

AGENCY: _____

PROGRAM: _____

FUNDING SOURCE: FORMULA () SUPPLEMENTAL ()

CONTRACT PERIOD: _____

PROGRAM ANALYST: _____

AACO MONTHLY DATA FORM FOR THE MONTH OF _____
(one month only)

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH TYPE OF UNIT OF SERVICE YOU PROVIDE. PLEASE USE ONE SHEET FOR EACH SERVICE UNIT IDENTIFIED IN YOUR SERVICE DESCRIPTION PAGE. **PLEASE DO NOT REVISE THIS FORM.**

SERVICE UNIT TYPE: _____

1. Number of units of service provided this month (current contract period): _____

2. Number of new unduplicated clients provided this service this month: _____
(a. clients **not** previously reported. A new client is an individual who received services from a particular provider for the **first time ever**. A person can be new to a provider only once. Clients who receive no services for a time, or clients who are considered deactivated by the provider, should not be reported as new every time they return or are reactivated. A provider should determine whether clients are old or new with readily available information. It is not expected to retrieve archived records or take other unreasonable measures.)

3. Total number of unduplicated clients provided this service this month: _____

4. Number of unduplicated clients provided this service from the start of the contract period through the month being reported: _____

ATTACHMENT B

RYAN WHITE TITLE I QUARTERLY NARRATIVE REPORT

Providers who receive Title I Formula and Supplemental funding as well as City funding for AIDS treatment services (home health, case management, transportation, etc.) through the AIDS Activities Coordinating Office, must complete this narrative report on a quarterly basis. The reporting quarters run on a calendar year schedule, i.e. January through March, April through June, July through September and October through December. **PLEASE COMPLETE A SEPARATE FORM IN CONNECTION WITH EACH TITLE I FORMULA, SUPPLEMENTAL AND CITY FUNDED AIDS TREATMENT SERVICE CONTRACT THAT YOU RECEIVE THROUGH AACO.** Do not complete this form in connection with CDC funded Prevention/Education contracts your agency may receive through AACO.

AGENCY NAME:

PROGRAM:

Year 07 Amount: _____ **Funding Source:** **Formula** _____
Supplemental _____
City General _____

1. Briefly describe the services offered by this program during the past quarter. Describe the target population(s) served by this contract and how this program has met the needs of this population. For the first report of this contracts fiscal year (i.e. for Supplemental - April through June and Formula - January through March), indicate the program's annual goals. Subsequent quarterly reports should indicate any AACO pre-approved changes made to this program's annual goals and the reason(s) for same.

Exhibit 7 (Cont.)

2. Describe the progress made by this program in meeting its annual goals during the past quarter. Please include the number of unduplicated clients served and the number of service units (case management encounters, visits, trips, etc.) provided to those clients. In some cases your program may have multiple service units. You should refer to your AACO service provisions as well as the AACO Monthly Data Forms in connection with this program in completing this section. If this program did not meet its service goals during the past quarter, please indicate the reason(s) and describe corrective steps either planned or being implemented.

2. If the services offered by this program are Medicaid eligible (i.e. case management, primary medical care, home health, dental and nutritional counseling) indicate a) how many of the reported unduplicated clients who received services during the quarter (indicated in question #2 above) were Medicaid eligible and b) how many of these Medicaid eligible clients reported in #3a received this service funded by Medicaid or Health Choices?

STANDARD
ANNUAL ADMINISTRATION REPORT

CONTACT INFORMATION

Provider Name (line 1 of 2):

Provider Name (line 2 of 2):

Address (line 1 of 2):

Address (line 2 of 2):

City:

State:

Zip Code:

Contact Name:

Title:

Phone:

Fax:

2. Provider Number: _____ 3. Reporting Period (Month/Day/Year):
_____ / ____ / _____ through ____ / ____ / _____

4. Zip Code of Principal Site: _____ 5. Total Number of Provider Sites: _____

6. Provider Type (circle one):

- (01) Hospital or hospital-based clinic
- () Public-funded community health center
- (03) Public-funded community mental center
- (04) Other community-based service organization
- (05) PWA coalition
- (06) Health department
- (07) Other public agency
- (08) Solo/group private health practice
- (09) Other
- (99) Unknown

7. Ownership Status (circle one):

- (01) Public/local
- (02) Public/state
- (03) Public/federal
- (04) Private/nonprofit
- (05) Private/for profit
- (06) Unincorporated
- (99) Unknown

8. Do members of minority racial/ethnic groups constitute a majority of Board members and/or a majority of staff (volunteer or paid) providing care? (circle one)

(1) Yes (2) No (9) Unknown

STANDARD
ANNUAL ADMINISTRATIVE REPORT (Cont.)

Total Number of Clients (nnn,nnn = number, 999,999 = unknown)

9. Total Unduplicated Number of Clients Served During Reporting Period	
10. Number of <u>New</u> Clients	
11. Number of Clients Without Client-Level Information (anonymous, drop-in)	
12. Number of clients who are:	Male Female
13. Number of Clients who are:	White (Non-Hispanic) Black (Non-Hispanic) Hispanic Asian/Pacific Islander American Indian/Aleutian/Native Alaskan/Eskimo
14. Number of clients who are:	Under 13 Years of Age 13-19 Years of Age Age 20 and Over
15. (Medical Providers only) Estimated % of Adult/Adolescent Clients by exposure category: 999.9 = Unknown	Men who have sex with men Injection Drug Use (IDU) Men who have sex with men AND IDU Heterosexual contact Other/Undetermined
16. HIV/AIDS Status: 999.9 = Unknown	Estimated % of clients who have HIV (non-AIDS) Estimated % of clients with an AIDS diagnosis

STANDARD
ANNUAL ADMINISTRATIVE REPORT (CONT.)

16. Total Office-Based Health Service Contacts this Reporting Period
(0= no contacts but deliver service; nn,nnn,nnn = number contacts;
99,999,998 = not applicable, does not deliver service; 99,999,999 = unknown)

_____	Medical care visits
_____	Dental care visits
_____	Mental health treatment/therapy/counseling visit
_____	Substance abuse treatment/counseling visits
_____	Rehabilitation services

16. Case Management Encounters
(0= no contacts but deliver service; nn,nnn,nnn = number contact;
99,999,998 = not applicable, does not deliver service, 99,999,999 = unknown)

_____	Face to face encounters
_____	Other encounters

16. Home Health Care Visits
(0 = no visits but deliver service; nn,nnn,nnn = number visits;
99,999,998 = not applicable, does not deliver service; 9,999,999 = unknown)

_____	Paraprofessional	(4 hours = 1 visit)
_____	Professional	(2 hours = 1 visit)
_____	Specialized	(2 hours = 1 visit)

**STANDARD
ANNUAL ADMINISTRATIVE REPORT (CONT.)**

16. Number of HIV/AIDS Clients who Received these Services:
 (0 = no contacts but deliver service; n,nnn,nnn = number contacts;
 9,999,998 = not applicable, does not deliver service; 9,999,999 = unknown)

_____	Residential hospice	_____	Housing assistance
_____	In-home hospice	_____	Food bank/home
_____	Buddy/companion	_____	Delivered meals
_____	Client advocacy	_____	Transportation
_____	Other counseling	_____	Education/risk
		reduction	
_____	Day or respite care	_____	Foster care/adoption
_____	Emergency financial assistance	_____	Other services

16. HIV/AIDS Funding (for HIV/AIDS clients):
 (nnn,nnn,nnn = actual dollar amount; 999,999,998 = not applicable; 999,999,999 = unknown)

_____	Title I CARE	_____	State/local public
_____	Title II CARE	_____	sources (other than
			than Medicaid)
_____	Title III CARE	_____	Other sources (fund-
			raising,
_____	Section 329, 330, 340	_____	contributions,etc.)
_____	HIV Pediatrics Demonstration	_____	Other Federal
_____	Projects, other Federal Pilots	_____	Funding

22. Expenditures for HIV/AIDS Related Services
 (nnn,nnn,nnn = amount spent; 999,999,998 = not applicable; 999,999,999 = unknown)

_____	Direct service staff	_____	Other direct
_____	Medications	_____	Total Expenditures
_____	Contracted services		

23. Staffing
 (000.0= applicable but no FTEs; nnn.n = number FTEs; 999.9 = not applicable)

_____	Total paid staff in full-time equivalent	_____	Total volunteer staff in full-time
			equivalents

24. Staff Added
 Were Title I and/or Title II CARE funds used to add any paid staff?
 (circle one for each category)

Physicians	Licensed mental health staff
(1) Yes (2) No (9) Unknown	(1) Yes (2) No (9) Unknown

Nurses, physician assistants, nurse practitioners

(1) Yes (2) No (9) Unknown

Case Managers

(1) Yes (2) No (9) Unknown

Dentists

(1) Yes (2) No (9) Unknown

Clerical/support staff

(1) Yes (2) No (9) Unknown

Attachment D

CITY OF PHILADELPHIA

DEPARTMENT OF PUBLIC HEALTH
500 S. Broad Street – 2nd Floor
Philadelphia, PA 19146

ESTELLE B. RICHMAN
Health Commissioner

JESSE MILAN, JR., ESQ.
Director

AIDS Activities Coordinating Office

March 13, 1997

Dear Title I Provider:

I am writing to inform you that federal Health Resources and Services Administration (HRSA) guidelines require your agency to have procedures and internal controls in place to document and ensure that all clients receiving Title I funded services are “eligible beneficiaries.” Eligible beneficiaries are Persons with HIV/AIDS and their families.

This mandatory documentation applies to all Ryan White funded services with only limited exceptions (for example, services to non-HIV infected family members or anonymous services).

Consistent with HRSA mandates, AACO requires the following of all service providers who receive Ryan White Title I funds in the nine county Philadelphia planning region:

- 1) The Ryan White provider should ensure that confidential primary documentation of a client's positive HIV serostatus is included in the client's file. This documentation must be in the form of either a lab test result issued by the testing laboratory or a physician's certification.
- 2) In cases where referrals are made for Ryan White funded services, other than case management or primary care, from another Ryan White funded provider, it is not necessary for the agency providing the new service to maintain HIV status documentation in the client's file. Rather, the referring Ryan White agency will maintain this information. The client file located at the site providing the service must contain a reference to this HIV documentation at the referring site. This will be either in the form of a certified referral form (signed and on agency letterhead) or a notation that such eligibility has been confirmed, including the name of the person and organization verifying eligibility, date, nature and location of primary documentation.
- 3) As stated above, where it is appropriate for a Ryan White agency to provide services to HIV-affected clients, it is the responsibility of the provider to maintain documentation in each client's chart as to the client's relationship to a Person With HIV/AIDS.

Your assigned AACO Program Analyst, during an upcoming site visit, will check client files to verify that the above referenced documentation is maintained by your agency.

If you have any further questions concerning this matter, please contact John Cella, Administrator for Ryan White Title I programs, or your assigned AACO Program Analyst.

Once again, thank you for your interest in this most important matter.

Sincerely,

Estelle B. Richman
Health Commissioner
EBR/d
cc: John Cella