

**INSTRUCTIONS
FOR COMPLETING
THE RYAN WHITE CARE ACT
DATA REPORT
(CARE ACT DATA REPORT)
(CROSS-TITLE DATA REPORT)**

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

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INSTRUCTIONS FOR COMPLETING THE RYAN WHITE CARE ACT DATA REPORT

WHO COMPLETES THE CARE ACT DATA REPORT?

The Ryan White CARE Act Data Report (CARE Act Data Report) should be completed by all Ryan White CARE Act Title I, II, III, and IV-funded grantees, provider agencies, and Title II consortia.

If the only services you provided were (1) planning or evaluations, (2) administrative or technical support, (3) fiscal intermediary services, (4) technical assistance, (5) capacity development, or (6) quality management, please complete Section 1, Parts 1.1–1.2.

Providers who receive funds under more than one Title should complete this form once and submit copies to all grantees from whom they receive CARE Act funds.

Each grantee of record should assemble all report forms completed by their providers, then complete one cover page and attach it to the assembled batch of completed forms. The grantee should then submit this entire package to the HRSA contractor.

WHICH CLIENTS SHOULD BE INCLUDED IN THE CARE ACT DATA REPORT?

Providers should report on all clients who received services **eligible** for CARE Act Title I, II, III, or IV funding, regardless of the actual funding source used to pay for those services.

Grantees and providers who choose to report only on the subset of clients who received services funded by CARE Act Title funds (see Reporting Scope in Section 1, Part 1.2 for more information) must have special permission to do so from their HRSA project officer.

The provider agency, or service provider, is the agency that provides direct services to clients and their families and is funded by the Ryan White CARE Act. Services may be funded by one or more Titles of the Ryan White CARE Act grants, or through sub-contract(s) with official Ryan White CARE Act grantees.

SECTIONS OF THE CARE ACT DATA REPORT

The CARE Act Data Report is divided into eight sections. Each section is then divided into various parts to be answered by the appropriate Title program. Not all Title programs are required to respond to each section; some parts are specific to Titles III and IV. Only programs administering a AIDS Drug Assistance Program (ADAP), a local AIDS pharmaceutical assistance (APA) program, or Health Insurance Program (HIP) should complete Sections 7 or 8.

Who Completes Each Section?

Title	I	II	III	IV
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/ Title-Specific Data for Titles III and IV				
Part 6.1. Title III Information			✓	
Part 6.2. Title IV Information				✓
Section 7. ADAP/APA Information	✓	✓		
Section 8. Health Insurance Program (HIP) Information	✓	✓		

Section 1. Service Provider Information

Part 1.1. Provider and Agency Contact Information

Name, address, phone number of person responsible for the CARE Act Data Report, and taxpayer ID number.

Part 1.2. Reporting and Program Information

Dates of the reporting period for the data in the report, client reporting scope, provider type, ownership status, source of Ryan White Care Act funding, target population, funding received, and staffing.

Section 2. Client Information

Total clients receiving services during the reporting period, new clients, gender, age, ethnicity, race, household income, living/housing arrangements, insurance, HIV/AIDS status, and vital/enrollment status.

Section 3. Service Information

Services provided and total number of clients receiving those services.

Section 4. HIV Counseling and Testing

Number of clients who received HIV counseling and testing, type of HIV counseling and testing, posttest counseling, number of clients who tested positive for HIV antibodies, and partner notification.

Section 5. Medical Information

Risk factors, testing and treatment, opportunistic infections, and pregnancy.

Section 6. Demographic Tables / Title-Specific Data for Titles III and IV**Part 6.1. Title III Information**

Demographic tables of patients who are HIV positive and who received primary medical care services by gender, ethnicity, race, and age.

Total cost of providing service, sources of income, and available services.

Part 6.2. Title IV Information

Demographic tables of clients who are HIV infected and affected by sex, ethnicity, and race.

Section 7. ADAP/APA Information

Type of pharmaceutical program administered, medical eligibility, funding received from eligible metropolitan areas (EMAs) and other sources, annual expenditures, and prescribed medications.

Section 8. Health Insurance Program (HIP) Information

Annual expenditures, number of unduplicated clients receiving HIP, and funding received from EMAs 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 CARE Act Data Report.

Is the correct information included in this report?

- Complete all questions that apply to your agency and the services you provide.
- The **reporting period** for the CARE Act Data Report is a calendar year. Your report should include information on all clients served and services delivered between January 1 and December 31 of a given year (not based on your fiscal calendar).
- Reports prepared using the **eligible reporting scope (found in Item 6)** should include all clients receiving services eligible for CARE Act funding, regardless of the funding source. Reports prepared using the **funded-only reporting scope (found in Item 6)** should only include clients receiving services funded by Title I, II, III, or IV.
- HIV/AIDS program staffing**: Report full-time equivalents for paid and volunteer staff, not the actual number of staff members.
- Funding**: All fiscal information should be annualized to reflect the January 1–December 31 reporting period. Please report **all** CARE Act funding (Titles I–IV, other CARE Act funding) **regardless of the reporting scope used to document clients and services**.
- Unduplication**: In an unduplicated client count, each individual is counted only once regardless of the number of services he or she received. Client counts should reflect the entire reporting period, and should be unduplicated across contracts, departments, and sites.
- All client totals** in Section 2 should add up to the number of unduplicated clients reported in Item 24.
- Check “unknown” boxes or report “unknown” counts only when necessary. For example, if more than 10% of your clients have unknown age, race/ethnicity, or HIV status (medical providers), then you should examine your data collection system and try to determine how it can be improved to lower this percentage.
- Important**: Primary medical care providers should complete information regarding HIV status and exposure distributions (Items 33 and 46).

Is the report consistent?

- New clients**: The number of *New Clients Served* is usually a subset of the *Total Number of Unduplicated Clients*. The only exception is in the case of a new provider agency, when all of the clients are new to the provider. New clients are those individuals in the current reporting period who were not previously enrolled or serviced by your agency in a prior year.
- Annual HIV/AIDS funding (Items 19–23)**: Although funding reported by providers will not match grant awards exactly due to administrative costs, delays in contract awards, and carry-over funds, the sum of grant awards falling within the calendar year and the **annual HIV/AIDS funding** amounts reported on the CARE Act Data Report should be reasonably similar.
- Service utilization (Section 3. Service Information)**: Complete entries only for those services you provide; *leave the other services blank*. The number of clients seen for a given service should not exceed the total number of unduplicated clients reported in Item 24. If the number of clients that were seen for a given service is unknown, check column 3b on the table in Section 3.

COVER PAGE

All Ryan White CARE Act grantees of record should complete the cover page.

Grantee of record

Enter the agency name of the grantee of record if different from provider.

Grantee of record is the official Ryan White CARE Act grantee that receives Federal funding directly from the Federal Government (HRSA). This agency may be the same as the provider agency or may be the agency through which the provider agency is subcontracted.

Grantee ID number

Enter the HRSA-designated grantee ID number.

Grantee taxpayer ID number

Enter the nine-digit taxpayer ID number of the agency listed above. This number has been given to the agency by the Internal Revenue Service and is a taxpayer identifying number issued to an organization or agency, upon application, for use in connection with filing requirements.

Grantee contact email

Enter an email address for a contact from the agency listed above.

Total number of providers

Indicate the total number of providers reporting data for this reporting period.

Grantee type

Indicate the Title(s) for which the agency is the grantee of record. Check all that apply.

REMEMBER: Each grantee of record is responsible for their provider reports. If hard copies are submitted, the grantee should assemble all report forms completed by their providers, then complete one cover page and attach it to the assembled batch of completed forms. The grantee can either enter the data online or submit this entire package via mail to the HRSA contractor. This year providers have the option of entering their data online. Grantees are required to review and approve the data submitted by each of their providers online.

Quality assurance personnel

Enter the name and signature of the grantee representative responsible for verifying the data found in this report.

SECTION 1. SERVICE PROVIDER INFORMATION

This section should be completed by all service providers and/or grantees funded through Ryan White CARE Act Titles I, II, III, and IV.

Part 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.

Provider agency/service provider is the agency that provides direct services to clients (and their families) that are funded by the Ryan White CARE Act. Services may be funded through one or more Federal Ryan White CARE Act grants or through subcontract(s) with official Ryan White CARE Act grantees. A provider may also be a grantee, such as in Titles III and IV.

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 of the provider agency. This number has been given to the agency by the Internal Revenue Service and is a taxpayer identifying number issued to an organization or agency, upon application, for use in connection with filing requirements.

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 number

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

d. Fax number

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

e. Email address

Enter the email 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 (if different from Item 3a).

b. Phone number

Enter the telephone number, including area code, of the person listed in Item 4a (if different from Item 3a).

Part 1.2. Reporting and Program Information

5. Reporting period

Enter the 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 CARE Act Title 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 using the predetermined response codes listed below. Select only one response code.

Code 01: ALL clients receiving a service ELIGIBLE for Title I, II, III, or IV funding.

Explanation: Reporting scope for providers reporting ELIGIBLE services. Data are based on all services that are eligible for funding from Ryan White Title I, II, III, or IV.

Under the ELIGIBLE reporting scope, clients receiving any service eligible for Ryan White Title I, II, III, or IV funding are included in the report even if the service was not paid for with Ryan White Title I, II, III, or IV funds. This reporting scope is preferred by HRSA.

Code 02: ONLY clients receiving a Title I, II, III, or IV FUNDED service.

Explanation: Reporting scope for providers reporting FUNDED clients. Data are based on clients for whom services are paid for by Ryan White Title I, II, III, or IV funding.

Under the FUNDED scope, only clients receiving services paid for exclusively with Ryan White Title I, II, III, or IV 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 HRSA; 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. **Select only one.**

Provider types:

Hospital or university-based clinic includes ambulatory/outpatient 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.

Publicly funded community health center includes community health centers, migrant health centers, rural health centers, and homeless health centers.

Publicly funded community mental health center is self-explanatory.

Other community-based service organization includes non-hospital-based organizations, 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 coalition includes organizations of People Living With HIV/AIDS that provide support services to individuals and families affected by HIV and AIDS.

VA facility is a facility funded through the Veterans Administration.

Other facility includes facilities other than those listed above.

8. Section 330 of PHSA funding

Check whether or not 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.

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.

9. Ownership status

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

Types of ownership status:

Public/local ownership means that the organization is funded by a local government entity and is operated by local government employees. Local health departments are examples of local publicly owned organizations.

Public/State ownership means that the organization is funded by a State government entity and is operated by State government employees. A State health department is an example of a State publicly owned organization.

Public/Federal ownership means that the organization is funded by the Federal government and is operated by Federal government employees. A Federal agency is an example of a Federal publicly owned organization.

Private, nonprofit (not faith-based) means that the organization is owned and operated by a private, not-for-profit, non-religious-based entity, such as a nonprofit health clinic.

Private, for-profit ownership means that 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.

Unincorporated means that an agency is not incorporated.

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

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

10. Source of funding

Check the provider agency's source(s) of funding under Ryan White CARE Act Titles I, II, III, or IV.

Check all that apply. This item includes funding that is received directly from the Federal government (grantee), through a subcontract with a CARE Act grantee (service provider), or through Title II funding to a Consortium.

Title I is the part of the Ryan White CARE Act that provides direct financial assistance to designated EMAs that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals with HIV disease and families; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, when medically appropriate, from inpatient facilities.

Title II is the part of the Ryan White CARE Act that 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. The CARE Act 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 among States and Territories based, in part, on the number of AIDS cases in each State (or Territory) as a proportion of the number of AIDS cases reported in the entire United States.

Title III is the part of the Ryan White CARE Act that 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, and case management and eligibility assistance.

Title IV is the part of the Ryan White CARE Act that supports coordinated services and access to research for children, youth, and women with HIV disease and their affected family members.

Title IV Adolescent Initiative is part of the Title IV program aimed at identifying adolescents who are HIV positive and enrolling them in care.

11. Service provided to grantee of record

For each of the six services listed, indicate whether or not the service was provided to the grantee of record by the provider agency by checking "yes" or "no." Check yes or no for each item. If the service provider is the grantee of record, check "yes" or "no" to each category and proceed to Item 12. If any of these services were the **only** services provided with CARE Act 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.

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, identify needed improvements, and/or make decisions about future programming.

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 or TA is the identification of need for and delivery of practical program and technical support to the CARE Act community. TA should assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating CARE Act-

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; conducting 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; conducting service evaluation; and cultural competency development.

Quality management is a continuous process to improve the degree to which a health or social service meets or exceeds established professional standards and user expectations. The purpose of a quality management program is to ensure that (a) services adhere to PHS guidelines and established clinical practice; (b) program improvements include supportive services; (c) supportive services are linked to access and adherence to medical care; and (d) demographic, clinical and utilization data are used to evaluate and address characteristics of the local epidemic. It is a systematic process with identified leadership, accountability, and dedicated resources, and uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. It also focuses on linkages, efficiencies, and provider and client expectations in addressing outcome improvement. This is a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement (QI) activities (e.g., JCAHO, Medicaid, and other HRSA programs). Data collected are used to feed back into the process to assure that goals are accomplished and are concurrent with improved outcomes.

12. ADAP or other APA program

Indicate whether the provider agency administered an ADAP or APA program during the reporting period.

If your answer is "yes," continue with Item 13. If your answer is "no," skip to Item 14.

ADAP is typically a centrally administered program operated at the State level that receives both Ryan White CARE Act Title II ADAP-earmarked and Title II base funds. Other AIDS pharmaceutical assistance programs typically operate at the local EMA 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 Title I and private sources.

ADAP, AIDS Drug Assistance Program, is a State-administered program authorized under Title II of the CARE Act that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

APA, AIDS pharmaceutical assistance program is a local pharmacy assistance program implemented by a Title I EMA or Title II State. The Title II grantee consortium or Title I 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 patients or clients that they serve through a Ryan White (or other funding sources) contract with their grantee.

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.

13. Type of pharmaceutical program

If your agency administers an ADAP or other APA program, specify the program type:

- State ADAP or
- Local pharmaceutical assistance program.

If either of these programs was the *only* service you provided under CARE Act funding, skip to and complete Section 7. Otherwise continue with Item 14.

14. HIP assistance

Indicate whether or not you provided health insurance through HIP (with Ryan White CARE Act funds) during the reporting period. If this was the *only* service you provided under CARE Act funding, complete Section 8 only.

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.

15. Target population

Check the box next to each population group that the program specially targeted (set as a goal to achieve and directly allocated funds to support) for outreach efforts or service delivery in 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.

16. Racial/ethnic minority group membership

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

17. Total paid staff

Report the number of paid staff, in full-time equivalencies (FTEs), that were funded by the CARE Act during this reporting period.

How to calculate FTEs:

Step One: Count each staff member who works full-time (at least 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 Titles I, II, III, and/or IV, you can 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, C&T 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.

18. 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. To calculate FTEs, follow the method of calculation indicated in Item 17.

19. Title I funding

Indicate the total dollar amount of Title I (EMA) funds received by the provider agency during the reporting period. This amount does not necessarily reflect how much of the Title I funds were expended by your organization. If no funds were received, report “zero” in the space provided.

20. Title II funding

Indicate the total dollar amount of Title II (State/Consortium) funds received during the reporting period. This amount does not necessarily reflect how much of the Title II funds were expended by your organization. If no funds were received, report “zero” in the space provided.

21. Title III funding

Indicate the total dollar amount of Title III funds received during the reporting period. This amount does not necessarily reflect how much of the Title III funds were expended by your organization. If no funds were received, report “zero” in the space provided.

22. Title IV funding

Indicate the total dollar amount of Title IV funds received during the reporting period. This amount does not necessarily reflect how much of the Title IV funds were expended by your organization. If no funds were received, report “zero” in the space provided.

23. Oral health care expenditures

Indicate the total amount of Ryan White CARE Act funds **EXPENDED** on oral health care during the reporting period. If no funds were spent, report “zero” in the space provided.

NOTE: For Items 19–23, all funding should be annualized to reflect the reporting period. See the method in the example that follows.

How to Annualize Fiscal Information*

Example:

Annualizing fiscal information—A provider received funding from these sources in 2002:

\$120,000 from Source A for a fiscal year beginning 10/1/2001 and ending 9/30/2002.

\$240,000 from Source B for a fiscal year beginning 3/1/2001 and ending 2/28/2002.

\$120,000 from Source C for the time period 12/1/2001 through 11/30/2002.

Follow a two-step process for each funding source: First calculate the funding amount per month and then add up the number of months this amount was received in 2002.

Source A:

a. $\$120,000$ over 12 months = $\$10,000$ per month

b. $\$10,000$ per month for 9 months of 2002 (January–September) = **$\$90,000$ ($9 \times \$10,000$)**

Source B:

a. $\$240,000$ over 12 months = $\$20,000$ per month

b. $\$20,000$ per month for 2 months (January–February) of 2002 = **$\$40,000$ ($2 \times \$20,000$)**

Source C :

a. $\$120,000$ over 12 months = $\$10,000$ per month

b. $\$10,000$ per month over 11 months (January–November) of 2002 = **$\$110,000$ ($11 \times \$10,000$)**

***NOTE:** This information is being “annualized” and may or may not equal the amount received this funding cycle.

SECTION 2. CLIENT INFORMATION

This section should be completed by all service providers funded through Ryan White CARE Act Titles I, II, III, and/or IV. 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 primary care or support services. *Affected clients include those who are HIV negative as well as those with unknown HIV status.*

Infected client is an individual who is HIV positive and who receives at least one Ryan White CARE Act-eligible service during the reporting period.

Affected client is a family member or partner who receives at least one Ryan White CARE Act supportive or case management 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).

NOTE: All affected clients must be linked to a client infected with HIV/AIDS.

Remember your reporting scope! If you chose Reporting Scope 01 on page 2, Item 6, provide information on all clients, whether funded by a CARE Act grant or other funding source. If you chose Reporting Scope 02 on page 2, Item 6, (with the permission of the HRSA project officer) include only those clients who received services funded by Title I, II, III, and/or IV.

24. Total number of unduplicated clients

Enter the respective total number of unique individuals receiving at least one Ryan White CARE Act-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.

25. 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 a person 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 to be new unless past records of their care are not available.

26. 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. The sum of the four categories should equal the respective total of unduplicated number of clients in Item 24. Do not leave any category blank or include any anonymous clients in these counts.

Transgender means exhibiting the appearance and behavioral characteristics of the opposite sex, and is based on self-report by the client.

27. Age of clients

Report the actual unduplicated number of clients in each age group using client ages at the end of the reporting period. The sum of the age groups should equal the respective total of unduplicated number of clients in Item 24. Do not include any anonymous clients in these counts.

28. Number of Hispanic or Latino/a clients

Report the number of clients who identify themselves as Hispanic or Latino/a. Clients of mixed ethnic identity should be counted in the category that best reflects their identity, based on their self-report. The sum of the categories should equal the respective total of unduplicated number of clients in Item 24. Do not include any anonymous clients in these counts.

Hispanic or Latino/a is a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

29. Race of clients

Report the actual unduplicated number of clients in each racial group, based on the self-report of the client. The sum of the racial categories should equal the respective total unduplicated number of clients in Item 24. Do not include any anonymous clients in these counts.

NOTE: Clients reported as Hispanic or Latino/a (Item 28) must be accounted for in this item.

The following racial category descriptions, defined in October 1997, will be required for all Federal reporting beginning in 2003, as mandated by the Office of Management and Budget (see <http://www.whitehouse.gov/omb/fedreg/ombdir15.html> for more information). HAB is mandating use of these categories as of January 2002.

All individuals who identify themselves with more than one race should be counted in the “More than one race” category.

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

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

Asian is a person 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.

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

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

More than one race is a person who identifies with more than one of the listed racial categories.

30. Annual household income

Report the annual household income category of the client at the end of the reporting period, or most recent data available within the reporting period.

Income is defined in ranges relative to the Federal poverty guidelines. The sum of the categories should equal the respective total unduplicated number of clients in Item 24. Do not include any anonymous clients in these counts.

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 person 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 15 years old and over, including household members not related to the householder, people living alone, and others in nonfamily households.

Families and persons 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 persons 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 line means that the client’s annual household income is the same as or below the Federal poverty line.

Within 101–200% of the Federal poverty line means that the client’s income is equal to or no more than double the Federal poverty line.

Within 201–300% of the Federal poverty line means that the client’s income is double or no more than triple the Federal poverty line.

More than 300% of the Federal poverty line means that the client’s income is triple or more above the Federal poverty line.

Unknown/unreported means that the client’s income is unknown or was not reported.

31. Housing arrangement categories

Enter 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. The sum of the categories should equal the respective total unduplicated clients in Item 24. Do not include any anonymous clients in these counts.

Housing/living arrangements:

Permanent housing includes apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited.

Non-permanent includes homeless, as well as 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 means other housing/living arrangements not listed above.

Unknown/unreported means housing/living arrangements were not reported.

32. Primary source of medical insurance

Enter the number of clients for each primary source of medical insurance for HIV-related care for the client at the end of the reporting period, or 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. The sum of the categories should equal the respective total unduplicated clients in Item 24. Do not include any anonymous clients in these counts.

Private means health insurance plans such as BlueCross/BlueShield, Kaiser Permanente, Aetna, etc.

Medicare is 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).

Medicaid is a jointly funded, Federal-State health insurance program for certain low-income and needy people.

Other public means other Federal, State, and/or local government programs providing a broad asset of benefits for eligible individuals. Examples include State-funded insurance plans, military health care (CHAMPUS), State Children's Insurance Program (SCHIP), Indian Health Services, and Veterans Health Administration.

No insurance means either the client has no insurance to cover the cost of services, or self-pay.

Other means client has an insurance type other than those listed above.

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

33. HIV/AIDS status

Report the total number of clients by their HIV/AIDS status at the end of the reporting period. This information is required of primary medical care providers and is requested from all other providers who collect this information.

HIV positive, not AIDS means the client has tested positive for and been diagnosed with HIV, but has not advanced to AIDS.

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

CDC-defined AIDS means the client has advanced to and been diagnosed with CDC-defined AIDS.

HIV negative (affected) means the client is HIV-negative and is an affected friend or family member of an individual who is HIV positive.

Unknown means the HIV/AIDS status of the client is unknown and not documented.

NOTE: Once a client has been diagnosed with AIDS, they are always counted in the CDC-defined

AIDS category regardless of disease indicators (i.e., CD4 counts).

34. 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 a client whose first point of contact with the program occurred during this reporting period.

Active, client continuing in program was a client when the period started and continued in the program.

Deceased means that the client died sometime during this reporting period.

Inactive means that the status of the client is inactive (as defined by your agency), which includes many possible reasons (e.g., client moved or is lost to follow-up).

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

blank or include any anonymous/drop-in clients or visits in columns 3 and 4.

NOTE: A client may only have one visit for each service category per day. For a residential substance abuse treatment center, each day in a residential facility equals one visit. For example, if a client spends 20 days in a residential facility, this counts as 20 visits.

Service categories:

a. *Ambulatory/outpatient 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. This 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 Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

b. *Mental health services* are psychological and psychiatric treatment and counseling services 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.

c. *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.

d. *Substance abuse services-outpatient* are the provision of medical or other treatment and/or

SECTION 3. SERVICE INFORMATION

Service providers from all Titles should complete this section. If you provided 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 provided 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.

35. Services provided, 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 provided by your organization, either directly or via a contractual arrangement with another service provider. For all services that you provide, as indicated with a check mark in column 2, enter 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 enter zeros in columns 3 and 4. Do not leave the columns

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

- e.** *Substance abuse services-residential* are the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) provided in an inpatient health service setting (short-term).
- f.** *Rehabilitation services* include 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.
- g.** *Home health: para-professional care* is the provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help clients with disabilities remain in their homes.
- h.** *Home health: professional care* is the provision of services in the home by licensed health care workers such as nurses.
- i.** *Home health: specialized care* is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.
- j.** *Case management services* are a range of client-centered services that link clients with health care, psychosocial, and other services. Ensures 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. Also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. 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. May include client-specific advocacy and/or review of utilization of services. This includes any type of case management (e.g., face-to-face).
- k.** *Buddy/companion service* is an activity provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.
- l.** *Child care services* are the provision of care for the children of clients who are HIV positive while the clients are attending medical or other appointments or attending Title-related meetings, groups, or training. NOTE: This does not include child care while client is at work.
- m.** *Child welfare services* are the provision of family preservation/unification, foster care, parenting education, and other child welfare services. Services designed to prevent the break-up of a family and to reunite family members. Foster care assistance to place children under the age of 21 years, whose parents are unable to care for them, in temporary or permanent homes and to sponsor programs for foster families. Other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of children who are HIV positive about risks and complications, caregiving needs, and developmental and emotional needs of children.
- n.** *Client advocacy* is the provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.
- o.** *Day or respite care for adults* 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.

- p.** *Developmental assessment/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. Involves assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. 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.
- q.** *Early intervention services for Titles I and II* are counseling, testing, and referral services to PLWHA who know their status but are not in primary medical care, or who are recently diagnosed and are not in primary medical care for the purpose of facilitating access to HIV-related health services.
- r.** *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.
- s.** *Food bank/home-delivered meals* is the provision of actual food, meals, or nutritional supplements. 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.
- t.** *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.
- u.** *Housing and housing-related services* are the provision of short-term assistance to support temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related services may be housing in medical treatment programs for chronically ill clients (e.g., assisted living facilities), specialized short-term housing, transitional housing, and non-specialized housing for clients who are HIV affected. Category includes access to short-term emergency housing for homeless people. This also includes assessment, search, placement, and the fees associated with them. NOTE: If housing services include other service categories (e.g., meals, case management, etc.) these services should also be reported in the appropriate service categories.
- v.** *Legal services* are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders, wills, trusts, bankruptcy proceedings, 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 CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.
- w.** *Nutritional counseling* is provided by a licensed registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietitian should be recorded under "Psychosocial support services."
- x.** *Outreach services* include programs that have as their principal purpose identification of people with HIV disease so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. 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.

- y.** *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.
- z.** *Psychosocial support services* are the provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, and play), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse, or nutritional counseling that are provided to clients, family and household members, and/or other caregivers and focused on HIV-related problems.
- aa.** *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 formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.
- ab.** *Referral to clinical research* is the provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research are studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an institutional review board (IRB) that initially approves and periodically reviews the research.
- ac.** *Residential or in-home hospice care* means room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients 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 patients.
- ad.** *Transportation services* include conveyance services provided, directly or through voucher,

to a client so that he or she may access health care or support services.

ae. *Treatment adherence services* are the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

af. *Other services* are other services not listed above.

SECTION 4. HIV COUNSELING AND TESTING

Title I, II, III, and IV 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 CARE Act funds can answer “Yes” to Item 36 in this section, “No” to Item 37, and skip to Section 5, Item 45. NOTE: Based on Ryan White CARE Act reauthorization, HIV counseling and testing is funded as a component of Early Intervention Services for Titles I and II.

Report on the number of individuals who received counseling and testing during the reporting period. Until these individuals receive at least one of the services listed in Section 3, they are **NOT** considered clients.

36. 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, respond to Item 36a. If HIV counseling and testing services were not provided during the reporting period, do not complete Items 36b through 44 in this section, but skip to Section 5.

36. b. If HIV counseling and testing services were provided, indicate the total number of infants (24 months or younger) tested during this reporting period.

37. Funding source for HIV counseling and testing services

Indicate whether CARE Act funds were used to support HIV counseling and testing services during the reporting period, regardless of where these

services were provided (that is, at your outpatient facilities or at another site within your program).

38. HIV pretest counseling

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

Confidential means information such as name, sex, age, etc., is collected on the client, and the client is reassured that no identifying information will be shared or passed on to anyone.

Anonymous means no identifying information is collected from the client.

39. Post-counseling HIV testing

Indicate the number of individuals who were tested for HIV antibodies after being counseled, during the reporting period. Not everyone who receives HIV pretest counseling elects to be tested.

40. HIV antibodies

Indicate the number of individuals who tested positive for HIV antibodies during the reporting period. This item is a subset of Item 39 above.

41. HIV posttest counseling

Indicate the number of individuals who, after being tested for HIV antibodies, returned for HIV posttest counseling from a person qualified to provide such counseling, during the reporting period, regardless of their test results. This includes every person tested for HIV, whether the test result was positive, negative, or indeterminate. This item is a subset of all clients tested for HIV in Item 39 above.

42. Did not return for HIV posttest counseling

Indicate the number of individuals who had a positive HIV-antibody test result and did not return for HIV posttest counseling, during the reporting period. This is a subset of the number of individuals who tested positive for HIV antibodies given in Item 40 above.

43. 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 physician in your EIS program notifies the partner of a client of possible exposure to HIV. 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.

44. 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 clients counseled on disclosure issues. Do not count number of clients who were referred to an agency that provided partner notification services.

SECTION 5. MEDICAL INFORMATION

This section should be completed by all medical service providers funded through Ryan White CARE Act Titles I, II, III, or IV or by authorized personnel who have access to this information.

45. Medical service provider is any service provider who provided ambulatory/outpatient medical care (Item 35, service category “a”).

Indicate the number of unduplicated clients being reported on in this section by gender.

NOTE: This total may be equal to or less than the number reported in Item 24.

46. HIV exposure category

Report the number of clients who are HIV positive with each of the following risk factors for HIV infection. This information is required of primary medical care providers and is requested from all other providers who collect this information.

Persons with more than one reported mode of exposure to HIV are counted in the exposure category listed first in the hierarchy, except for persons with a history of both homosexual/bisexual contact and injection drug use. They are counted in a separate category.

NOTE: This total may be equal to or less than the number reported in Item 45.

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 persons 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 individuals with delayed clotting of the blood.

Heterosexual contact cases are persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., an injection drug user).

Receipt of transfusion of blood, blood components, or tissue

Mother with/at risk for HIV infection (perinatal transmission) cases include transmission of disease 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 means the individual's exposure is known, but not listed above.

Undetermined/unknown, risk not reported or identified means the individual's exposure is unknown or not reported for data collection.

47. Services provided

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.

48. AIDS-defining conditions

Report the number of clients diagnosed with each AIDS-defining condition during the reporting period.

49. Antiretroviral therapy

Enter the number of clients who were on the listed antiretroviral therapies at the end of the reporting period.

NOTE: This total may be equal to or less than the number reported in Item 45.

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

Salvage therapy is a treatment effort for people who are not responding to, or cannot tolerate, the preferred, recommended treatments for a particular condition. In the context of HIV infection, these are drug treatments that are used or studied in individuals who have failed one or more HIV drug regimens, including protease inhibitors. In this case, failed refers to the inability to achieve or sustain low viral load levels.

For more information on treatment guidelines visit <http://hivatis.org/trtgdlns.html>.

50. Female gynecological exams

Report the total number of clients who received a pelvic exam and Pap smear during the reporting period.

51. Pregnant women

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

52. Trimester of first visit for care

Of the number of pregnant clients who were HIV positive, reported in Item 51, indicate the number of clients by the trimester of pregnancy when they entered care at the provider site.

NOTE: This total may be equal to or less than the number reported in Item 51.

53. Antiretroviral medications received by pregnant women

Enter the total the number of pregnant clients from Item 51 above who received antiretroviral medications during the reporting period.

54. Children delivered

Enter the total number of children delivered (live births) to clients who were HIV positive (Item 51 above) during the reporting period.

55. Number of children delivered who tested HIV positive

Of the total number of children delivered (Item 54 above), enter the number who tested HIV positive during the reporting period.

SECTION 6. DEMOGRAPHIC TABLES/TITLE-SPECIFIC DATA FOR TITLES III AND IV

This section should be completed by Title III and IV grantees/service providers. All others should skip to Section 7. Part 6.1 is specific to Title III. Part 6.2 is specific to Title IV.

Part 6.1. Title III Information

Part 6.1 should be completed only by Title III grantees/service providers. When reporting on clients in this section, only report on PATIENTS WHO ARE HIV POSITIVE who received PRIMARY CARE SERVICES.

Patients include all individuals with HIV infection who received at least one primary health care service during the reporting period.

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

56. Hispanic or Latino/a ethnicity by gender and age

Enter the number of patients who are HIV positive who received primary care services during the reporting period by ethnicity, gender, and age.

57. Race by gender and age

Enter the number of patients who are HIV positive who received primary care services during the reporting period by race, gender, and age.

58. HIV exposure category by gender and race

Enter the number of patients who are HIV positive who received primary care services during the

reporting period by exposure category, gender, and race.

59. HIV exposure category by gender and age

Enter the number of patients who are HIV positive who received primary care services during the reporting period by exposure category, gender, and age.

60. Cost and revenue

Your response to each of the following items will indicate the cost of or revenue for providing “Primary 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 patient who is HIV positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, 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 Title III reporting purpose, refers to optional services that are eligible for Title III funds. Examples include 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. If you are providing a Title III eligible service that is *fundable*, include it, 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 early intervention 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.

b. Title III grant funds expended

Indicate the amount of the Title III funds expended to support each category of service during the reporting period. This is the amount of Title III monies used to

cover part of the total cost of providing each service (reported in Item 60a). If Title III money was not used to support a particular service, the response for that service should be a zero (\$ 0.00). Do not leave any line blank.

c. Direct collections from patients

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 patients that is used to cover part of the total cost of providing each service (reported in Item 60a). If direct collections from patients are not received or used to support a particular service, the response should contain a zero. 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 (reported in Item 60a). If third-party money is not used to support a service, the response should contain a zero. Do not leave any line blank.

e. Other sources of income

Indicate the amount of other sources of income or revenue (other than Ryan White CARE Act Title III, direct collections from patients, and reimbursements received from third-party payers, as reported in Item 60b, Item 60c, and Item 60d) 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 (reported in Item 60a). Other sources may be from city, county, or State agencies; academic institutions, foundations, and corporations; and fundraising activities, bequests, and donations. Any other Ryan White CARE Act funding, such as Title I, Title II, or Title IV, and any other Federal agency funding (CDC, SAMHSA, BPHC, etc.) used to support any category of service should also be included here. If these other sources of income did not provide money to support EIS services, the response should contain a zero. Do not leave any line blank.

61. Early intervention service sites

Check whether or not the grantee organization provided Early Intervention Services, that is, Title III-eligible services, at more than one site during the reporting period.

62. Number of EIS sites

If you answered “yes” to Item 61, indicate the number of sites at which EIS were provided during the reporting period.

63. Available services

Check whether each health service was available to patients who are HIV positive, within the EIS program or through referral to providers outside of the EIS program, during the reporting period.

EIS program is a program that encompasses the care supported by the Title III 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 Title III grantee or its parent organization.

It is not necessary to indicate how many patients received each service or how many patient 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 patient had required them within the EIS program or through referral. If services other than those listed here were available, check “other.” See list below for description of services.

Description of services:

Ambulatory/outpatient 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. This 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 Health Service 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.

Mental health services are psychological and psychiatric treatment and counseling services, 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.

Nutritional counseling is services provided by a licensed/registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

Obstetrics/gynecology services refer 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.

Rehabilitation services include 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.

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

Other services are other Title III-eligible, primary care services not listed above.

64. Referrals outside the EIS program

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

Part 6.2. Title IV Information

Part 6.2 should be completed only by Title IV grantees/service providers. Report only on the Title IV clients who are HIV INFECTED AND AFFECTED (family member or partner of a client who is HIV positive).

65. Gender and HIV status by age

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

66. Hispanic or Latino/a ethnicity by HIV status and age

Enter the number of clients during the reporting period by ethnicity, HIV status, and age.

67. Race and HIV status by age

Enter the number of clients during the reporting period by race, HIV status, and age.

68. Exposure category by age

Enter the number of clients who are HIV positive during the reporting period by exposure category and age.

SECTION 7. AIDS PHARMACEUTICAL ASSISTANCE PROGRAMS

This section should be completed by all Ryan White CARE Act Title II grantees who administer their State AIDS Drug Assistance Program, or Title I/II-funded grantees that administer a local AIDS pharmaceutical assistance (APA) program. See Section 1, Item 12 on page 8 for definitions of ADAP and APA programs.

NOTE: If ADAP funds were used to pay for health insurance, these clients should be reported in this section.

1. Medical eligibility

Report the medical criteria used to determine whether clients qualify for pharmaceutical assistance. Programs requiring proof of HIV seropositivity only should choose “HIV positive.” **Check all that apply.**

2. Processing period

Check the average length of the processing period. Select the category that best describes the average length of time between a client’s application to your program and actual approval of eligibility. Do not include time periods for clients whose applications were still pending approval on the last day of the reporting period.

3. Frequency of recertification

Check the frequency of recertification. Select how often your program requires clients to prove their continued eligibility for drug assistance. Do not include the initial certification required for acceptance into the program.

4. Total number of unduplicated clients

Enter the total number of unique individuals who received at least one drug from the ADAP or other AIDS pharmaceutical assistance program during the

reporting period. In an unduplicated client count, an individual receiving many different drugs is counted only once.

Unduplicated client count is an accounting of clients in which a single individual is counted only once. For example, if John Doe received 20 prescriptions for 5 different drugs, he should be counted as one client.

5. New clients

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

6. Gender of clients

Report the actual unduplicated numbers of male, female, and transgender clients (based on self-report) and the number of clients for whom gender is unknown or unreported. The sum of the four categories should equal the total number of unduplicated clients reported in Item 4. Do not leave any category blank or include any anonymous clients in these counts.

7. Age of clients

Report the actual number of unduplicated clients in each age group using client ages at the end of the reporting period. The sum of the age groups should equal the total number of unduplicated clients reported in Item 4. Do not include any anonymous clients in these counts.

8. Number of Hispanic or Latino/a clients

Report the number of clients who identified themselves as Hispanic or Latino/a. Clients of mixed ethnic identity should be counted in the category that best reflects their identity, based on their self-report. The sum of the three groups should equal the total number of unduplicated clients reported in Item 4. Do not include any anonymous clients in these counts.

Hispanic or Latino/a is a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

9. Race of clients

Report the actual number of unduplicated clients in each racial group. The sum of the racial categories should equal the total number of unduplicated clients

reported in Item 4. Do not include any anonymous clients in these counts.

The following racial category descriptions, defined in October 1997, will be required for all Federal reporting beginning in 2003, as mandated by the Office of Management and Budget (see <http://www.whitehouse.gov/omb/fedreg/ombdir15.html> for more information). HAB is mandating use of these categories as of January 2002.

All individuals who identify themselves with more than one race should be counted in the “More than one race” category.

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

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

Asian is a person 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.

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

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

More than one race is a person who identifies with more than one racial category.

10. Funding received from EMA(s)

Enter the funding received from each of the following sources. An EMA is an eligible metropolitan area and is the area that has been designated to receive funding from an official Title I grantee.

Total Title I funds should equal the total dollar amount of all monies received from EMAs. EMA codes, listed below, should be used to identify each Title I funding source separately.

EMA codes are as follows:

Anaheim/ Orange Co.	9923	New Orleans	9919
Atlanta	9910	New York	9901
Austin/ Travis County	9935	Newark	9904
Baltimore	9918	Norfolk	9953
Boston	9914	Oakland	9917
Caguas	9936	Orlando	9929
Chicago	9909	Passaic/Bergen	9932
Cleveland/ Lorain	9943	Philadelphia	9911
Dallas	9913	Phoenix	9930
Denver	9926	Ponce, PR	9925
Detroit	9924	Portland	9939
Dutchess County	9937	Riverside/ San Bernardino	9931
Fort Lauderdale	9912	Sacramento	9948
Ft. Worth/ Arlington	9944	San Antonio	9940
Hartford	9945	San Diego	9915
Houston	9906	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
Miami	9905	Tampa/ Saint Petersburg	9921
Middlesex/ Somerset	9946	Vineland/ Milleville	9942
Minneapolis/ St. Paul	9947	Washington D.C.	9907
Nassau/Suffolk	9922	West Palm Beach	9934
New Haven/ Fairfield	9928		

11. Funding received from other sources

Enter the total funding received from each of the following sources:

Federal Section 330 is funding from the Public Health Services Act fostering the planning and development of community health centers, migrant health centers, and health care for the homeless (Section 330).

Other Federal funding (excluding Medicaid/Medicare) is funding from any Federal source except the Ryan White CARE Act, Sections 330 of the Public Health Services Act, and Federal pilot projects reported in other funding categories.

State/local (other than Medicaid) is funding from State or local appropriations, not including Medicaid.

Client payments are funding received directly from clients.

Manufacturers' rebates are dollars received from drug manufacturers, which represent a percentage of the cost of the drug.

All other sources not included above may include funding from foundations, businesses, or research and clinical trials.

Note: All AIDS pharmaceutical assistance program funding should be annualized to reflect the reporting period.

Calculating Annual Fiscal Information*

Example: *Annualizing fiscal information*—A provider agency received funding from the following sources in 2002:

- \$120,000 from Source A for a fiscal year beginning 10/1/2001 and ending 9/30/2002.
- \$240,000 from Source B for a fiscal year beginning 10/1/2002 and ending 9/30/2003.
- \$120,000 from Source C for the time period 12/1/2001 through 11/30/2002.

Source A: \$120,000 / 12 months = \$10,000 per month / 9 months (January–September) of 2002 = \$90,000

Source B: \$240,000 / 12 months = \$20,000 per month / 3 months (October–December) of 2002 = \$60,000

Source C: \$120,000 / 12 months = \$10,000 per month / 11 months (January–November) of 2002 = \$110,000

Total funding for the 2002 reporting period = \$90,000 from Source A + \$60,000 from Source B + \$110,000 from Source C = \$260,000

***NOTE:** This information is being “annualized” and may or may not equal the amount received in the funding cycle.

your program offers (e.g., premium payments) report the total cost of providing that service, the unduplicated number of clients receiving that service during the reporting period, and the total client-months for which the program provided that service.

If your program does not cover a particular service, report that category as “zero.”

13. Annual expenditures for services under the Flexibility Policy

Enter the annual cost for providing the listed services under the Flexibility Policy.

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 increase adherence to medication regimens, improve access to medications, and help clients monitor their progress in taking HIV-related medications. Please note that grantees **must** request in writing to use ADAP dollars for services other than medications.

14. Total expenditures

Enter the total expenditures for your State ADAP or local APA program. Include health insurance costs, flexibility costs, plus administrative costs, including dispensing costs.

15. Medication prescribed

Enter the type of drug (using HRSA's drug codes) and number of clients receiving any drug and the total cost of the drug. Each drug code should be reported only once.

For a list of HRSA drug codes visit <http://hab.hrsa.gov/tools.htm>

SECTION 8. HEALTH INSURANCE PROGRAM (HIP) INFORMATION

*Section 8 (Items 1–10) should be completed only by all State and other entities that used CARE Act funds to pay for or supplement a client's health insurance. This section should **not** be completed by CARE Act programs that provide funding to HIP programs, but do not provide health insurance.*

12. Annual expenditures for health insurance services within State ADAP or local APAs

Report specific Health Insurance Program activities and expenditures in this section. For each service

The State agency or other entity receiving Ryan White CARE Act funding for Health Insurance Programs is required to submit this section.

1. Total number of unduplicated clients

Enter 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. 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.

2. 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.

3. 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. The sum of the four categories should equal the total number of unduplicated clients reported in Item 1. Do not leave any category blank or include any anonymous clients in these counts.

4. Age of clients

Report the actual number of unduplicated clients in each age group using client ages at the end of the reporting period. The sum of the age groups should equal the total number of unduplicated clients reported in Item 1. Do not include any anonymous clients in these counts.

5. Number of Hispanic or Latino/a clients

Report the number of clients who identified themselves as Hispanic or Latino/a. Clients of mixed ethnic identity should be counted in the category that best reflects their identity, based on their self-report. The sum of the three groups should equal the total number of unduplicated clients reported in Item 1. Do not include any anonymous clients in these counts.

Hispanic or Latino/a is a person of Mexican, Puerto Rican, Cuban, Central or South American, or

other Spanish culture or origin, regardless of race.

6. Race of clients

Report the actual number of unduplicated clients in each racial group. The sum of the race categories should equal the total number of unduplicated clients reported in Item 1. Do not include any anonymous clients in these counts.

The following racial category descriptions, defined in October 1997 will be required for all Federal reporting beginning in 2003, as mandated by the Office of Management and Budget (see <http://www.whitehouse.gov/omb/fedreg/ombdir15.html> for more information).

All individuals who identified themselves with more than one race should be counted in the “More than one race” category.

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

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

Asian is a person 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.

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

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

More than one race is a person who identifies with more than one racial category.

7. Annual expenditures for HIP

Report specific Health Insurance Program 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.

If your program does not cover a particular service, report that category as “zero.”

8. Total expenditures

Report the Total Health Insurance Expenditures from Item 7 plus any other administrative costs.

9. Annual HIP funding by CARE Act funds

Enter the HIP funding received from each of the listed sources. An EMA is an eligible metropolitan area. See the EMA codes in Section 7, Item 10.

All HIV/AIDS Health Insurance Program funding should be annualized to reflect the reporting period. See the method provided in Section 7, Item 11.

10. Funding for HIP by other sources

Enter the funding received from each of the listed sources. See the definitions in Section 7, Item 11.

All HIV/AIDS Health Insurance Program funding should be annualized to reflect the reporting period. See the method provided in Section 7, Item 11.

GLOSSARY OF CARE ACT DATA REPORT TERMS

ADAP	<i>AIDS Drug Assistance Program</i> —A State-administered program authorized under Title II of the CARE Act that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.
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. Please note that grantees <i>must</i> request in writing to use ADAP dollars for services other than medications.
Affected client	A family member or partner of an infected client who receives at least one Ryan White CARE Act supportive or case management 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	<i>Acquired immune deficiency syndrome</i> —A disease caused by the human immunodeficiency virus.
Ambulatory/outpatient medical care	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. This 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 Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
American Indian or Alaskan Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
Antiretroviral	A substance that fights against a retrovirus, such as HIV. (See Retrovirus)
APA	<i>AIDS pharmaceutical assistance</i> —A local pharmacy assistance program implemented by a Title I EMA or Title II state. The Title II Grantee, consortium or Title I Planning Council contracts with one or more organizations to provide medications to clients. These organizations may or may not provide other services (e.g., primary care, case management) to the patients or clients that they serve through a Ryan White (or other funding sources) contract with their grantee.
Asian	A person 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	A person having origins in any of the black racial groups of Africa.
Buddy/companion service	An activity provided by volunteers/peers to assist the client in performing household or personal tasks, and providing mental and social support to combat the negative effects of loneliness and isolation.

CARE Act	<i>Ryan White Comprehensive AIDS Resources Emergency Act</i> —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 CARE Act was enacted in 1990 (Pub. L. 101-381), reauthorized in 1996 as the Ryan White CARE Act Amendments of 1996, and reauthorized again in 2000 as the Ryan White CARE Act Amendments of 2000.
Case management services	A range of client-centered services that link clients with health care, psychosocial, and other services. Ensures 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. Also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from inpatient facility. 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. May include client-specific advocacy and/or review of utilization of services.
CDC	<i>Centers for Disease Control and Prevention</i> —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.
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.
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 1500 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.
CEO	<i>Chief Elected Official</i> —The official recipient of Title I CARE Act funds within the EMA, 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 CARE Act in the EMA and ensuring that all legal requirements are met. In EMAs with more than one political jurisdiction, the recipient of Title I CARE Act 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.
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 Title-related meetings, groups, or training. This does not include child care while the client is at work.
Child welfare services	The provision of family preservation/unification, foster care, parenting education, and other child welfare services. Services designed to prevent the break-up of a family and to reunite family members. Foster care assistance to place children under the age of 21 years, whose parents are unable to care for them, in temporary or permanent homes, and to sponsor programs for foster families. Includes other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents’ rights. Involves presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of children who are HIV positive about risks and complications, caregiving needs, and developmental and emotional needs of children.
Client	See infected client or affected client.

Client advocacy	The provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.
Combination therapy	Two or more drugs or treatments used together to achieve optimum results against HIV infection and/or AIDS. For more information on treatment guidelines, visit http://hivatis.org/trtgdlns.html .
Co-morbidity	A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.
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 Title II 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.
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.
Day or respite care for adults	Community or home-based, nonmedical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of an adult client.
DCBP	<i>Division of Community Based Programs</i> —The division within HRSA’s HIV/AIDS Bureau that is responsible for administering Title III, Title IV, and the HIV/AIDS Dental Reimbursement Program.
Developmental assessment/early intervention services	The provision of professional early intervention by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. Involves assessment of an infant’s or child’s developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. Includes comprehensive assessment of infants and children taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provides information about access to Head Start services, appropriate educational setting for HIV-affected clients, and education/assistance to schools.
Dispensing of pharmaceuticals	The provision of prescription drugs to prolong life or prevent deterioration of health.
DSS	<i>Division of Service Systems</i> —The division within HRSA’s HIV/AIDS Bureau that is responsible for administering Title I and Title II (including the AIDS Drug Assistance Program, ADAP).
DTTA	<i>Division of Training and Technical Assistance</i> —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.
Early intervention	See HIV/EIS (<i>HIV Early Intervention Services/Primary Care</i>)
Early intervention services for Titles I and II	A combination of services that include outreach, HIV counseling and testing, referral, and the provision of outpatient medical care and supportive services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care.
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 Federal Poverty Level (FPL), such as 200% FPL. Medical eligibility is most often a positive HIV diagnosis. Eligibility criteria vary among ADAPs.
EMA	<i>Eligible Metropolitan Area</i> —The geographic area eligible to receive Title I CARE Act funds. The boundaries of the eligible metropolitan area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the Centers for Disease Control and Prevention (CDC). Some EMAs include just one city and others are composed of several cities and/or counties. Some EMAs extend over more than one State.

Emergency financial assistance	The provision of short-term payment for essential utilities and for medication assistance when other resources are not available.
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 Title IV 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).
Food bank/home-delivered meals	The provision of actual food, meals, or nutritional supplements. 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.
FTEs	<i>Full-time equivalent</i> —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 in the EIS Program 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 CARE Act grantee that receives Federal funding directly from the Federal government (HRSA). This agency may be the same as the provider agency, or may be the agency through which the provider agency is subcontracted.
HAART	<i>Highly active antiretroviral therapy</i> —An aggressive anti-HIV treatment usually including a combination of three or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels.
HAB	<i>HIV/AIDS Bureau</i> — The bureau within the Health Resources and Services Administration (HRSA) of the DHHS that is responsible for administering the Ryan White CARE Act. Within HAB, the Division of Service Systems administers Title I, Title II, and the AIDS Drug Assistance Program (ADAP); the Division of Community Based Programs administers Title III, Title IV, 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 Office of Science and Epidemiology administers the Special Projects of National Significance (SPNS) Program.
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.
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	<i>Health Insurance Program</i> —A program authorized and primarily funded under Title II of the CARE Act that makes premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to maintain his/her health insurance coverage.
Home health: para-professional care	The provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes.

Home health: professional care	The provision of services in the home by licensed health care workers such as nurses.
Home health: specialized care	The provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.
Housing or housing-related services	The provision of short-term assistance to support temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related services may be housing in medical treatment programs for chronically ill clients (e.g., assisted living facilities), specialized short-term housing, transitional housing, and non-specialized housing for HIV-affected clients. Category includes access to short-term emergency housing for homeless people. This also includes assessment, search, placement, and the fees associated with them.
Hispanic or Latino/a	A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
HIV/AIDS status	The outcome of the client’s HIV test result, which includes: (1) HIV-positive not AIDS—client tested positive for and being diagnosed with HIV, but has not advanced to AIDS; (2) HIV-positive AIDS status unknown—client 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 friend or family member; and (5) unknown—HIV/AIDS status of the client is unknown and not documented.
HIV counseling and testing	<p>The delivery of HIV counseling to an individual. Counseling includes pretest and posttest counseling activities (e.g., offering the individual the HIV antibody test, as appropriate; services discussing the benefits of testing, including the medical benefits of diagnosing HIV disease in the early stages and of receiving early intervention primary care; reviewing the provisions of laws relating to confidentiality, including information regarding any disclosures that may be authorized under applicable law, and information regarding the availability of anonymous counseling and testing; and discussing the significance of the results, including the potential for developing HIV disease). Testing refers to antibody tests administered by health professionals to ascertain and confirm the presence of HIV infection (includes ELISA and Western Blot).</p> <p>Counseling and testing <u>does not</u> include tests to measure the extent of the deficiency in the immune system because these tests are considered to be fundamental components of comprehensive primary care. This service category excludes mental health counseling/therapy, substance abuse counseling/treatment, and psychosocial support services. These services are listed separately.</p>
HIV disease	Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.
HIV/EIS	<i>HIV Early Intervention Services/Primary Care</i> —A program that encompasses the care supported by the Title III 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.
Hospital or university-based clinic	Includes ambulatory/outpatient 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.
HRSA	<i>Health Resources and Services Administration</i> —The 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 CARE Act.
IDU	<i>Injection drug user</i>

Infected client	An individual who is HIV positive who receives at least one Ryan White CARE Act-eligible service during the reporting period.
Lead agency	The agency responsible for contract administration; also called a fiscal agent. An incorporated consortium sometimes serves as the lead agency.
Legal services	The provision of services to individuals with respect to powers of attorney, do not resuscitate orders, wills, trusts, bankruptcy proceedings, 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 CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.
Local, county or State health department	Publicly funded health department administered by a local, county, or State government.
Manufacturers' rebates	Dollars received from drug manufacturers, which represent a percentage of the cost of the drug.
Medicaid	A jointly funded, Federal-State health insurance program for certain low-income and needy people.
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.
More than one race	A person who identifies with more than one racial category.
Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
NDC	<i>National Drug Code</i> —The identifying drug number maintained by the FDA. For purposes of the Section 340B Drug Discount Program, the NDC number is used including labeler code (which is assigned by the FDA and identifies the establishment), product code (which identifies the specified product or formation), and package size code when reporting requested information.
New clients	Persons 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 persons 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.
Nutritional counseling	Services provided by a licensed registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietitian should be recorded under "Psychosocial support services."
OI	<i>Opportunistic infection</i> —An infection or cancer that occurs in persons 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	<i>Office of Management and Budget</i> —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.

OSE	<i>Office of Science and Epidemiology</i> —The office within HRSA’s HIV/AIDS Bureau that administers the SPNS Program, HIV/AIDS evaluation studies, and the CARE Act Data Report.
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.
Outreach services	Include programs which have as their principal purpose identification of people with HIV disease so that they may become aware of, and may be enrolled in, care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. 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 HIV-infected individuals 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 Title III grantee or its parent organization.
Patients	All individuals with HIV infection who received at least one primary health care service during the reporting period.
Permanency planning	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.
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.
PLWHA	<i>People living with HIV/AIDS.</i>
PLWHA coalition	Organizations of people living with HIV/AIDS that provide support services to individuals and families affected by HIV and AIDS.
Primary health care service	Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a patient who is HIV positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, 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) that are funded by the Ryan White CARE Act. Services may be funded through one or more Federal Ryan White CARE Act grants, or through subcontract(s) with official Ryan White CARE Act grantees. A provider may also be a grantee such as in Titles III and IV.

Psychosocial support services	The provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, play, and other rehabilitation therapies), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse, or nutritional counseling that are provided to clients, family and household members, and/or other caregivers and focused on HIV-related problems.
Public/Federal ownership	The organization is funded by the Federal government and is operated by Federal government employees. A Federal agency is an example of a publicly owned organization.
Public/local ownership	The organization is funded by a local government entity and is operated by local government employees. Local health departments are examples of publicly owned organizations.
Public/State ownership	The organization is funded by a State government entity and is operated by State government employees. A State health department is an example of a publicly owned organization.
Publicly funded community health center	Includes community health centers, migrant health centers, rural health centers, and homeless health centers.
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. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.
Referral to clinical research	The provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research involves studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an IRB that initially approves and periodically reviews the research.
Referrals for health services	The act of directing a patient who is HIV positive to a health service not available within an EIS program. For the purposes of Title III data reporting, the process of making a referral is independent of the health service provided, and does not require evidence that the patient actually received the service for which he or she was referred. However, if the service that the patient is being referred for is paid for by the EIS program, then the cost of providing referral services should be reported. Title III funds can be used to pay for the costs associated with making the referral, as well as to pay for the services for which the patient was referred. The referrals reported by Title III programs should be referrals for health services provided outside of the EIS Program. Case management and other referrals for social or support services should not be reported in the Referrals Section, nor should they be factored into the cost of providing referral services. Examples of health services for which patients may be referred outside of the EIS Program include primary health care or specialty health services, any diagnostic health services such as radiology, lab tests, mental health evaluations, biopsies, and so forth.
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 CARE Act Title funding for an entire calendar year.
Residential or in-home hospice care	Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients 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 patients.

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 a person at risk for disease. For HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work.
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	Client paid for the majority of his or her own care.
Solo/group private medical practice	Includes all health and health-related private non-profit practitioners and practice groups.
SPNS	<i>Special Projects of National Significance</i> —A health services demonstration, research, and evaluation program funded under Part F of the CARE Act. SPNS projects are awarded competitively.
STI	<i>Sexually transmitted infection</i> —Infections spread by the transfer of organisms from person to person during sexual contact.
Substance abuse treatment center	An agency that focuses on the delivery of substance abuse treatment services.
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 or illegal drugs) provided in outpatient setting rendered by a physician or under the supervision of a physician, or other qualified personnel.
Substance abuse services-residential	The provision of treatment to address substance abuse (including alcohol and/or legal and illegal drugs) problems provided in an inpatient health service setting (short term).
Target population	A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.
TB skin test (PPD Mantoux)	The abbreviation for purified protein derivative, a substance used in intradermal testing for tuberculosis.
Title I	The part of the Ryan White CARE Act that provides direct financial assistance to designated Eligible Metropolitan Area (EMAs) that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related: (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals and families with HIV disease; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, when medically appropriate, from inpatient facilities.
Title II	The part of the Ryan White CARE Act that 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. The CARE Act emphasizes that such care and support is 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 among States and Territories based, in part, on the number of AIDS cases in each State (or Territory) as a proportion of the number of AIDS cases reported in the entire United States.
Title III	The part of the Ryan White CARE Act that provides support for early intervention services, including preventive, diagnostic, and therapeutic services for HIV/AIDS clients. This particularly includes a continuum of comprehensive primary health care, referrals for specialty care, counseling and testing, outreach, case management, and eligibility assistance.

Title IV	The part of the Ryan White CARE Act that supports coordinated services and access to research for children, youth, and women with HIV disease and their affected family members.
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.
Transportation services	Conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services.
Treatment adherence services	Provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.
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 provider's sites.
Unique record number (URN)	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	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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