count* is an accounting of clients in which a single individual is counted only once.

75. Total number of new clients

Report the number of unduplicated clients whose first receipt of HIP services occurred during the reporting period. Clients served anonymously should not be considered new clients and should not be reported in this item.

Data Quality Check
The total number of new clients reported in Item 75 must be less than or equal to the total number of clients reported in Item 74.

76. Gender of clients

Report the actual unduplicated numbers of male, female, and transgender clients and the number of clients for whom gender is unknown or unreported. Do not include any anonymous clients in these counts.

Data Quality Check
The total number of clients reported in Item 76 must be equal to the total number of clients reported in Item 74.

77. Age of clients

Report the actual number of unduplicated clients in each age group using client ages at the end of the reporting period. Do not include any anonymous clients in these counts.

Data Quality Check
The total number of clients reported in Item 77 must be equal to the total number of clients reported in Item 74.

78. Race and ethnicity

Report the actual number of unduplicated clients in each racial and ethnic group based on client self-report. All clients who identify with more than one race should be included in the "More than one race" category and in the Hispanic or non-Hispanic column. If clients report race, but not ethnicity, report them in the appropriate category in the non-Hispanic column. Clients who do not self-report race or ethnicity should be included in the "Not reported" race category and in the non-Hispanic column. Do not include any anonymous clients in these counts.

Data Quality Check
The total number of clients reported in Item 78 must be equal to the total number of clients reported in Item 74.

The following racial category descriptions, defined in October 1997, are required for all Federal reporting, as mandated by the Office of Management and Budget (For more information go to http://www.whitehouse.gov/omb/fedreg/1997standards.html).

Race and ethnicity categories:

American Indian or Alaska Native is an individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian is an individual having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American is an individual having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander is an individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White is an individual having origins in any of the original peoples of Europe, the Middle East, or North Africa.

More than one race is an individual who identifies with more than

Not reported is an individual who did not self-report either race or ethnicity.

Hispanic (or Latino) is an individual of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

79. Annual expenditures for HIP

Report specific HIP activities and expenditures in this section. For each service your program offers (e.g., premium payments) report the total cost of providing that service, the number of unduplicated clients receiving that service during the reporting period, and the total client-months for which the program provided that service.

Total client-months is a calculation obtained by adding together the number of months that either a premium, deductible, or co-pay was made for each unduplicated client (e.g. if an agency pays the premiums for Client A's insurance for 12 months and Client B's insurance for 8 months, the total client-months equals 20 months).

80. Total expenditures

Report the Total Health Insurance Expenditures from Item 79, plus any other administrative costs.

81. Annual HIP funding by Ryan White HIV/AIDS Program sources:

Enter the HIP funding expended from each of the listed sources. An EMA is an eligible metropolitan area. A TGA is a transitional grant area. See the EMA/TGA codes in the table on the next page.

> Item 82 is pre-populated in the online form. The sources of Part A funding listed are based on the associations reported by grantees during Provider List Verification.

82. Annual HIP funding by other sources

Enter the funding received from each of the listed sources.

All HIV/AIDS HIP funding received from other sources should be annualized to reflect the reporting period. See the method provided in the following example.

EMA/TGA) codes:

Anaheim/ Orange Co.	9923		Nashville	9959
Atlanta	9910		Nassau/Suffolk	9922
Austin/ Travis County	9935		New Haven/ Fairfield	9928
Baltimore	9918		New Orleans	9919
Baton Rouge	9955		New York	9901
Boston	9914		Newark	9904
Caguas, PR	9936		Norfolk	9953
Charlotte	9956		Oakland	9917
Chicago	9909		Orlando	9929
Cleveland/ Lorain	9943		Passaic/Bergen	9932
Dallas	9913		Philadelphia	9911
Denver	9926		Phoenix	9930
Detroit	9924		Ponce, PR	9925
Dutchess County	9937		Portland	9939
Fort Lauderdale	9912		Riverside/ San Bernardino	9931
Ft. Worth/ Arlington	9944		Sacramento	9948
Hartford	9945		San Antonio	9940
Houston	9906		San Diego	9915
Indianapolis	9957		San Francisco	9902
Jacksonville	9938		San Jose	9949
Jersey City	9916		San Juan	9908
Kansas City	9927		Santa Rosa/ Petaluma	9941
Las Vegas	9954		Seattle	9920
Los Angeles	9903		St. Louis	9933
Memphis	9958		Tampa/ Saint Petersburg	9921
Miami	9905		Vineland/Millville	9942
Middlesex/ Somerset	9946		Washington D.C.	9907
Minneapolis/ St. Paul	9947		West Palm Beach	9934

GLOSSARY OF RYAN WHITE DATA REPORT TERMS

Active client continuing in program	An individual who was a client when the period started and continued in the program.
Active client new to the program	A client whose first point of contact with the program occurred during this reporting period.
ADAP	*AIDS Drug Assistance Program*—A State-administered program authorized under Part B of the Ryan White HIV/AIDS Program that provides FDA-approved medications to low-income individuals with HIV/AIDS disease who have limited or no coverage from private insurance, Medicaid, or Medicare.
ADAP Flexibility Policy	HIV/AIDS Bureau's (HAB) Policy Notice 00-02 provides grantees greater flexibility in the use of ADAP funds and permits expenditures of ADAP funds for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications. **NOTE:** Grantees *must* request in writing to use ADAP dollars for services other than medications.
Administrative or technical support	The provision of qualitative and responsive "support services" to an organization. Services may include human resources, financial management and administrative services (e.g., property management, warehousing, printing/publications, libraries, claims, medical supplies, and conference/training facilities).
Affected client	A family member or partner of an infected client who receives at least one Ryan White HIV/AIDS Program support service during the reporting period.
Agency reporting for multiple fee-for-service provider	An agency that reports data for more than one fee-for-service provider.
Aggregate data	Combined data, composed of multiple elements, often from multiple sources. For example, combining demographic data about clients from all primary care providers in a service area generates aggregate data about client characteristics.
AIDS	*Acquired immune deficiency syndrome—*A disease caused by the human immunodeficiency virus.
American Indian or Alaska Native	An individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
Anonymous individual	No identifying information is collected from the individual.
APA	*AIDS Pharmaceutical Assistance*—A local pharmacy assistance program implemented by a Part A EMA/TGA), a Part B State, or a Part C agency. The Part B grantee consortium or Part A planning council contracts with one or more organizations to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., primary care, case management) to the clients that they serve through a Ryan White (or other funding sources) contract with their grantee.
ARV	*Antiretroviral*—A substance that fights against a retrovirus, such as HIV. (See **retrovirus**)
Asian	An individual having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American	An individual having origins in any of the black racial groups of Africa.
Capacity development	A set of core competencies that contribute to an organization's ability to develop effective HIV health care services, including the quality, quantity, and cost effectiveness of such services. These competencies also sustain the infrastructure and resource base necessary to develop and support these services. Core competencies include: management of program finances; effective HIV service delivery, including quality assurance; personnel management and board development; resource development, including preparation of grant applications to obtain resources and purchase of supplies/equipment; service evaluation; and cultural competency development.
Case management services (medical)	(See **medical case management services**)
Case management services (non-medical)	Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.
CD4 cell count	The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal range for CD4 cell counts is 500 to 1,500 per cubic millimeter of blood. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm^3. If the count is lower, testing every 3 months is advised. A CD4 count of 200 or less indicates AIDS.
CD4 or CD4+ cells	Also known as "helper" T-cells, these cells are responsible for coordinating much of the immune response. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections.
CDC	*Centers for Disease Control and Prevention*—The DHHS agency that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process, among other programs. The CDC is responsible for monitoring and reporting infectious diseases, administers AIDS surveillance grants, and publishes epidemiologic reports such as the HIV/AIDS Surveillance Report.
CEO	*Chief Elected Official*—The official recipient of Part A Ryan White HIV/AIDS Program funds within the EMA/TGA), usually a city mayor, county executive, or chair of the county board of supervisors. The CEO is ultimately responsible for administering all aspects of the Ryan White HIV/AIDS Program in the EMA/TGA and ensuring that all legal requirements are met. In EMAs/TGAs with more than one political jurisdiction, the recipient of Part A Ryan White HIV/AIDS Program funds is the CEO of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of people with AIDS in the EMA/TGA.
Child care services	The provision of care for the children of clients who are HIV-positive while the clients are attending medical or other appointments or attending Ryan White HIV/AIDS Program-related meetings, groups, or training. This does not include child care while the client is at work.
Client	(See **infected client** or **affected client**)
Co-morbidity	A disease or condition, such as mental illness or substance abuse, co-existing with HIV/AIDS.
Combination therapy	Two or more drugs or treatments used together to achieve optimum results against HIV/AIDS. For more information on treatment guidelines, visit http://www.aidsinfo.nih.gov/guidelines.
Confidential	Information such as name, gender, age, etc., that is collected on the client, and the client is reassured that no identifying information will be shared or passed on to anyone.

Consortium/HIV Care Consortium	An association of one or more public, and one or more nonprofit private, health care, and support service providers, people with HIV/AIDS, and community-based organizations operating within areas determined by the State to be most affected by HIV disease. The consortium agrees to use Part B grant assistance to plan, develop, and deliver (directly or through agreement with others) comprehensive outpatient health and support services for individuals with HIV disease. Agencies comprising the consortium are required to have a record of service to populations and sub-populations with HIV/AIDS.
Continuum of care	An approach that helps communities plan for, and provide, a full range of emergency and long-term service resources to address the various needs of PLWHA.
Core Services	A set of essential, direct health care services provided to persons with HIV/AIDS and specified in the Ryan White HIV/AIDS Treatment Modernization Act. Under the new law, grantees receiving funds under Parts A, B, and C must spend at least 75 percent of funds on "core medical services."
DCBP	*Division of Community-Based Programs—*The division within HRSA's HIV/AIDS Bureau that is responsible for administering Part C, Part D, and the HIV/AIDS Dental Reimbursement Program.
Dispensing of pharmaceuticals	The provision of prescription drugs to prolong life or prevent deterioration of health.
DSP	*Division of Science and Policy—*The division within HRSA's HIV/AIDS Bureau that serves as the principal source of program data collection and evaluation, the development of innovative models of HIV care, and the focal point for coordination of program performance activities and development of policy guidance.
DSS	*Division of Service Systems—*The division within HRSA's HIV/AIDS Bureau that is responsible for administering Part A and Part B including the AIDS Drug Assistance Program (ADAP).
DTTA	*Division of Training and Technical Assistance—*The division within HRSA's HIV/AIDS Bureau that is responsible for administering the AIDS Education and Training Centers (AETC) Program and technical assistance and training activities of the HIV/AIDS Bureau.
Dual therapy	The use of two antiretroviral drugs at one time to reduce the amount of detectable HIV.
Early intervention	(See **HIV/EIS**—*HIV/Early Intervention Services/Primary Care)*
EIS for Parts A and B	*Early intervention services for Parts A and B* include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
Eligibility criteria	The standards set by a State ADAP, usually through an advisory committee, to determine who receives access to ADAP services. Financial eligibility is usually determined as a percentage of the Federal Poverty Level (FPL), such as 200% FPL. Medical eligibility is most often a positive HIV diagnosis. Eligibility criteria vary among ADAPs.
EMA/TGA)	*Eligible Metropolitan Area/Transitional Grant Area—*The geographic area eligible to receive Part A Ryan White HIV/AIDS Program funds. The boundaries of the eligible metropolitan area/transitional grant area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the CDC. Some EMAs include just one city and others are composed of several cities and/or counties. Some EMAs extend across more than one State.

Emergency financial assistance	The provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. Part A and Part B programs must be allocated and tracked, and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02).
Epidemic	A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.
Exposure category	(See **risk factor**)
Faith-based organization	An organization that is owned and operated by a religiously affiliated entity, such as a Catholic hospital.
Family centered	A model in which systems of care under Ryan White Part D are designed to address the needs of PLWHA and affected family members as a unit, by providing or arranging for a full range of services. The family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated caregivers.
Family members	Includes children, partners, biological parents, adoptive parents, foster parents, grandparents, other caregivers, and siblings (who may or may not be living with HIV).
Fiscal intermediary services	Reimbursements received or collected on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts.
Food bank/home-delivered meals	The provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.
FTE	*Full-time equivalent*—A standard measurement of full-time staff (either paid or volunteer), which is based on a 35 to 40 hour work week. It is calculated by taking the sum of all hours worked by staff and dividing by 35 to 40, depending on how your organization defines full-time employment. For example, 2 staff members who work 20 hours each per week represent 1 FTE, assuming full-time employment is defined as 40 hours per week.
Grantee of record	The official Ryan White HIV/AIDS Program grantee that receives Federal funding directly from the Federal government (HRSA). A grantee may also be a provider if it provides direct services in addition to administering its grant.
HAART	*Highly active antiretroviral therapy—*An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels.
HAB	*HIV/AIDS Bureau—* The Bureau within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS) that is responsible for administering the Ryan White HIV/AIDS Program. Within HAB, the Division of Service Systems administers Part A, Part B, and the AIDS Drug Assistance Program (ADAP); the Division of Community-Based Programs administers Part C, Part D, and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Centers (AETC) Program. The Bureau's Division of Science and Policy administers the SPNS Program, HIV/AIDS evaluation studies, and the Ryan White HIV/AIDS Program Data Report.
Health education/risk reduction	The provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling, to help clients with HIV improve their health status.

Health insurance premium & cost sharing assistance	The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Hemophilia/ coagulation disorder	Individuals with delayed clotting of the blood.
Heterosexual contact	Individuals who report specific heterosexual contact with an individual with, or at increased risk for, HIV infection (e.g., an injection drug user).
High-risk insurance pool	A State health insurance program that provides coverage for individuals who are denied coverage due to a pre-existing condition or who have health conditions that would normally prevent them from purchasing coverage in the private market.
HIP	*Health Insurance Program*—a program of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Hispanic or Latino/a	According to the OMB, the term Hispanic or Latino refers to persons who trace their origin or descent to Mexico, Puerto Rican, Cuban, Central and South American, or other Spanish cultures regardless of race.
HIV counseling and testing	The delivery of HIV counseling and testing may include antibody tests administered by health professionals to ascertain and confirm the presence of HIV infection (including rapid tests, ELISA, and Western Blot). HIV counseling—both pre and post testing—may include discussions of the benefits of testing, including the medical benefits of diagnosing HIV disease in the early stages and of receiving early intervention primary care; the provisions of laws relating to confidentiality, including information regarding any disclosures that may be authorized under applicable law; the availability of anonymous counseling and testing; and the significance of the results, including the potential for developing HIV disease. Counseling and testing *does not* include tests to measure the extent of the deficiency in the immune system because these tests are fundamental components of comprehensive primary care. This service category also excludes mental health counseling/therapy, substance abuse counseling/treatment, and psychosocial support services. These services are listed separately.
HIV disease	Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.
HIV/AIDS status	The outcome of the client's HIV test result, which includes (1) HIV-positive not AIDS—client has tested positive for and been diagnosed with HIV, but has not advanced to AIDS; (2) HIV-positive AIDS status unknown—client has tested positive for and been diagnosed with HIV, but it is unknown whether or not the client has advanced to AIDS; (3) CDC-defined AIDS—client has advanced to and been diagnosed with CDC-defined AIDS; (4) HIV-negative (affected)—client is HIV-negative and is an affected individual of an HIV-positive partner or family member; and (5) unknown—HIV/AIDS status of the client is unknown and not documented.
HIV/EIS	*HIV/Early Intervention Services/Primary Care*—A program that encompasses the care supported by the Part C and Part D legislation and is made available by the grantee organization and its subcontractors. Subcontractors render care to clients referred to them by the grantee organization, and are reimbursed for their services, or otherwise have a remunerative relationship with the grantee for the referred service. **NOTE:** Early Intervention Services provided by Ryan White Part C and Part D programs should be included under Item 33a, *Outpatient/ambulatory medical care*.

Home and community-based health services	Includes skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.
Home health care	The provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.
Hospice services	Includes room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.
Hospital or university-based clinic	Includes outpatient/ambulatory care/outpatient medical care departments or clinics, emergency rooms, rehabilitation facilities (physical, occupational, speech), hospice programs, substance abuse treatment programs, STD clinics, AIDS clinics, and inpatient case management service programs.
Household	All people who occupy a house, an apartment, a mobile home, a group of rooms, or a single room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of unrelated people who share living arrangements.
Household income	The sum of money received in the previous calendar year by all household members 15 years old and over, including household members not related to the householder, people living alone, and others in non-family households.
Housing services	The provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.
HRSA	*Health Resources and Services Administration*—The U.S. Department of Health and Human Services (DHHS) agency that is responsible for directing national health programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA is also responsible for administering the Ryan White HIV/AIDS Program.
IDU	*Injection drug user*—Individuals who report use of drugs intravenously or through skin-popping.
Inactive client	A client whose status is inactive (as defined by an agency), which includes many possible reasons (e.g., client moved or is lost to follow-up).
Indeterminate client	A child under the age of 2 whose HIV status is not yet determined, but was born to an HIV-infected mother.
Infected client	An individual who is HIV-positive who receives at least one Ryan White HIV/AIDS Program-eligible service during the reporting period.
Inpatient setting	This includes hospitals, emergency rooms and departments, and residential facilities where clients typically receive food and lodging as well as treatments.

Institution	This includes residential, health care, and correctional facilities. Residential facility includes supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses.
Legal services	The provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.
Linguistics services	The provision of interpretation and translation services.
Local county or State health department	Publicly funded health department administered by a local, county, or State government.
LTBI	Latent Treatment of Mycobacterium tuberculosis infection (LTBI) prevents the development of active disease and has been an essential component of tuberculosis (TB) control in the United States for several decades.
MAI	*Minority AIDS Initiative—*A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. This initiative was enacted to address the disproportionate impact of the disease in such communities. It was formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.
Medicaid	A jointly funded, Federal-State health insurance program for certain low-income and needy people.
Medical case management services (including treatment adherence)	A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Medical nutrition therapy	Provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.
Medical transportation services	Conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.
Medicare	A health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Mental health services	Psychological and psychiatric treatment and counseling services, for individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
Monotherapy	The use of only one antiretroviral drug to reduce the amount of detectable HIV.
More than one race	An individual who identifies with more than one racial category.
Mother with/at risk for HIV infection (perinatal transmission)	Transmission of disease from mother to child during pregnancy.
MSM	*Men who have sex with men*—Men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).
Native Hawaiian or Other Pacific Islander	An individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
New clients	Individuals who received services from a provider for the first time ever during this reporting period. Individuals who returned for care after an extended absence are not considered to be new unless past records of their care are not available.
Non-permanent	Includes individuals who are homeless, as well as transient or in transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for sleeping. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program.
OI	*Opportunistic infection*—An infection or cancer that occurs in individuals with weak immune systems due to AIDS, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus are all examples of opportunistic infections.
OMB	*Office of Management and Budget*—The office within the executive branch of the Federal Government, which prepares the President's annual budget, develops the Federal Government's fiscal program, oversees administration of the budget, and reviews Government regulations.
Oral health care	Includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Other community-based service organization	Includes non-hospital-based organizations, AIDS service and volunteer organizations, private non-profit social service and mental health organizations, hospice programs (home and residential), home health care agencies, rehabilitation programs, substance abuse treatment programs, case management agencies, and mental health care providers.
Outpatient setting	A hospital, clinic, medical office, or other place where clients receive health care services, but do not stay overnight.

Outpatient/ ambulatory medical care	Includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **NOTE:** Early Intervention Services provided by Ryan White Part C and Part D Programs should be reportedunder *Outpatient/ambulatory medical care*.
Outreach services	Programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status (i.e., case finding), so that they may become aware of, and may be enrolled in care and treatment services. Outreach services do not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.
Outside the EIS program	A referral made to a provider that (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Part C grantee or its parent organization.
Part A	The part of the Ryan White HIV/AIDS Program that provides direct financial assistance to designated EMAs/TGAs that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related core medical and support services to people living with HIV/AIDS and their affected partners and family members.
Part B	The part of the Ryan White HIV/AIDS Program that authorizes the distribution of Federal funds to States and Territories to improve the quality, availability, and delivery of core medical and support services for individuals living with HIV/AIDS and their affected partners and family members. The Ryan White HIV/AIDS Program emphasizes that such care and support is part of a coordinated continuum of care designed to improve medical outcomes.
Part C	The part of the Ryan White HIV/AIDS Program that provides support for early intervention services, including preventive, diagnostic, and therapeutic services for people living with HIV/AIDS and their affected partners and family members. This support includes a comprehensive continuum of outpatient HIV primary care services including: HIV counseling, testing, and referral; medical evaluation and clinical care; other primary care services; and referrals to other health services.
Part D	The part of the Ryan White HIV/AIDS Program that supports coordinated family-centered outpatient care for women, infants, children, and youth with HIV/AIDS and their affected partners and family members. The Adolescent Initiative is a separate grant under the Part D program that is aimed at identifying adolescents who are HIV-positive and enrolling and retaining them in care.

Partner Notification	A service provided by a clinician in your program to notify the partner of a client of possible exposure to HIV. (Check State and local laws for specific requirements.) It is not the number of individuals who tested positive for HIV antibodies and offered partners' names for notification, nor is it the number of individuals who came to your program because of a referral by a partner notification service.
Pediatric developmental assessment and early intervention services	The provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or a child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category. NOTE: Only Part D programs are eligible to provide Pediatric developmental assessement and early intervention services.
Permanency planning	The provision of services to help clients/families make decisions about the placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
Permanent housing	Includes apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited.
PHSA	*Public Health Service Act.*
Planning or evaluation	The systematic collection of information about the characteristics, activities, and outcomes of services or programs to assess the extent to which objectives have been achieved, needed improvements have been identified, and/or decisions about future programming have been made.
PLWHA coalition	*People living with HIV/AIDS coalition—*Organizations of people living with HIV/AIDS that provide support services to individuals and families infected with and/or affected by HIV and AIDS.
Primary health care service	Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client who is HIV-positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, medical case management, and pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; and counseling and testing.
Private health insurance	Health insurance plans such as Blue Cross/Shield, Kaiser Permanente, Aetna, etc.
Private, for-profit ownership	The organization is owned and operated by a private entity, even though the organization may receive government funding. A privately owned hospital is an example of a private, for-profit organization.
Private, nonprofit (not faith-based)	The organization is owned and operated by a private, not-for-profit, non-religious-based entity, such as a non-profit health clinic.
Prophylaxis	Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has been brought under control (secondary prophylaxis).
Provider agency/ service provider	The agency that provides direct services to clients (and their families) A provider agency may receive funds as a grantee (such as under Parts C and D) or through a contractual relationship with a grantee funded directly by the HRSA's Ryan White HIV/AIDS Program.

Psychosocial support services	The provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.
Public/Federal ownership	The organization is funded and operated by the Federal Government. An example is a Federal agency.
Public/local ownership	The organization is funded and operated by a local government entity. An example is a city health department.
Public/State ownership	The organization is funded and operated by a State government entity. An example is a State health department.
Publicly funded community health center	Includes community health centers, migrant health centers, rural health centers, and homeless health care centers.
Publicly funded community mental health center	A community-based agency, funded by local, state, or Federal funds, that provides mental health services to low income people.
Quality management	A systematic process with identified leadership, accountability, and dedicated resources that uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs should also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change. The process is continuous and should fit within the framework of other program quality assurance and quality improvement activities, such as JCAHO and Medicaid Data collected as part of this process should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized.
Referral for health care/supportive services	The act of directing a client to a service in person or through telephone, written, or other type of communication. **NOTE:** Referrals for health care/supportive services that were not part of ambulatory/outpatient or case management services (medical or non-medical) should be reported under Item 33z. Referrals for health care/supportive services provided by outpatient/ambulatory medical care providers should be included under Item 33a, Outpatient/ambulatory medical care. Referrals for health care/supportive services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category, Item 33k Medical Case Management or Item 33m Case management (nonn-medical).
Rehabilitation services	Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.
Reporting period	A calendar year, January 1 through December 31 of the reporting year. The reporting period may be shorter than a year if a provider agency did not receive Ryan White HIV/AIDS Program funding for an entire calendar year.

Reporting scope	Scope 01 is the reporting scope for providers reporting ELIGIBLE services. Under the ELIGIBLE reporting scope, clients receiving any service eligible for Ryan White Parts A, B, C, D, and F (MAI) funding are included in the report even if the service was not paid for with Ryan White Parts A, B, C, D, and F (MAI) funds. This reporting scope is preferred by HRSA.
	Scope 02 is the reporting scope for providers reporting FUNDED clients. Under the FUNDED scope, only clients receiving services paid for exclusively with Ryan White A, B, C, D, and F (MAI) funds are included in the report. Typically, this is a subset of the eligible reporting scope. Providers using the funded-only reporting scope must have an adequate mechanism for tracking clients and services by funding stream and have secured prior approval from their grantee in consultation with HRSA.
Respite care	The provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.
Retrovirus	A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.
Risk factor or risk behavior/exposure category	Behavior or other factor that places an individual at risk for disease. For HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work.
Ryan White HIV/AIDS Program	*The Ryan White HIV/AIDS Treatment Modernization Act of 2006*—The Federal legislation created to address the health care and service needs of people living with HIV/AIDS (PLWHA) disease and their families in the United States and its Territories. The newly enacted law changes how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS.
Section 330 of PHSA	Supports the development and operation of community health centers that provide preventive and primary health care services, supplemental health and support services, and environmental health services to medically underserved areas/populations.
Self-pay	A client pays out of pocket for the majority of his or her health care costs.
Solo/group private medical practice	Includes all health and health-related private non-profit practitioners and practice groups.
SPNS	*Special Projects of National Significance*—A health services demonstration, research, and evaluation program funded under Part F of the Ryan White HIV/AIDS Program. SPNS projects are awarded competitively.
STI	*Sexually transmitted infection*—Infections spread by the transfer of organisms from person to person during sexual contact.
Substance abuse services–residential	The provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term). **NOTE**: Part C programs are not eligible to provide Substance abuse services–residential.
Substance abuse services–outpatient	The provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Substance abuse treatment center	An agency that focuses on the delivery of substance abuse treatment services.
Target population	A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

Taxpayer ID #	The unique nine-digit number issued to an organization or agency by the Internal Revenue Service for use in connection with filing requirements. This may be the same as your Employer Identification Number (EIN).
TB blood test (QuantiFERON-TB® Gold)	A blood test used to detect latent infection with TB bacteria. The QFT-G measures the response to TB proteins when they are mixed with a small amount of blood.
TB skin test (PPD Mantoux)	The abbreviation for purified protein derivative (PPD), a substance used in intradermal testing for tuberculosis.
Technical assistance or TA	The identification of need for and delivery of practical program and technical support to the Ryan White HIV/AIDS Program community. TA should assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating Ryan White HIV/AIDS Program supported planning and primary care service delivery systems.
Total client-months	A calculation obtained by adding together the number of months that a premium, deductible, or co-pay was made for each unduplicated client. (e.g., If an agency pays the premiums for Client A's insurance for 12 months and Client B's insurance for 8 months, the total client-months equals 20 months.)
Transgender	An individual who exhibits the appearance and behavioral characteristics of the opposite sex.
Transmission category	A grouping of disease exposure and infection routes. In relation to HIV disease, exposure groupings include injection drug use, men who have sex with men, heterosexual contact, perinatal transmission, etc.
Treatment adherence counseling	Provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.
Unduplicated client count	An accounting of clients in which a single individual is counted only once. For providers with multiple sites, a client is only counted once, even if he or she receives services at more than one of the providers' sites.
URN	*Unique record number—A* nine-digit encrypted record number following HRSA's URN specifications that distinguishes the client from all other clients and that is the same for the client across all provider settings. The URN is constructed using the first letter of the first name, the third letter of the first name (if blank use middle initial, if no middle initial use '9'), first letter of the last name, third letter of the last name (if blank, use '9'), month of birth, day of birth, and gender code. This string is then encrypted using a HRSA-supplied algorithm that can be incorporated into the provider's data collection system.
VA facility	Any facility funded through the Veterans Administration.
Viral load test	A test that measures the quantity of HIV RNA in the blood. Results are expressed as the number of copies per milliliter of blood plasma. This test is employed as a predictor of disease progression.
White	An individual having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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