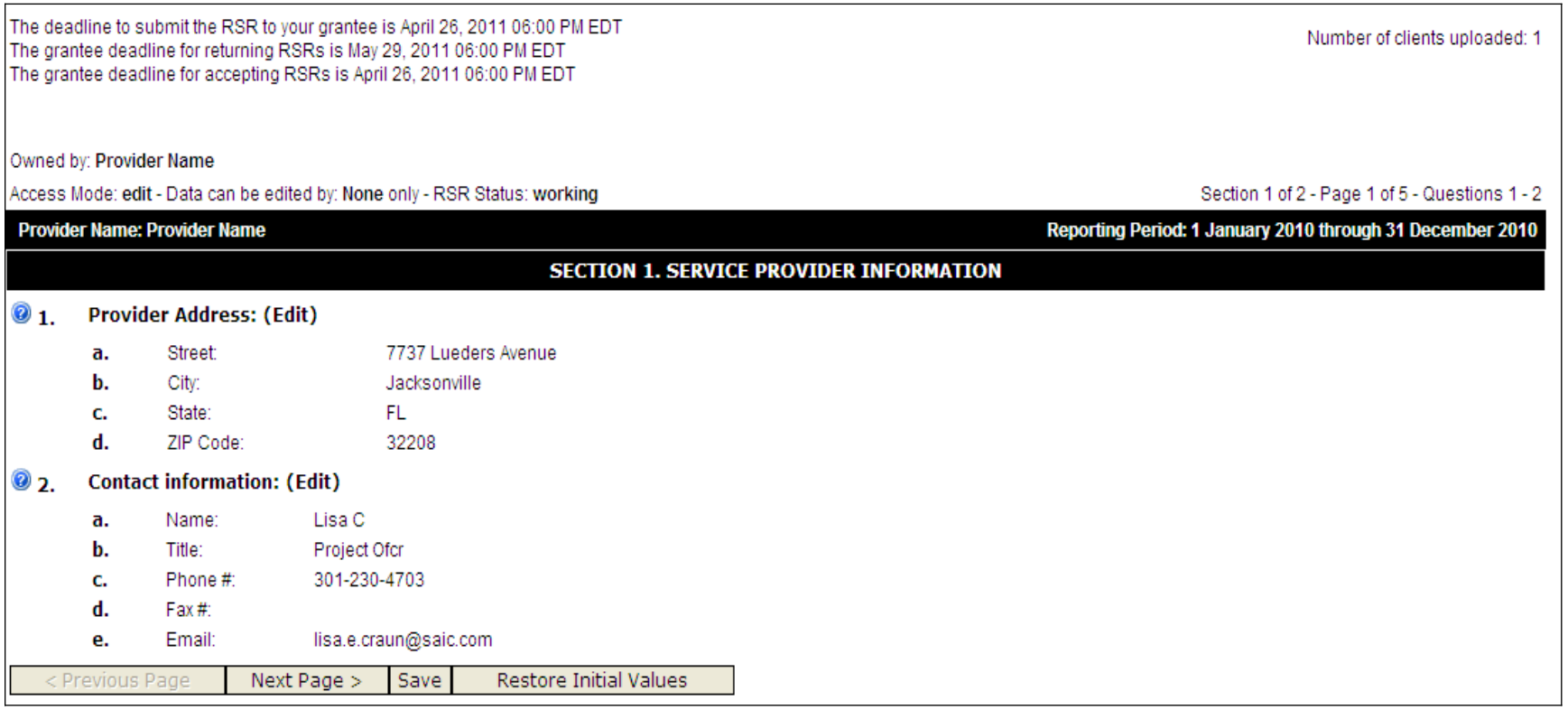
Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program Client-Level Data Report

PROVIDER FORM



The deadline to submit the RSR to your grantee is April 26, 2011 06:00 PM EDT
The grantee deadline for returning RSRs is May 29, 2011 06:00 PM EDT
The grantee deadline for accepting RSRs is April 26, 2011 06:00 PM EDT

Number of clients uploaded: 1

Owned by: **Provider Name**

Access Mode: **edit** - Data can be edited by: **None** only - RSR Status: **working**

Section 1 of 2 - Page 1 of 5 - Questions 1 - 2

Provider Name: Provider Name | **Reporting Period: 1 January 2010 through 31 December 2010**

SECTION 1. SERVICE PROVIDER INFORMATION

1. Provider Address: (Edit)

a.	Street:	7737 Lueders Avenue
b.	City:	Jacksonville
c.	State:	FL
d.	ZIP Code:	32208

2. Contact information: (Edit)

a.	Name:	Lisa C
b.	Title:	Project Ofcr
c.	Phone #:	301-230-4703
d.	Fax #:	
e.	Email:	lisa.e.craun@saic.com

< Previous Page | Next Page > | Save | Restore Initial Values

Items 1 – 2: If the information in Item 1 or Item 2 is incorrect, it must be corrected. Providers may edit the information by selecting the "edit" link next to the Item.

Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program Client-Level Data Report

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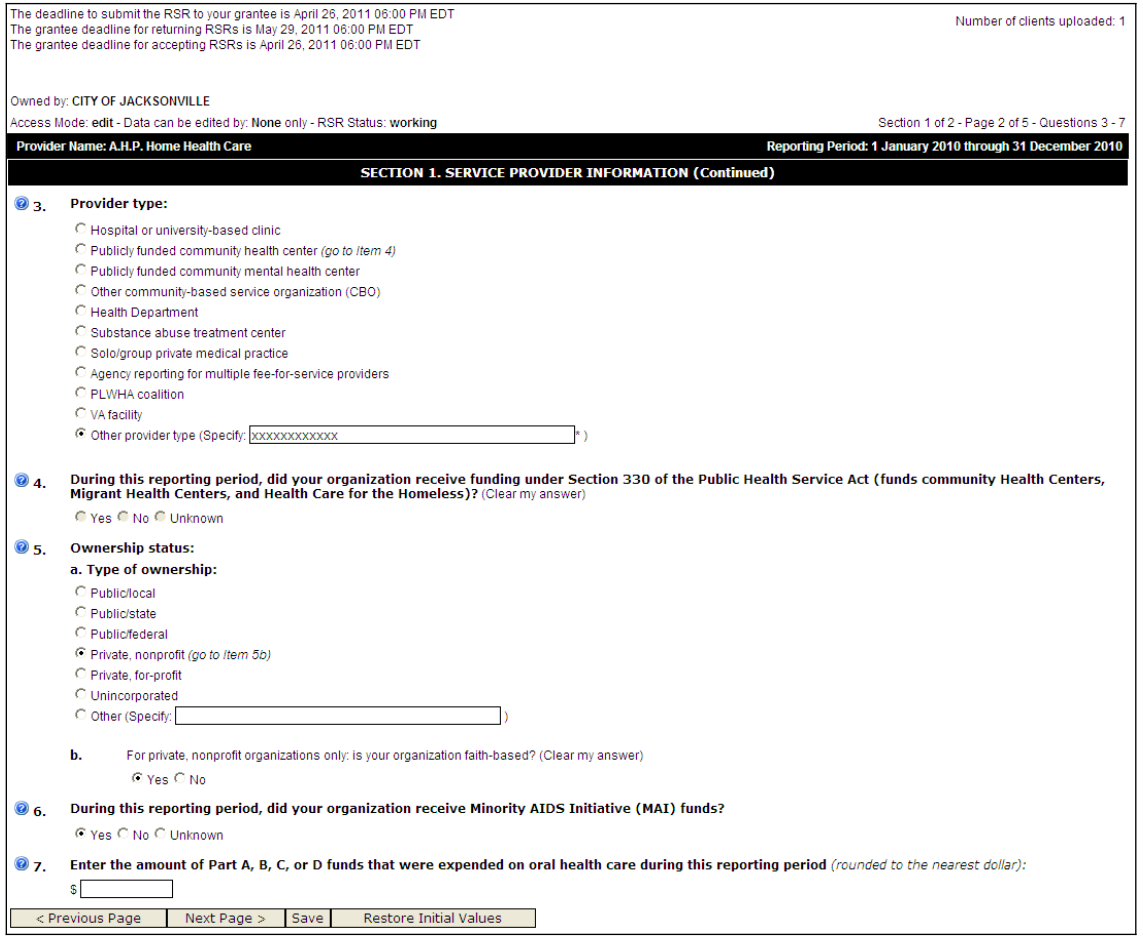

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Section 1 of 2 - Page 2 of 5 - Questions 3 - 7

Provider Name: A.H.P. Home Health Care — **Reporting Period: 1 January 2010 through 31 December 2010**

SECTION 1. SERVICE PROVIDER INFORMATION (Continued)

3. Provider type:

- ○ Hospital or university-based clinic
- ○ Publicly funded community health center *(go to Item 4)*
- ○ Publicly funded community mental health center
- ○ Other community-based service organization (CBO)
- ○ Health Department
- ○ Substance abuse treatment center
- ○ Solo/group private medical practice
- ○ Agency reporting for multiple fee-for-service providers
- ○ PLWHA coalition
- ○ VA facility
- ◉ Other provider type (Specify: xxxxxxxxxxx *)

4. During this reporting period, did your organization receive funding under Section 330 of the Public Health Service Act (funds community Health Centers, Migrant Health Centers, and Health Care for the Homeless)? (Clear my answer)

○ Yes ○ No ○ Unknown

5. Ownership status:

a. Type of ownership:

- ○ Public/local
- ○ Public/state
- ○ Public/federal
- ◉ Private, nonprofit *(go to Item 5b)*
- ○ Private, for-profit
- ○ Unincorporated
- ○ Other (Specify:)

b. For private, nonprofit organizations only: is your organization faith-based? (Clear my answer)

◉ Yes ○ No

6. During this reporting period, did your organization receive Minority AIDS Initiative (MAI) funds?

◉ Yes ○ No ○ Unknown

7. Enter the amount of Part A, B, C, or D funds that were expended on oral health care during this reporting period *(rounded to the nearest dollar):*

$

< Previous Page | Next Page > | Save | Restore Initial Values

Item 3: Select the provider type that best describes the organization. After the initial submission, this item will be pre-populated in subsequent data reports.

Item 4: Indicate if your organization received funding under Section 330 of the Public Health Service Act during the given reporting period.

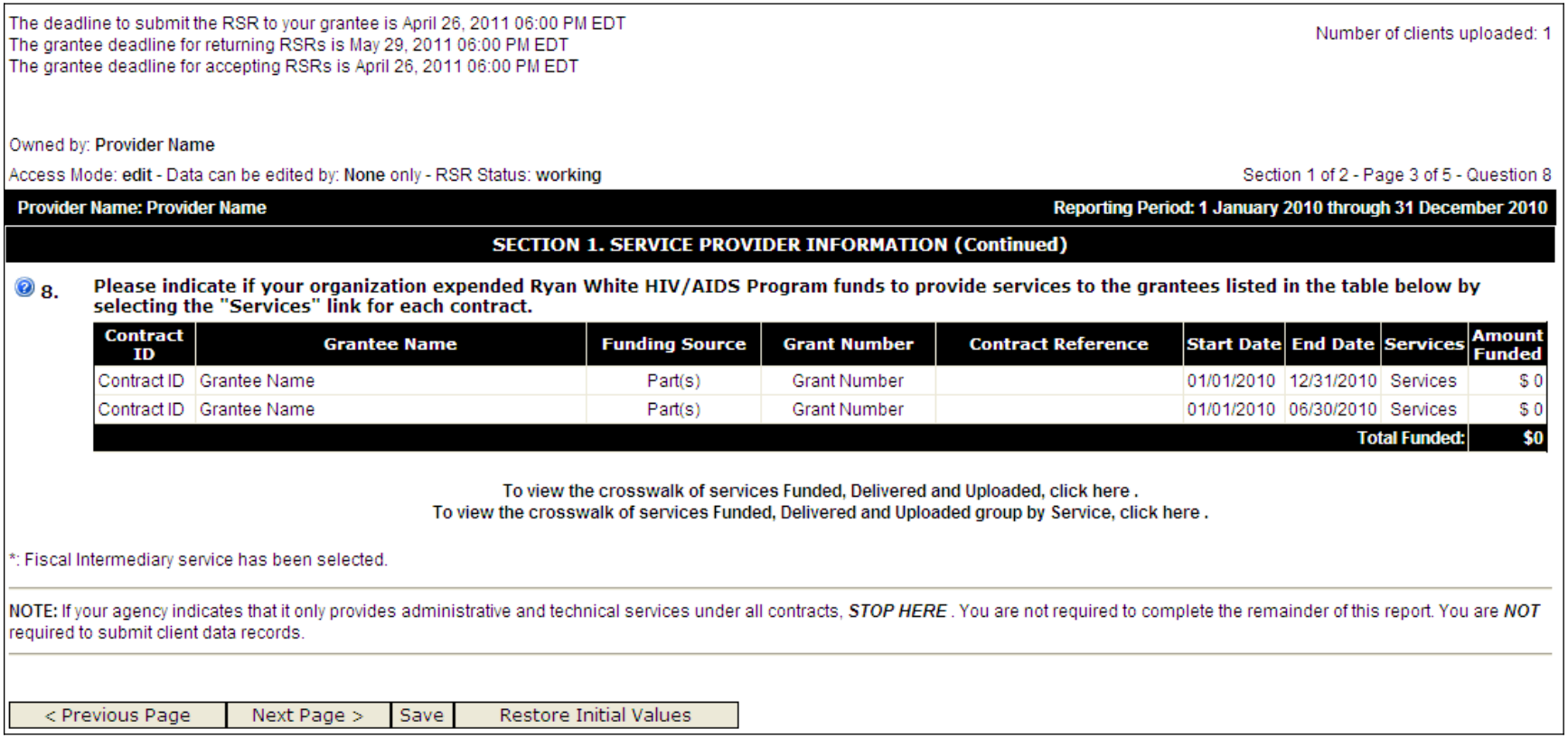
Item 5: Select the category that best describes your organization's ownership status. If "Private, nonprofit" is selected, you must answer Item b. After the initial submission, this item will be pre-populated in subsequent data reports.

Item 6: Indicate if your organization received Minority AIDS Initiative (MAI) funds during the given reporting period.

Item 7: Enter the amount of Ryan White Program funds expended on oral health care during the given reporting period

Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program Client-Level Data Report

PROVIDER FORM



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Number of clients uploaded: 1

Owned by: **Provider Name**

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Section 1 of 2 - Page 3 of 5 - Question 8

Provider Name: Provider Name — **Reporting Period: 1 January 2010 through 31 December 2010**

SECTION 1. SERVICE PROVIDER INFORMATION (Continued)

8. **Please indicate if your organization expended Ryan White HIV/AIDS Program funds to provide services to the grantees listed in the table below by selecting the "Services" link for each contract.**

Contract ID	Grantee Name	Funding Source	Grant Number	Contract Reference	Start Date	End Date	Services	Amount Funded
Contract ID	Grantee Name	Part(s)	Grant Number		01/01/2010	12/31/2010	Services	$ 0
Contract ID	Grantee Name	Part(s)	Grant Number		01/01/2010	06/30/2010	Services	$ 0
							Total Funded:	**$0**

To view the crosswalk of services Funded, Delivered and Uploaded, click here .
To view the crosswalk of services Funded, Delivered and Uploaded group by Service, click here .

*: Fiscal Intermediary service has been selected.

NOTE: If your agency indicates that it only provides administrative and technical services under all contracts, ***STOP HERE*** . You are not required to complete the remainder of this report. You are ***NOT*** required to submit client data records.

< Previous Page | Next Page > | Save | Restore Initial Values

Item 8: Grantee/contract information: This list of contracts is populated with information provided by Ryan White HIV/AIDS Program grantees. The contract reference, if specified, will help you report the data associated with a particular contract. (**Note**: For the purposes of the Ryan White Data Report, "contracts" include formal contracts, memorandum of understanding, and other agreements.)
Services: This link opens another screen (see page 3).

Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program Client-Level Data Report

PROVIDER FORM

Grantee: Grantee Name
Provider: Provider Name
Contract ID: Contract ID

Funding Source: Part
Grant #: Grant Number
Contract Reference: Contract Reference

ADMINISTRATIVE SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
☐	☐	Planning or evaluation
☐	☐	Administrative or technical support
☐	☐	Fiscal intermediary support
☐	☐	Other fiscal services
☐	☐	Technical assistance
☐	☐	Capacity development
☐	☐	Quality management

CORE MEDICAL SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
☐	☐	Outpatient/ambulatory medical care
☐	☐	Local AIDS Pharmaceutical Assistance
☐	☐	Oral health care
☐	☐	Early intervention services (Parts A and B)
☐	☐	Health Insurance Premium & Cost Sharing Assistance
☑	☑	Home health care
☐	☐	Home and community-based health services
☐	☐	Hospice services
☐	☐	Mental health services
☐	☐	Medical nutrition therapy
☐	☐	Medical case management (including treatment adherence)
☐	☐	Substance abuse services-outpatient

SUPPORT SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
☐	☐	Case management (non-medical)
☐	☐	Child care services
☐	☐	Pediatric development assessment/early intervention services
☐	☐	Emergency financial assistance
☐	☐	Food bank/home-delivered meals
☐	☐	Health education/risk reduction
☐	☐	Housing services
☐	☐	Legal services
☐	☐	Linguistics services
☐	☐	Medical transportation services
☐	☐	Outreach services
☐	☐	Permanency planning
☐	☐	Psychosocial support services
☐	☐	Referral for health care/supportive services
☐	☐	Rehabilitation services
☐	☐	Respite care
☐	☐	Substance abuse services-residential
☐	☐	Treatment adherence counseling

HIV COUNSELING AND TESTING SERVICES

Check the box if this agency was funded to provide HIV Counseling and Testing services under this agreement.

Funded	Delivered	Service
☐	☐	HIV Counseling and Testing

- Select the services delivered under each agreement during the given reporting period.

Please see the following pages (pgs. 5-6) for magnified views of each service section.

Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program Client-Level Data Report

PROVIDER FORM

Grantee: Grantee Name
Provider: Provider Name
Contract ID: Contract ID

Funding Source: Part
Grant #: Grant Number
Contract Reference: Contract Reference

ADMINISTRATIVE SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
☐	☐	Planning or evaluation
☐	☐	Administrative or technical support
☐	☐	Fiscal intermediary support
☐	☐	Other fiscal services
☐	☐	Technical assistance
☐	☐	Capacity development
☐	☐	Quality management

- Please select the administrative services delivered under this agreement during the given reporting period (check all that apply).

Funded	Delivered	Service
☐	☐	Quality management

CORE MEDICAL SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
☐	☐	Outpatient/ambulatory medical care
☐	☐	Local AIDS Pharmaceutical Assistance
☐	☐	Oral health care
☐	☐	Early intervention services (Parts A and B)
☐	☐	Health Insurance Premium & Cost Sharing Assistance
☑	☑	Home health care
☐	☐	Home and community-based health services
☐	☐	Hospice services
☐	☐	Mental health services
☐	☐	Medical nutrition therapy
☐	☐	Medical case management (including treatment adherence)
☐	☐	Substance abuse services-outpatient

SUPPORT SERVICES

- Please select the core medical services delivered under this agreement during the given reporting period (check all that apply).

Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program Client-Level Data Report

PROVIDER FORM

SUPPORT SERVICES

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

Funded	Delivered	Service
☐	☐	Case management (non-medical)
☐	☐	Child care services
☐	☐	Pediatric development assessment/early intervention services
☐	☐	Emergency financial assistance
☐	☐	Food bank/home-delivered meals
☐	☐	Health education/risk reduction
☐	☐	Housing services
☐	☐	Legal services
☐	☐	Linguistics services
☐	☐	Medical transportation services
☐	☐	Outreach services
☐	☐	Permanency planning
☐	☐	Psychosocial support services
☐	☐	Referral for health care/supportive services
☐	☐	Rehabilitation services
☐	☐	Respite care
☐	☐	Substance abuse services-residential
☐	☐	Treatment adherence counseling

HIV COUNSELING AND TESTING SERVICES

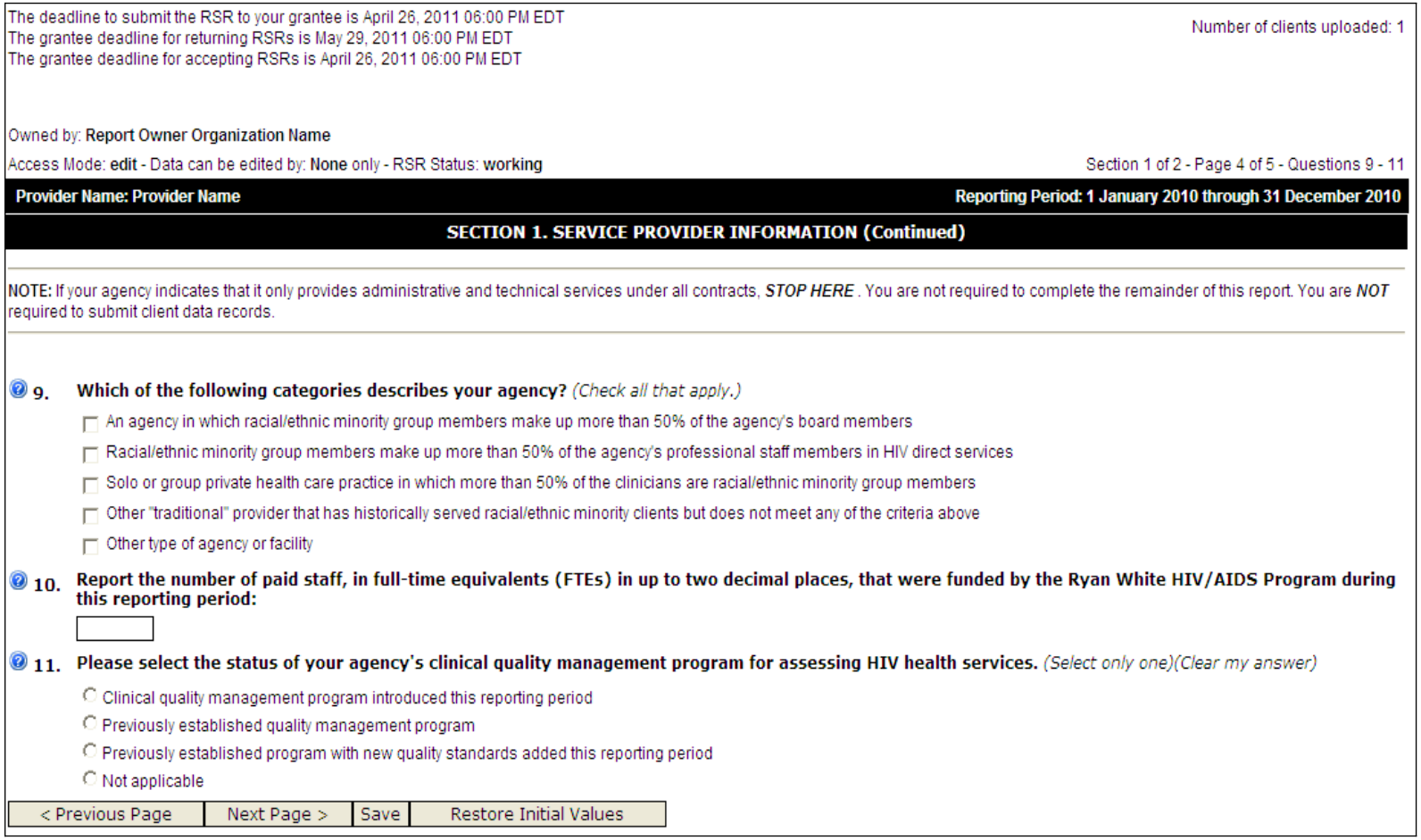
Check the box if this agency was funded to provide HIV Counseling and Testing services under this agreement.

Funded	Delivered	Service
☐	☐	HIV Counseling and Testing

- Please select the support services delivered under this agreement during the given reporting period (check all that apply).
- Please check the box if this agency delivered HIV Counseling and Testing Services during the given reporting period.

Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program Client-Level Data Report

PROVIDER FORM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Owned by: **Report Owner Organization Name**

Access Mode: **edit** - Data can be edited by: **None** only - RSR Status: **working**

Section 1 of 2 - Page 4 of 5 - Questions 9 - 11

Provider Name: Provider Name | **Reporting Period: 1 January 2010 through 31 December 2010**

SECTION 1. SERVICE PROVIDER INFORMATION (Continued)

NOTE: If your agency indicates that it only provides administrative and technical services under all contracts, ***STOP HERE*** . You are not required to complete the remainder of this report. You are ***NOT*** required to submit client data records.

9. Which of the following categories describes your agency? *(Check all that apply.)*

- ☐ An agency in which racial/ethnic minority group members make up more than 50% of the agency's board members
- ☐ Racial/ethnic minority group members make up more than 50% of the agency's professional staff members in HIV direct services
- ☐ Solo or group private health care practice in which more than 50% of the clinicians are racial/ethnic minority group members
- ☐ Other "traditional" provider that has historically served racial/ethnic minority clients but does not meet any of the criteria above
- ☐ Other type of agency or facility

10. Report the number of paid staff, in full-time equivalents (FTEs) in up to two decimal places, that were funded by the Ryan White HIV/AIDS Program during this reporting period:

11. Please select the status of your agency's clinical quality management program for assessing HIV health services. *(Select only one)(Clear my answer)*

- ○ Clinical quality management program introduced this reporting period
- ○ Previously established quality management program
- ○ Previously established program with new quality standards added this reporting period
- ○ Not applicable

< Previous Page | Next Page > | Save | Restore Initial Values

Items 9 through 11 – Core Medical Services
If you indicated in Item 8 (services delivered), that you delivered ONLY "Administrative Services" and/or "Support Services," then Items 9 through 17 are <u>not</u> required.
You will STOP here.
Conversely, if you indicated that you did deliver "Core Medical Services," then Items 9 through 11 will be required.

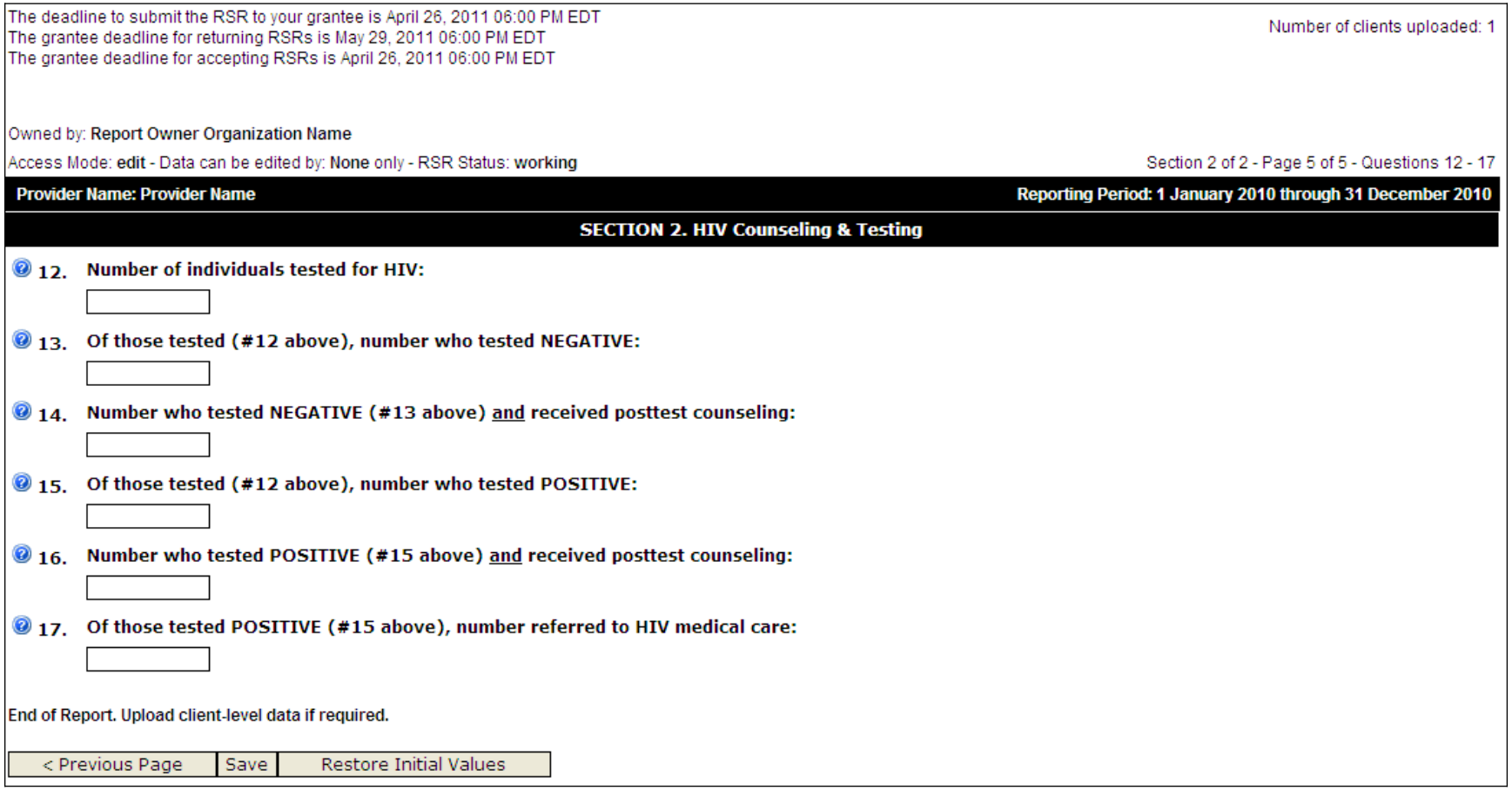
Item 9: Select the categories that best describe your organization.

Item 10: Report the number of paid staff, in full-time equivalents (FTEs), funded by the Ryan White HIV/AIDS Program during the given reporting period.

Health Resources and Services Administration (HRSA)
Ryan White HIV/AIDS Program Client-Level Data Report

PROVIDER FORM

Item 11: Select the status of your agency's clinical quality management program



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Owned by: Report Owner Organization Name

Access Mode: edit - Data can be edited by: None only - RSR Status: working

Section 2 of 2 - Page 5 of 5 - Questions 12 - 17

Provider Name: Provider Name **Reporting Period: 1 January 2010 through 31 December 2010**

SECTION 2. HIV Counseling & Testing

12. Number of individuals tested for HIV:

13. Of those tested (#12 above), number who tested NEGATIVE:

14. Number who tested NEGATIVE (#13 above) and received posttest counseling:

15. Of those tested (#12 above), number who tested POSITIVE:

16. Number who tested POSITIVE (#15 above) and received posttest counseling:

17. Of those tested POSITIVE (#15 above), number referred to HIV medical care:

End of Report. Upload client-level data if required.

< Previous Page | Save | Restore Initial Values

Items 12–17: If a grantee indicates in **Item 8** that your organization was contracted to provide HIV counseling and testing services during the given reporting period, your organization then **Items 12 through 17** ARE required.

Conversely, if you indicated that you did NOT deliver "HIV Counseling and Testing", then Items 12 through 17 will be disabled.

Item 12 – Number Tested for HIV
Item 13 – Number of Test Results Negative
Item 14 – Number of Results Negative & Received Counseling
Item 15 – Number of Test Results Positive

PROVIDER FORM

Item 16 – Number of Test Results Positive & Received Counseling
Item 17 – Number of Test Results Positive and Referred