

**CITY OF PHILADELPHIA  
SUBRECIPIENT AUDIT GUIDE**

**Issued By:  
Office of the Director of Finance**

# CITY OF PHILADELPHIA SUBRECIPIENT AUDIT GUIDE

Highlights of Changes

June 1997

## SECTION 100

- The 1997 Audit Guide will apply if total federal financial assistance expended by a subrecipient through City of Philadelphia contract(s) (either directly from the City or indirectly through another City subrecipient) is \$300,000 or more during the subrecipients fiscal year.
- The \$300,000 is not the total assistance provided under City of Philadelphia contract(s) but only the federal portion.
- The City or any of the Departments in the City have the right to require an audit or agreed-upon procedures to be performed below the \$300,000 level. This requirement will be communicated to the provider agency.
- The new audit requirements are effective for provider agencies in the fiscal years beginning on or after July 1, 1996.
- Notification of Engagement of Auditor Form needs to be submitted by the organization's year-end and not 60 days prior to the year-end as previously required (Section 103.17).
- Name, address, telephone and fax number changes for certain City Departments (Sections 104.03 and 105.01).
- Office of Housing and Community Development needs to receive additional copies of report for certain CFDA programs funded through other City Departments (Section 103.03 - Note No.(2))

## SECTION 200

- Addition of following technical references:
- AICPA SAS No. 82 - Consideration of Fraud in a Financial Statement Audit (Section 202.06)
- OMB A-133 (Revised June 24, 1997) (Section 204.07)
- OMB A-133 Compliance Supplement - Provisional 6/97 (Section 204.10)

## SECTION 300

- In accordance with OMB Circular A-133 (Revised June 24, 1997) auditors are to utilize a risk-based approach to determine which Federal programs are major programs. For the purposes of this Audit Guide only the Federal portion of a City of Philadelphia contract award is to be considered in the determination of major programs.
- Risk-based approach is to be utilized on auditing the Federal funds passed through a City of Philadelphia contract (Section 305.02).
- New OMB A-133 Compliance Supplement (Provisional 6/97) is required to be utilized in testing of major programs (Section 305.05 to 305.08).
- City of Philadelphia Compliance Audit Requirements (Section 306.11) changed regarding auditing/reporting, as follows:
- For certain City of Philadelphia Department's a supplemental financial schedule will be required when the total assistance provided by the City for a contract is \$300,000 or more. This is the total amount of assistance expended, whether Federal, State or City funded.

- In most instances the supplemental financial schedules will require an auditor's opinion in accordance with the City of Philadelphia, Subrecipient Audit Guide. In some instances the supplemental financial schedules will only require an agreed-upon procedures report on whether the amounts reflected in the schedule are in agreement with the agency's books of account.

- The auditor is to report questioned costs in the schedule of findings and questioned costs for known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program or where an audited supplemental schedule is required. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program or when an audited supplemental schedule is required (Section 308.05).

- Requirements of revised OMB A-133 regarding follow-up of prior audit findings has been added to the Audit Guide. This new requirement necessities work by the organization on the current status of prior audit findings (Section 311).

#### **SECTION 400**

- To be provided at a later date.

#### **SECTION 500**

- Changed program audit requirement to the organization's fiscal year rather than the contract period (Section 502.01).

- Reporting requirements to be provided at a later date.

#### **SECTION 1000**

- Addition of Micro-Enterprise Assistance Program to Sections 1110 and 1130.

- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 1150.01).

- Agreed-upon procedures report when supplemental schedules are required (Section 1150.01).

#### **SECTION 2000**

- Change in CFDA numbers (Section 2120.01)

- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 2150.01).

- Auditor's opinion will be required on the supplemental schedules (Section 2150.01).

#### **SECTION 3000**

- Certain program types were eliminated from this section since they are no longer pertinent.

#### **SECTION 4000**

- Changes in CFDA numbers (Section 4120.01).

- Reference to OMB Circular Compliance Supplement (Provisional 6/97) and Catalog of Federal Domestic Assistance (CFDA) as sources for program and financial compliance procedures (Sections 4130 and 4140).

- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 4150.01).

- Agreed-upon procedures report when supplemental schedules are required (Section 4150.01).

## **SECTION 5000**

- Addition of Innovative Homeless Initiatives Demonstration Project Program to Sections 5110, 5120 and 5130.

## **SECTION 6000**

### **AACO Programs:**

- Change of program name of Support Services to Aids Care Services.
- Addition of HIV Prevention: Education and Risk Reduction Program to Sections 6130.12 to 6130.15.
- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 6150.01).
- Auditor's opinion will be required on the supplemental schedules (Section 6150.01).
- New Exhibits

### **CODAAP Programs:**

- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 6250.01).
- New Exhibits

### **OMH/MR Programs:**

- Changes to CFDA Numbers (Section 6320.01).
- Addition of compliance procedures on Early Intervention Program (Section 6330.50).
- Changes to financial auditing procedures relating to:
  - Third party revenue (Section 6340.15)
  - Retained revenue (Section 6340.17)
- Addition of the line item "Retained Revenue Allowance" to the Schedule of Adjustments on Program Activity Invoice Summary (Section 6350.04).
- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 6350.01).
- Auditor's opinion will be required on the supplemental schedules (Section 6350.01).

### **Office of Maternal and Child Health:**

- Changes to various program descriptions.
- Change in CFDA Numbers (Section 6420.01).
- Requirement of supplemental financial schedules only when the total expenditures for a City contract is \$300,000 or more (Section 6450.01).
- Auditor's opinion will be required on the supplemental schedules (Section 6450.01).
- New Exhibits

### **Division of Disease Control:**

- No changes.

### **Appendix:**

**CITY OF PHILADELPHIA  
SUBRECIPIENT AUDIT GUIDE**

**TABLE OF CONTENTS**

	SECTION REF.
<b>SECTION 100 - ADMINISTRATION AND OVERVIEW</b>	
Purpose and Effective Date of Audit Guide	101
Applicability of Audit Guide	102
Auditor Selection and Qualification	103
Audit Report Delivery and Distribution	104
Who to Contact for Assistance	105
<b>SECTION 200 - SUMMARY OF APPLICABLE LITERATURE</b>	
General Information	201
American Institute of Certified Public Accountants	202
General Accounting Office	203
Office of Management and Budget	204
Code of Federal Regulations	205
City of Philadelphia	206
Commonwealth of Pennsylvania	207
Audit Hierarchy	208
<b>SECTION 300 - GENERAL AUDITING STANDARDS AND REQUIREMENTS</b>	
Introduction	301
Working Papers	302
Planning	303
Testing of Compliance with Laws and Regulations	304
Major Program Determination	305
Auditing Requirements	306
Audit Sampling	307
Questioning of Costs	308
Subrecipient Requirements	309
Disclosure of Possible Fraud, Irregularities and Other Illegal Acts	310
Follow-up on Prior Audit Report Findings	311
Written Representations from Management	312
Exit Conference	313
<b>SECTION 400 - REPORTING STANDARDS AND REQUIREMENTS</b>	
SINGLE AUDITS	(To be issued)
<b>SECTION 500 AUDITING AND REPORTING STANDARDS AND REQUIREMENTS</b>	
<b>PROGRAM AUDIT ON AN AWARD (NON - SINGLE AUDIT)</b>	
Background	501
Audit Period	502
Auditing Requirements	503
Reporting Requirements	504

**CITY OF PHILADELPHIA  
SUBRECIPIENT AUDIT GUIDE**

SECTION  
REF.

**SECTION 600 TO 900**

(Reserved for Future Use)

**SECTION 1000 - CITY REPRESENTATIVE AND DEPARTMENT OF COMMERCE**

General Information	1001
Program Descriptions and Operations	1110
Federal CFDA Numbers/Other Regulations	1120
Program Compliance Procedures	1130
Financial Compliance Procedures	1140
Supplemental Financial Schedules and Reports	1150

**SECTION 2000 - DEPARTMENT OF HUMAN SERVICES**

General Information	2001
Children and Youth Division and Juvenile Justice Services	2100
General Information	2101
Program Descriptions and Operations	2110
Federal CFDA Numbers/Other Regulations	2120
Program Compliance Procedures	2130
Financial Compliance Procedures	2140
Supplemental Financial Schedules and Reports	2150
Exhibits	
Other Human Services Programs	2200
General Information	2201
Program Descriptions and Operations	2210
Federal CFDA Numbers/Other Regulations	2220
Program Compliance Procedures	2230
Financial Compliance Procedures	2240
Supplemental Financial Schedules and Reports	2250

**SECTION 3000 - MAYOR'S OFFICE OF COMMUNITY SERVICES**

General Information	3001
Program Descriptions and Operations	3110
Federal CFDA Numbers/Other Regulations	3120
Program Compliance Procedures	3130
Financial Compliance Procedures	3140
Supplemental Financial Schedules and Reports	3150

**SECTION 4000 - OFFICE OF HOUSING AND COMMUNITY DEVELOPMENT**

General Information	4001
Program Descriptions and Operations	4110
Federal CFDA Numbers/Other Regulations	4120
Program Compliance Procedures	4130
Financial Compliance Procedures	4140
Supplemental Financial Schedules and Reports	4150

**CITY OF PHILADELPHIA  
SUBRECIPIENT AUDIT GUIDE**

SECTION REF.

**SECTION 5000 - OFFICE OF EMERGENCY SHELTER AND SERVICES**

General Information	5001
Program Descriptions and Operations	5110
Federal CFDA Numbers/Other Regulations	5120
Program Compliance Procedures	5130
Financial Compliance Procedures	5140
Supplemental Financial Schedules and Reports	5150

**SECTION 6000 - DEPARTMENT OF PUBLIC HEALTH**

General Information	6001
---------------------	------

**AIDS ACTIVITIES COORDINATING OFFICE:**

General Information	6100
Program Descriptions and Operations	6110
Federal CFDA Numbers/Other Regulations	6120
Program Compliance Procedures	6130
Financial Compliance Procedures	6140
Supplemental Financial Schedules and Reports	6150
Exhibits	

**COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS:**

General Information	6201
Program Descriptions and Operations	6210
Federal CFDA Numbers/Other Regulations	6220
Program Compliance Procedures	6230
Financial Compliance Procedures	6240
Supplemental Financial Schedules and Reports	6250
Exhibits	

**OFFICE OF MENTAL HEALTH AND MENTAL RETARDATION:**

General Information	6301
Program Descriptions and Operations	6310
Federal CFDA Numbers/Other Regulations	6320
Program Compliance Procedures	6330
Financial Compliance Procedures	6340
Supplemental Financial Schedules and Reports	6350
Exhibits	

**OFFICE OF MATERNAL AND CHILD HEALTH:**

General Information	6401
Program Descriptions and Operations	6410
Federal CFDA Numbers/Other Regulations	6420
Program Compliance Procedures	6430
Financial Compliance Procedures	6440
Supplemental Financial Schedules and Reports	6450
Exhibits	

**DIVISION OF DISEASE CONTROL:**

General Information	6501
Program Descriptions and Operations	6510
Federal CFDA Numbers/Other Regulations	6520
Program Compliance Procedures	6530
Financial Compliance Procedures	6540
Supplemental Financial Schedules and Reports	6550

**CITY OF PHILADELPHIA  
SUBRECIPIENT AUDIT GUIDE**

**APPENDIX**

- A Notification of Engagement of Independent Auditor
- B Office of Management and Budget Circular A-133
- C City of Philadelphia - Contract Cost Principles and Guidelines

(Rev. 6/97)

## **SECTION 6000**

### **DEPARTMENT OF PUBLIC HEALTH**

#### **Section 6001 - General Information**

- .01 The Philadelphia Department of Public Health provides a broad range of services. It has grown since its inception during the nineteenth century to a multi-faceted agency which serves thousands of Philadelphians each year.
- .02 The Department of Public Health serves the public through many roles. It offers ambulatory care services, health promotion and education.

## **SECTION 6100 - AIDS ACTIVITIES COORDINATING OFFICE**

#### **Section 6101 - General Information**

- .01 The mission of the AIDS Activities Coordinating Office (AACO) is to stop the transmission of the Human Immunodeficiency Virus (HIV) in Philadelphia through education and prevention activities and to provide services to people with AIDS and to individuals with HIV infection related conditions. The Office is charged with coordination of all City of Philadelphia activities related to AIDS.
- .02 The AIDS Activities Coordinating Office includes four major divisions. These are: Medical Affairs, Policy and Planning; AIDS Prevention and Education Services; AIDS Agency Services; and AIDS Program Administration. Of these four divisions, the two with responsibility for the development and monitoring of contract service activities are AIDS Agency Services and AIDS Program Administration. Program development and monitoring are the responsibility of the former while contract and fiscal management rests with the latter.

#### **Section 6110 - Program Descriptions and Operations**

- .01 Some of the services provided by AACO include the following:

- a. **AIDS Care Services:**

Support services consist of those services that are provided directly to those individuals who are HIV positive and/or have been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS). In addition, care services are intended to provide support for family members and the loved ones of those who are infected with the Human Immunodeficiency Virus (HIV). Services usually consist of helping the individual in maintaining their self worth, independence, and human dignity while living with AIDS.

AIDS case management services consists of performing a needs assessment and developing, implementing, and monitoring a service/care plan as well as arranging for or referring a client to needed services. Such services, to which clients may be referred or which are arranged for clients, can be any services needed for activities of daily living, caring for HIV/AIDS infected individuals, and alleviation of psychological and social consequences of infection. Case management services require a thorough needs assessment and the development and monitoring of a formal services plan for the client.

- b. **Education:**

Education consists of activities aimed at changing knowledge, attitudes, and behaviors of individuals or groups for the purpose of motivating them to avoid contracting or transmitting HIV or alleviating anxiety about transmission and effects of the virus. Education is further defined as activities geared to increasing knowledge and skills of those who perform services for the HIV infected or their friends, families or significant others. Education activities normally consist of presentations, consultations, training, instruction, outreach, hotline operations, and media efforts.

## Section 6110 (Cont.)

- .02 All agencies under contract with the City of Philadelphia through AACO must submit monthly financial status reports. The purpose of the procedures package is to effectively and efficiently process requests for payment from each contract agency. The package indicated what types of reports were required, information to be included in each report and examples of how each report should look.
- .03 In order for an agency to invoice AACO (City of Philadelphia) for the expenditure of funds allocated through a contract, the submission of a cover letter, an invoice, a monthly budget performance report, and a personnel roster is required. Authorized advance payments must be requested in a letter. Additional information may also be required. Actual requirements for the preceding documents are detailed as follows:
- Invoices may differ in format but must include all of the following:
    - a) date submitted;
    - b) period of service for which invoice is being submitted for;
    - c) contract number;
    - d) contract name;
    - e) current period's expenses (as categorized in the contract budget.)
  - (Exhibit 1) Monthly Budget Performance Reports must accompany each invoice. This report identifies expenditures in the categories listed on the AACO approved line item budget form and must show current month and year-to-date expenses as well as total budget and the total amount remaining for each line item of the budget. Each column (current month, year-to-date, annual budget, budget amount remaining) must be totaled. Revenue offsetting program/contract costs must be indicated and subtracted from total expenses in all columns.
  - (Exhibit 2) Personnel Rosters must also accompany each invoice. Each roster must identify names of personnel being charged to a specific program/contract as well as expenditures for each position title. Columns showing current month and year-to-date expenses as well as total budget and total amount remaining for each position must be included and each column must be totaled.
  - Advance Payments allow for a percentage of the total contract to be paid upon conformation of the contract and must be requested in the form of a letter on Agency/Corporate letterhead. All of the following must be included in each letter:
    - a) contract name;
    - b) contract number;
    - c) signature of authorized corporate official;
    - d) percentage of the contract total requested and the amount.

## Section 6120 - Federal CFDA Numbers/Other Regulations

.01 The following Federal CFDA numbers are applicable to AACO Programs:

<b>Program</b>	<b>CFDA No.</b>
AIDS Surveillance and Seroprevalence Grant	93.118, 93.944
AIDS Prevention Project	93.940
HIV Emergency Relief Grant (Formula) (Ryan White)	93.915
HIV Emergency Relief Grant (Supplemental) (Ryan White)	93.914
HIV Early Intervention Project	93.918
HIV Early Intervention Services	
Network Demonstration Project	93.118

## **Section 6130 - Program Compliance Procedures**

.01 As discussed in Sections 300 and 500 of this Audit Guide, each City of Philadelphia Department program has specific auditing requirements. These requirements are in addition to those areas of audit specified in Sections 300 and 500 of this Guide. The audit requirements listed on the following pages are not all inclusive and do not represent an audit program for conducting a financial and compliance audit of the program(s). The audit requirements listed are presented as highlights of areas of special interest to the Department. Any deficiencies noted as a result of the procedures are to be disclosed in the Schedule of Findings and Questioned Costs.

### **Program Description and Personal Data Questionnaire**

.02 The AIDS Agency Services Unit monitors and evaluates programs and direct services for persons with HIV infection. These services include, but are not limited to, AIDS education, support, case management, housing, and HIV counseling and testing. Epidemiology and miscellaneous service contracts are also the responsibility of this unit. All agencies are required to report to their respective AACO program analyst on the progress of the services being rendered.

.03 Each service is different in nature and requires specific reporting procedures to be followed; however, there are a few reports which AACO requires all contract agencies to submit. These reports include a Position Description and Personal Data Questionnaire (PDPDQ) (Exhibit 3) and monthly statistical and narrative reports. At this time, the PDPDQ is the only standardized form relevant to all AACO contract agencies. Each Agency is required to submit this form to AACO within six months of the contract effective date for all personnel funded by the contract. New staff are required to fill the questionnaires out at the time of their hiring and the agency must submit the forms within thirty (30) days of the hiring date.

.04 Audit procedures are to include a determination that the PDPDQ is on file at the Organization and that the reporting and filing requirements described above have been met

### **Aids Care Services**

.05 AACO has many contracts with agencies whose services are provided directly to those individuals who are HIV positive and/or have been diagnosed as having AIDS. Care services help individuals maintain their self worth, independence and dignity while living with AIDS. Such services include, but are not limited to primary care, dental, skilled nursing, transportation, homemaker services, respite care, case management and other required services. Quarterly narrative reports (see Exhibit 7) must contain specific information. In addition to the reporting requirements, the resultant auditing procedure is also stipulated.

- Skilled nursing agencies are required to submit in their monthly reports statistics reflecting the number of Medicaid waivers completed per month. The auditor should determine, on a test basis, that reports include this information and are in compliance with the contract service provisions.
- Agencies providing homemaker services must include in their monthly reports statistics reflecting the number of clients served each month and the number of hours provided per client per month. Minimum and maximum numbers of clients and hours are provided in the contract service provisions. The auditor should determine, on a test basis, that reports include this information and are in compliance with the provisions.
- Agencies providing transportation services must include statistics reflecting the number of trips taken per month and the number of clients transported per month in each monthly report. As with homemaker services, minimum and maximum numbers of trips to be taken and clients to be transported are provided in the contract service provisions. The auditor should determine, on a test basis, that reports include this information and are in compliance with the provisions.

## **AIDS Care Services**

- .06 AIDS Case Management services consist of thorough assessments of clients' needs and the development and monitoring of a formal services plan for each client. Agencies providing this type of service assign case managers who aid clients with their daily living needs. These needs vary with each client; therefore, documentation of services provided is extremely important.
- .07 AACO's analytical staff must be able to make their programmatic decisions based on monthly reports from provider agencies. These reports are similar in format to other services' monthly reports; however, more specific information is required. Although no standardized forms are available to agencies at the present time, AACO program staff are in the process of developing a standardized statistical form to be included in future contracts. Nonetheless, statistical information regarding number of clients seen per month, per case manager, is important to AACO.
- .08 Currently, all case management service providers are required to keep a file on each client served. Each client case record file should contain the following list of documents:
  - Assessment Form
  - Data Entry Form
  - Case Management
  - Client Agreement Form
  - Authorization to obtain release of information.
  - Surveillance letters:
    - (a) To physician
    - (b) To AACO Surveillance Unit.
  - Agency Consent Form
  - Buddy Agreement Form
  - Buddy Program Work Sheet
  - Treatment Care Plan
  - Physician Release Form
  - Case Management Activities Log
  - Progress Notes Form
- .09 The auditor should determine on a test basis that:
  - The statistical information reported by the organization to AACO on the monthly statistical reports are traceable to, and in agreement with, supporting records.
  - Client files contain the information required under Section 6130.21.

## **Counseling and Testing Services**

- .10 The counseling and testing programs are required to provide AACO with a monthly report (Exhibit 4) which includes various statistical, programmatic, and staffing information.
- .11 The auditor should determine, on a test basis, that the:
  - Statistical information included on the report is traceable to records maintained by the Organization to support the report submitted to AACO. The statistical information needed to be verified by the auditor includes number of individuals pre-tested, number of individuals counseled and not tested, number of individuals tested, and number of individuals post-tested. The source document to be used in verifying the above information is included in Exhibit 4.

## **HIV Prevention: Education and Risk Reduction**

- .12 The education and risk reduction programs are required to provide AACO with a monthly report (Exhibit 5) which includes various statistical, programmatic, and staffing information.
- .13 The auditor should determine, on a test basis that the statistical information included on the report is traceable to records maintained by the organization to support the report(s) submitted to AACO.

## **HIV Prevention: Education and Risk Reduction**

- .14 For hotline services, all calls received must be documented on a hotline call record form (Exhibit 6). This is a standardized form which must be completed by a counselor during each telephone conversation.
- .15 The auditor should determine, on a test basis, that the hotline call record forms are utilized and maintained on file at the organization.

## **AIDS Education**

- .16 Other than the Position Description and Personal Data Questionnaire (PDPDQ) which all providers must submit to AACO, AIDS Education Programs must submit a monthly statistical report with narratives within ten working days after the end of each month. These reports document the various education activities performed by each agency. There are no format requirements; however, each report should include the same information regarding the activities conducted during the report period, projected activities for subsequent periods, problems encountered and how they were solved, and supporting statistical data for quantifiable information.
- .17 Each agency is required to track participant attendance for all presentations, workshops, consultations, trainings, and instructions. Attendance sheets are the responsibility of the agency and may be in whatever format they choose to follow; however, participants' names, instructors'/educators' names, and the date of the activity must be included on the form.
- .18 Before and after each educational activity, the instructor/educator must test the knowledge of each participant. This is done through a standardized test which the agency or AACO has developed. Each test, although very often the same, must be presented as two separate distinguishable tests. The first test should be labeled "Pre-test" and the second test should be labeled "Post-test."
- .19 The monthly statistical/narrative report should include a summary of the above information.
- .20 The auditor should determine, on a test basis, the counseling and testing services, that:
  - Statistical information reported corresponds with supporting documents/records maintained at the Organization.
  - Attendance records are utilized and kept on file for participants attending presentations, workshops, consultations, training and instruction.

## **Section 6140 - Financial Compliance Procedures**

### **Revenues:**

- .01 Program funding is the most common method employed by AACO to fund its provider agencies. This method allows AACO to fund a provider agency's actual eligible expenditures for a provider agency's service(s), offsetting these expenses by anticipated revenues to be received directly by the provider, and establishing the remaining deficit as its authorized level of funding (allocation). Reimbursement is affected on a "last-dollar-in" basis and is based upon actual eligible expenses incurred less actual revenue generated, up to the maximum contract funding.
- .02 Audit procedures should include the following:
  - Does the Agency have a system in place to adequately account for all applicable income received or earned by the agency and that such income was properly reported to AACO.
  - Determine that billings to AACO and reimbursement from AACO are net of other non-AACO revenue.

## Section 6150 - Supplemental Financial Schedules and Reports

.01 The organization's audit report must include the following supplemental financial schedule for each City of Philadelphia contract with \$300,000 or more of expenditures in addition to the financial statements as specified in Sections 400 and 500 of this Audit Guide. A designation has been made for the supplemental schedule required for a "single audit" report (Section 400) on a "program audit" report (Section 500). The auditor will be required to issue an opinion on the Supplemental Schedules listed below as specified in Section 400 of this Audit Guide.

Supplemental Financial Schedule	Section Ref. to Sample Format	Single Audit Report	Program Audit Report
Schedule of Program Expenditures and Program Revenue (1)	6150.02	Yes	No (2)

### Explanatory Notes:

- (1) The schedule must reflect the categorization of expenditures by the AACO budget with the organization.
- (2) The categories of expenditures provided on the program audit financial statement should coincide with the categories of expenditures on the AACO budget.

**Section 6150.02**

**ABC NOT-FOR-PROFIT CORPORATION  
AACO CONTRACT NUMBER XX-XXXX  
STATEMENT OF PROGRAM EXPENDITURES AND PROGRAM REVENUE  
FOR THE YEAR ENDED JUNE 30, 19XX**

**Expenditures**

Personnel:	
Salaries	\$ XXX,XXX
Fringe benefits	<u>XX,XXX</u>
<b>Total personnel expenditures</b>	<b>\$ XXX,XXX</b>
Operating:	
Occupancy	XX,XXX
Renovation	X,XXX
Communications	XXX
Office Supplies	XXX
Education/Program supplies	X,XXX
Travel	X,XXX
Contract Services	X,XXX
Insurance	X,XXX
Condoms	<u>X,XXX</u>
<b>Total operating expenditures</b>	<b>XX,XXX</b>
Equipment:	
Purchase	XX,XXX
Lease/rental	X,XXX
Repairs	<u>X,XXX</u>
<b>Total equipment expenditures</b>	<b>XX,XXX</b>
<b>Total direct expenditures</b>	<b>XXX,XXX</b>
<b>Administration</b>	<b><u>XX,XXX</u></b>
<b>Total expenditures</b>	<b>XXX,XXX</b>
<b>Program Revenue</b>	<b>(X,XXX)</b>
<b>Net AACO funded expenditures</b>	<b>\$ XXX,XXX</b>

**AACO - EXHIBITS  
TABLE OF CONTENTS**

EXHIBIT	DESCRIPTION
1	Monthly Budget Performance Report
2	Personnel Roster
3	Position Description and Personal Data Questionnaire
4	Counseling and Testing Package
5	Education and Risk Reduction Package
6	Hotline Call Record Form
7	Aids Care Services/Ryan White Package

## Exhibit 1

### BUDGET STATEMENT AIDS AGENCY XYZ COUNSELING SERVICES (CONTRACT XX-XXXX) AUGUST, 19XX

	August	Year To-Date	Total Budget	Budget Remaining
<b>Expenses</b>				
<b>Personnel:</b>				
Salaries	\$ 18,510	\$ 35,489	\$ 267,000	\$ 231,511
Benefits	2,124	4,072	30,638	26,566
Other	-0-	-0-	300	300
Sub-total personnel	20,634	39,561	297,938	258,377
<b>Operating</b>				
Occupancy	3,045	6,090	36,540	30,450
Renovation	-0-	-0-	-0-	-0-
Communications	1,245	1,900	8,700	6,800
Office Supplies	603	603	2,500	1,897
Education/Program supplies	262	524	1,750	1,226
Travel	174	348	2,784	2,436
Contract Services	-0-	-0-	-0-	-0-
Insurance	85	170	1,025	855
Condoms	150	250	1,500	1,250
Sub-total operating	5,564	9,885	54,799	44,914
<b>Equipment</b>				
Purchase	-0-	-0-	3,000	3,000
Lease/rental	39	78	468	390
Repairs	-0-	-0-	500	500
Sub-total equipment	39	78	3,968	3,890
Subtotal direct	26,237	49,524	356,705	307,181
Administration	933	1,874	13,500	11,626
Sub-total	27,170	51,398	370,205	318,807
Revenue	(500)	(1,000)	(7,121)	6,121)
Grand total	\$ 26,670	\$ 50,398	\$ 363,084	\$ 312,686

**Exhibit 2**

**AIDS AGENCY XYZ  
CONTRACT XX-XXXX**

	August Billing	Cumulative Billings	Budget Per Budget Contract	Remaining
<b>Personnel Service (by position):</b>				
<b>Prog. Coord.</b>				
B. Smith	\$3,333	\$6,666	\$40,000	\$33,334
<b>Counselor</b>				
J. Jones	2,500	5,000	30,000	25,000
<b>Educator</b>				
A. Carter	2,667	5,334	32,000	26,666
<b>Secretary</b>				
M. Cuyler (hired 7/15/XX)	1,625	2,437	19,500	17,063
<b>Educator</b>				
C. Jackson (term. 7/31/XX)	-0-	2,667	32,000	29,333
D. Kelly (hired 8/1/XX)	2,667	2,667	-0-	(2,667)
<b>Counselor</b>				
G. Martin	2,500	5,000	30,000	25,000
<b>Counselor</b>				
F. Berk	2,500	5,000	30,000	25,000
<b>Education</b>				
Vacant	-0-	-0-	32,000	32,000
<b>Phlebotomist</b>				
N. Mill (hired 8/10/XX)	718	718	21,500	20,782
Total	\$ 18,510	\$ 35,489	\$ 267,000	\$ 231,511

**ATTACHMENT C**  
**Exhibit 3**

**Position Description and Personal Data Questionnaire**  
**City of Philadelphia Aids Activities Coordinating Office Personnel Action Plan**

1. Position Number \_\_\_\_\_  
2. Request for personnel action on \_\_\_\_\_  
Existing position \_\_\_\_\_

**New Incumbent - New Position (Explain)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Position (Explain)**

\_\_\_\_\_  
\_\_\_\_\_

**Conversion**

3. Last Name \_\_\_\_\_ First \_\_\_\_\_ Mi \_\_\_\_\_  
4. Agency \_\_\_\_\_  
5. Service, division, unit \_\_\_\_\_  
6. Total working hrs per week in agcy. \_\_\_\_\_  
7. No. working hrs. chgd to county prog. \_\_\_\_\_  
8. Requested "Pap" title \_\_\_\_\_  
9. Usual working title \_\_\_\_\_  
10. Annual salary (for total hrs. worked, #6) \_\_\_\_\_

11. Describe types of work you do during working hours on County Program. Use separate paragraph for each kind of work and explain in detail. List your duties in order of importance, showing estimate of time spent on each duty by percentage, fractions, \_\_\_ days or hours in "Time" column. Special or occasional duties should be last.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Time \_\_\_\_\_

Work Performed \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(Continue on additional sheets)

12. Name and title of your immediate supervisor \_\_\_\_\_

Are you in a supervisory capacity \_\_Yes\_\_ No

13. Give name and title of employees you supervise if five or less, if more than five, give the number under each title.

Name \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

14. Describe your contact with other agencies outside organizations and general public.

\_\_\_\_\_  
\_\_\_\_\_

**ATTACHMENT C**  
**Exhibit 3**

**Position Description and Personal Data Questionnaire**  
**City of Philadelphia Aids Activities Coordinating Office Personnel Action Plan**

**Personal Data**

Home Address \_\_\_\_\_  
Zip \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_  
Date started this position \_\_\_\_\_ Starting salary \_\_\_\_\_

**Education**

Schools (Circle highest grade or year completed)  
College \_\_\_\_\_  
Postgrad/Professional 1 2 3 4 5 6 7 8 9 10 11 12 \_\_\_\_\_ 1 2 3 4 \_\_\_\_\_ 1 2 3 4  
Degree Major/Specialty \_\_\_\_\_

Describe other education or training

\_\_\_\_\_  
\_\_\_\_\_

**Previous employment**

(List related experience. Begin with the most recent employment and work backward)

Title \_\_\_\_\_  
Major duties \_\_\_\_\_  
Employer \_\_\_\_\_  
From (Mo. Yr) \_\_\_\_\_ To (Mo. Yr) \_\_\_\_\_ Last salary \_\_\_\_\_

Title \_\_\_\_\_  
Major duties \_\_\_\_\_  
Employer \_\_\_\_\_  
From (Mo. Yr) \_\_\_\_\_ To (Mo. Yr) \_\_\_\_\_ Last salary \_\_\_\_\_

Title \_\_\_\_\_  
Major duties \_\_\_\_\_  
Employer \_\_\_\_\_  
From (Mo. Yr) \_\_\_\_\_ To (Mo. Yr) \_\_\_\_\_ Last salary \_\_\_\_\_

I hereby certify that the above answers are my own and are accurate and complete.

Employees Signature \_\_\_\_\_ Date \_\_\_\_\_

**STATEMENT OF IMMEDIATE SUPERVISOR**

15. Comment on statements of employee. Indicate any exceptions or additions and what you consider the most important duties of this position.

\_\_\_\_\_  
\_\_\_\_\_

17. Background desirable of a new appointee to fill this position in case of a vacancy. Disregard qualifications present incumbent may happen to have or not have. Training and experience give kind and length  
Signature immediate supervisor \_\_\_\_\_

**STATEMENT OF DEPARTMENT HEAD OR OTHER ADMINISTRATIVE OFFICER**

18. Comment on above statements of employee and supervisor. Indicate any inaccuracies or statement with which you disagree. Also, comment on qualifications suggested by supervisor.

Signature department head/administrative officer \_\_\_\_\_  
Title \_\_\_\_\_ Date \_\_\_\_\_

**Exhibit 4  
Attachment B**

**PATIENT FOLLOW-UP/PARTNER NOTIFICATION FORM**

**Check One:**

Patient Follow-Up \_\_\_\_\_ Partner Notification \_\_\_\_\_

Date Tested \_\_\_\_\_

Date Interviewed \_\_\_\_\_

Name: \_\_\_\_\_ Alias/Nickname: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Work Address/Hangouts: \_\_\_\_\_

\_\_\_\_\_

Marital Status: \_\_\_\_\_

Work Hours: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

Exposure Information: \_\_\_\_\_

\_\_\_\_\_

First: Sex \_\_\_\_\_ Needle Sharing \_\_\_\_\_ Other \_\_\_\_\_

Last: \_\_\_\_\_ Freq: \_\_\_\_\_

Race: \_\_\_\_\_ Asian \_\_\_\_\_ Black \_\_\_\_\_ Hispanic \_\_\_\_\_ White \_\_\_\_\_ Other \_\_\_\_\_

Skin Complexion: \_\_\_\_\_ Facial Hair: \_\_\_\_\_ Beard \_\_\_\_\_ Mustache \_\_\_\_\_ Height: \_\_\_\_\_

Weight: \_\_\_\_\_ Identifying Information: (i.e. scars/tattoos) \_\_\_\_\_

Hair Color: \_\_\_\_\_ Glasses: \_\_\_\_\_

Reporting Agency: \_\_\_\_\_ Site #: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Submit to: Kevin F. Green  
Program Administrator, Counseling & Testing  
500 S. Broad St. 3rd Floor  
Philadelphia, PA 19146

## Exhibit 4 (Cont.)

### COUNSELOR OBSERVATION

#### Pretest Counseling

1. How long did the observed pretest counseling session last? \_\_\_\_\_

2. Did the counselor (s) introduce her/himself and explain the purpose of the session? Yes\_\_\_\_ No\_\_\_\_

3. Did the counselor(s) use open-ended questions? (Give examples) \_\_\_\_\_

\_\_\_\_\_

4. Was a risk assessment conducted? Yes\_\_\_\_ No\_\_\_\_

If yes, \_\_\_\_\_ how was it conducted? (check appropriate box)

As an interactive process which provided the client(s) opportunities to ask questions and explored their ongoing behaviors and circumstances, (e.g., sexual history, STD history, drug use)?

\_\_\_\_ or as a data collection, form driven, appraisal of the client(s) behavior?

If no, please explain how this impacted the counseling session.

\_\_\_\_\_

5. Describe the HIV education and prevention information presented to the client (e.g., accurate, relevant, lecture format). \_\_\_\_\_

\_\_\_\_\_

### Pretest Counseling/Observation

#### Counselor Observation

6. Did the client have an opportunity to talk? If yes, how much? \_\_\_\_\_

7. Did the counselor(s) explore past attempts at prevention behaviors tried by the clients(s)?

Yes\_\_\_\_ No\_\_\_\_

If yes, describe how the counselor did this (e.g., reinforced successful strategies, discussed prevention failures or flawed strategies). \_\_\_\_\_

\_\_\_\_\_

8. Was a personalized incremental risk reduction plan(s) negotiated with the client(s), e.g., tailored to the behaviors, circumstances and special needs of the clients(s)?

Yes\_\_\_\_ No\_\_\_\_

If yes, was the plan documented in the record for review in post-test sessions or subsequent retesting sessions?

Yes\_\_\_\_ No\_\_\_\_

If no, what risk reduction messages were provided to the client? \_\_\_\_\_

\_\_\_\_\_

## Exhibit 4 (cont.)

### Pretest Counseling/Observation

#### Counselor Observation

9. \_\_\_\_\_ Were condoms discussed? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, did the counselor:

a. Demonstrate their proper use? Yes \_\_\_\_\_ No \_\_\_\_\_

b. Role play condom negotiating strategies? Yes \_\_\_\_\_ No \_\_\_\_\_

c. Provide condoms? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

10. Client was provided information on the following:

Counselor \_\_\_\_\_ Video/Pamphlet \_\_\_\_\_ Not Provided \_\_\_\_\_

a. Purpose of the test \_\_\_\_\_  
\_\_\_\_\_

b. Meaning of results \_\_\_\_\_  
\_\_\_\_\_

c. AIDS prognosis \_\_\_\_\_  
\_\_\_\_\_

d. Value of testing \_\_\_\_\_  
\_\_\_\_\_

e. Condom use \_\_\_\_\_  
\_\_\_\_\_

Please provide examples for questions #11-16.

### Pretest Counseling/Observation

#### Counselor Observation

11. How well did the counselor provide information at a level of comprehension which was consistent with the client's age and learning skills? Explain. \_\_\_\_\_  
\_\_\_\_\_

12. How well did the counselor provide/demonstrate culturally competent messages, (e.g., provided in a style and format respectful of cultural norms)? Explain. \_\_\_\_\_  
\_\_\_\_\_

13. How linguistically appropriate was the counselor with the client, (e.g., presented in a dialect and terminology consistent with the client's native language and style of communication)? Explain. \_\_\_\_\_  
\_\_\_\_\_

14. How do clients schedule appointments to return for results at the time of the pretest session? \_\_\_\_\_  
\_\_\_\_\_

15. How well did the counselor reinforce the importance of returning for test results/counseling? Explain. \_\_\_\_\_  
\_\_\_\_\_

16. What and when is related paperwork completed by the counselor? Explain. \_\_\_\_\_  
\_\_\_\_\_

## Exhibit 4 (Cont.)

### Pretest Counseling/Observation

Counselor Observation

#### OBSERVATIONAL COMMENTS

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#### COUNSELOR OBSERVATION

Post-Test Counseling

1. How long did the observed post-test counseling session last?

2. Did the counselor(s) introduce her/himself and explain the purpose of the session? Yes\_\_\_\_ No\_\_\_\_

3. Did the counselor(s) use open-ended questions? (Give examples) \_\_\_\_\_

---

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Yes\_\_\_\_ No\_\_\_\_

4. Did the counselor(s) ascertain if a personal risk reduction plan was established in the pretest session?

Yes\_\_\_\_ No\_\_\_\_

5. If yes to #4, did the counselor (check if "yes"):

- a. reinforce successful efforts?
- b. discuss failed efforts?
- c. provide additional coaching on risks remaining?

6. If no plan had previously been established, did the counselor (check if "Yes"):

- a. Negotiate a personalized, incremental risk reduction plan with the client(s), i.e. tailored to the behaviors, circumstances and special needs of the client(s) during the posttest session?
- b. Deliver global prevention messages independent of the clients personal risk behaviors and circumstances?
- c. Fail to discuss risk reduction in the post-test session?

If a risk reduction plan was discussed, was it revised or updated in the record or review in any subsequent retesting sessions? Yes\_\_\_\_ No\_\_\_\_

7. Did the counselor (s) (check if "yes")

Routinely recommend retesting at 3-6 months?

Recommend retesting if unsafe behaviors occurred within the last three months or should occur in the future?

Not discuss retesting?

### Posttest Counseling/Observation

Counselor Observation

#### OBSERVATIONAL COMMENTS (IF ANY):

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**Attachment E**

**City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit**

**PREVENTION COUNSELING PROGRAM  
PROGRESS REPORT AGENCY**

Program/Activity	Report Period
Contract Period	AACO Funding for this Program
Funding Source	Report Submitted by

**Section I – Goals**

A. \_\_\_\_\_  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

B. \_\_\_\_\_  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

**Section II – Progress in Meeting Goals**

A.  
Number \_\_\_\_\_  
Prevention Counseled \_\_\_\_\_

Number \_\_\_\_\_  
Counseled/ Not Tested \_\_\_\_\_

Number Tested \_\_\_\_\_  
Number of Result Sessions \_\_\_\_\_

Number of Counselor/s Hours Worked  
Site No. \_\_\_\_\_  
Site No. \_\_\_\_\_  
Site No. \_\_\_\_\_  
Site No. \_\_\_\_\_  
Site No. Totals \_\_\_\_\_

B.  
1. \_\_\_\_\_  
a. \_\_\_\_\_  
b. \_\_\_\_\_  
2. \_\_\_\_\_  
a. \_\_\_\_\_  
b. \_\_\_\_\_  
3. \_\_\_\_\_  
a. \_\_\_\_\_  
b. \_\_\_\_\_

## Exhibit 4 (Cont.)

### Section III Accomplishments

- A. Programmatic
- B. Administrative
- C. Fiscal

### Section IV – Challenges

- A. Programmatic
- B. Administrative
- C. Fiscal

### Section V – Plan of Action to Meet Challenges in Section IV

- A. Programmatic
- B. Administrative
- C. Fiscal

### Section VI – Collaboration

Please footnote all changes that relate to the addition or deletion of agencies with which you hold Letters of Agreement.

- A. Names of agencies with Letters of Agreement on file and numbers of referrals:

Name	Number
------	--------

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

- B. Other (specify):

Name	Number
------	--------

- 1.
- 2.
- 3.
- 4.
- 5.

**Exhibit 4 (Cont.)**

**EQUIPMENT INVENTORY FORM  
HIV Prevention Services  
AIDS Activities Coordinating Office  
Revised 11/95**

Any equipment acquired with AACO funds, and a purchase price greater than \$500 should be entered below.  
This form should be submitted with the monthly invoice as the line item justification for that purchase.

Date Purchased	Equipment Description	Serial Number	Location
1.			
2.			
3.			
4.			
5.			

**Exhibit 5  
Attachment B**

**City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit**

**PROGRAM PROGRESS REPORT**

Program/Activity  
Contract Period  
Funding Source

Report Period  
AACO Funding for this Program  
Report Submitted by

**Section I – Goals**

- A.
  
- B.

  - 1.
  - 2.
  - 3.
  - 4.
  - 5.

**Section II – Progress in Meeting Goals**

- A.

## Exhibit 5 (Cont.)

### Attachment B (Cont.)

B. Enter goals stated in Section I-B of this report:

### Section III – Accomplishments

- A. Programmatic
- B. Administrative
- C. Fiscal

#### INSTRUCTIONAL TEMPLATE

City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit

Risk Reduction  
PROGRAM PROGRESS REPORT AGENCY  
(Enter agency name)

Program/Activity  
(Enter name of program or activity  
for this contract)

Report Period  
(Enter month being reported on)

Contract Period  
(Enter start and end dates)

AACO Funding for this Program  
(Enter dollar amount of contract/s)

Funding Source  
(Enter source, indicate City, State, or  
Federal completing)

Report Submitted by  
(Enter name of individual  
responsible for the report)

### Section I – Goals

- A. (Enter Section II part A of contract service provisions)
- B. (Enter goals that have been established with AACO Program Analyst)
  - 1.
  - 2.
  - 3.
  - 4.
  - 5.

## **Section II – Progress in Meeting Goals**

- A. (Enter statistics for the month using the table/s provided)

### **Program Progress Report**

- B. Enter the goals stated in Section I-B of this report:
  - 1. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)
  - 2. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)
  - 3. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)
  - 4. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)
  - 5. (Enter goal)
    - a. (Enter work statement/s)
    - b. (Enter progress and/or barriers to implementing work statement/s)

## **Section III – Accomplishments**

(Enter overall accomplishments, excluding statistics mentioned in Section II A and achievements mentioned in Section II B):

- A. Programmatic
- B. Administrative
- C. Fiscal

## **Section IV - Challenges**

(Enter overall challenges, excluding difficulties stated in Section II):

- A. Programmatic
- B. Administrative
- C. Fiscal

## **Section V – Plan of Action to Meet Challenges in Section IV (Enter plan)**

- A. Programmatic
- B. Administrative
- C. Fiscal

## Section VI – Collaboration

(Enter the number of referrals made to agencies of which you hold Letters of Agreement. Agencies with Letters of Agreement should become permanent entries.)

- Please footnote all changes that relate to the addition or deletion of agencies with which you hold Letters of Agreement.

A. Names of agencies with Letters of Agreement on file and numbers of referrals:

(Enter name of agency)

(Enter number of referrals)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

B. Other (specify):

(Enter name of agency)

(Enter number of referrals)

- 1.
- 2.
- 3.
- 4.
- 5.

**Attachment C**  
**EQUIPMENT INVENTORY FORM**  
**HIV Prevention Services**  
**AIDS Activities Coordinating Office**  
**Revised 11/95**

Any equipment acquired with AACO funds, and a purchase price greater than \$500 should be entered below. This form should be submitted with the monthly invoice as the line item justification for that purchase.

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

**Exhibit 6**

**HOTLINE CALL RECORD - FY 97**

Data entry use only:

Prep By \_\_\_\_\_ Date \_\_\_\_\_ Time: Start \_\_\_\_\_ Finish \_\_\_\_\_

**CALL MADE BY GENDER**

- |                        |                  |
|------------------------|------------------|
| 1. Consumer            | 1. Female        |
| 2. Friend/partner/rel. | 2. Male          |
| 3. Hospital/clinic     | 3. Mixed group   |
| 4. Agency              | 4. Transgendered |
| 5. School              | 5. Unknown       |

**INSURANCE**

- |                     |
|---------------------|
| 1. MA/SSI           |
| 2. Military/VA      |
| 3. Employer/Private |
| 4. None             |
| 5. Unknown          |

**RACE/ETHNICITY**

- |   |
|---|
| 1. African-American                                   |
| 2. Caucasian  |
| 3. Hispanic/Latino                                    |
| 4. Asian-American/<br>Pacific Islander                |
| 5. Native American/Aleutian/<br>Native Alaskan/Eskimo |
| 6. Other  |
| 7. Unknown  |
| 8. N/A  |
| 9. Refused  |

**AGE** \_\_\_\_\_

- |                |
|----------------|
| 1. Mixed Group |
| 2. Unknown     |
| 3. Refused     |

6. CHOICE Counselor

7. Other

- |            |
|------------|
| 6. N/A     |
| 7. Refused |

- |                           |
|---------------------------|
| 1. Advocacy               |
| 2. Call in Spanish        |
| 3. Call in other language |
| 4. TTY                    |

PA COUNTY  
CODE \_\_\_\_\_

ZIP CODE \_\_\_\_\_

- |                                 |
|---------------------------------|
| 1. Outside of Phila. Metro area |
| 2. Unknown                      |
-

## SUBJECT

- |                             |                |                                       |                                 |
|-----------------------------|----------------|---------------------------------------|---------------------------------|
| 1. Abortion                 | M              | Teen Access                           | 8. Financial assistance/MA      |
| 2. Abuse                    | A. Rape        | D. Parental consent                   | 9. Food/shelter                 |
| 3. Adoption                 | B. Incest      | E. Out-of-state                       | 10. General health              |
| 4. Birth control            | C. Life-threat | F. Court-bypass                       | 11. Gyn                         |
| A. Cervical cap             |                | G. Undecided                          | 12. Infertility                 |
| B. Depo Provera             |                |                                       | 13. Healthy Start               |
| C. Diaphragm                |                |                                       | 14. HIV/AIDS *                  |
| D. Female condom            |                | Abortion/Prenatal Care/<br>Pregnancy: | 15. Legal/legislative           |
| E. Foam                     |                | H. First trimester                    | 16. Menstruation cycle          |
| F. IUD                      |                | I. Second trimester                   | 17. Pregnancy/childbirth        |
| G. Male condom              |                | J. Third trimester                    | 18. Pregnancy options           |
| H. Norplant                 |                | K. Unknown                            | 19. Pregnancy support/parenting |
| I. Pills                    |                | L. N/A                                | 20. Pregnancy test/symptoms     |
| J. Post-Coital pill         |                |                                       | 21. Prenatal care               |
| K. Sponge                   |                |                                       | 22. Sexuality                   |
| L. Natural FP/CMBBT         |                |                                       | 23. STD/infection               |
| 5. Counseling/mental health |                |                                       | 24. Sterilization               |
| 6. Drug abuse               |                |                                       | 25. Other                       |
| 7. Education/job training   |                |                                       |                                 |

## HIV/AIDS

Type of Call	Consumer's Status		Consumer's Concerns			
1. Case management	6. Symptoms	A. HIV	1. Blood transfusion/products	6. Pediatric		
2. General Info	7. Testing	B. HIV+asymptomatic	2. Caregiver/partner	7. Sexual	A. F/M	
3. Housing	8. Transmission	C. HIV+ symptomatic	3. Casual contact	8. Work related	B. M/M	
4. Medical care	9. Treatment	D. AIDS	4. Health care related	9. Other	C. F/F	
5. Support/counseling	10. Other	E. Unknown	5. IDU	10. Unknown	D. Unknown	
	F. N/A	11. N/A	E. N/A			

## HOW HEARD OF HOTLINE

1. Called before	7. Other outreach/materials	13. SEPTA car card	19. Campaign E
2. Friend/relative/partner	8. Newspaper ad/coverage	14. Healthy Start Campaign	20. Unknown
3. Agency	9. Radio ad/coverage	15. Campaign A	21. Other
4. Hospital/clinic	10. TV ad/coverage	16. Campaign B	22. N/A
5. Private Practitioner	11. Phone book/information	17. Campaign C	
6. CHOICE outreach/ materials	12. School	18. Campaign D	

## NUMBER CALLED

- |                   |                   |        |
|-------------------|-------------------|--------|
| 1. 985-3300       | 5. 1-800-84-TEENS | 1. FPC |
| 2. 985-AIDS       | 6. Other          | 2. MCH |
| 3. 1-800-985-AIDS | 7. Transfer from  |        |
| 4. 1-800-876-MOMS | 8. 1-800-662-6080 |        |

## FUNDING SOURCE

- |                      |                     |
|----------------------|---------------------|
| 4. AACO              | 6. Other Non-Funded |
| 5. Ryan White        |                     |
| 3. Abortion/adoption |                     |
| 7. AIDS Fact Line    |                     |

## REFERRAL SUMMARY

**Exhibit 7**

**ATTACHMENT A**

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: \_\_\_\_\_

**Exhibit 7 (Cont.)**

**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.

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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.

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3. 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?

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**Exhibit 7 (Cont.)**

- 4. a) Briefly discuss any significant barriers that your program has experienced in the provision of this service to your clients, problems encountered in delivering services and unmet needs.

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- b) Describe how this program has worked to overcome the barriers indicated above. Also, indicate any actions that were taken or plans formulated to respond to these areas of concern.

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- 5. Describe technical assistance needs this program has identified.

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- 6. Describe any changes in staff funded by this contract during the past quarter (i.e. has anyone been hired, fired, promoted). Indicate if new job titles were created. Provide job descriptions as appropriate.

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- 7. Describe any organizational budget changes in the last quarter that affect the delivery of services in this contract.

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- 8. Discuss trends and share insight regarding demand/needs that affect or may affect the provision of this program's services from your organization's point of view. Provide documentation as appropriate.

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- 9. Indicate any significant programmatic accomplishments/highlights relevant to the quarter.

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10. Indicate the level of involvement and participation of Persons With HIV/AIDS in the design and delivery of Title I funded services both at your agency and with regard to this particular program. Please be as specific as possible (i.e. indicate the number of consumers who are involved in the delivery of Title I services, the number of paid versus volunteer HIV consumer staff, support groups conducted by and for Persons With HIV/AIDS, HIV consumer needs assessments conducted by your agency, etc.). Please indicate how your agency and/or this program documents HIV consumer involvement.

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11. Indicate any mechanisms/ processes in place at your agency which allows for the assessment of Title I funded services by Persons With HIV/AIDS.

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**Exhibit 7 (Cont.)**

**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
- (02) 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

**Exhibit 7 (Cont.)**

**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 New 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) Men who have sex with men	
Estimated % of Adult/Adolescent Injection Drug Use (IDU)	
Clients by exposure category: Men who have sex with men	
AND IDU 999.9 = Unknown Heterosexual contact	
Other/Undetermined	
16. HIV/AIDS Status: Estimated % of clients who have HIV (non-AIDS)	
999.9 = Unknown Estimated % of clients with an AIDS diagnosis	

**Exhibit 7 (Cont.)**

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

17. 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

18. 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

19. 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)

**Exhibit 7 (Cont.)**

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

20. 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

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

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

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

## Exhibit 7 (Cont.)

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

ation programs, assures the well-being of all residents through its environmental protection programs and offers essential treatment to residents with specialized health needs. The Department's programs are used by Philadelphians of all ages and races and by residents throughout the city.

.03 Information and auditing and reporting requirements for the following Department of Public Health program services are provided in the referenced Sections of the Audit Guide.

- AIDS Activities Coordinating Office (Section 6100)
- Coordinating Office for Drug and Alcohol Abuse Programs (Section 6200)
- Office of Mental Health and Mental Retardation (Section 6300)
- Office of Maternal and Child Health (Section 6400)
- Division of Disease Control (Section 6500)

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## SECTION 6100

### AIDS ACTIVITIES COORDINATING OFFICE

#### Section 6101 - General Information

- .01 The mission of the AIDS Activities Coordinating Office (AACO) is to stop the transmission of the Human Immunodeficiency Virus (HIV) in Philadelphia through education and prevention activities and to provide services to people with AIDS and to individuals with HIV infection related conditions. The Office is charged with coordination of all City of Philadelphia activities related to AIDS.
- .02 The AIDS Activities Coordinating Office includes four major divisions. These are: Medical Affairs, Policy and Planning; AIDS Prevention and Education Services; AIDS Agency Services; and AIDS Program Administration. Of these four divisions, the two with responsibility for the development and monitoring of contract service activities are AIDS Agency Services and AIDS Program Administration. Program development and monitoring are the responsibility of the former while contract and fiscal management rests with the latter.

#### Section 6110 - Program Descriptions and Operations

- .01 Some of the services provided by AACO include the following:
  - a. AIDS Care Services:

Support services consist of those services that are provided directly to those individuals who are HIV positive and/or have been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS). In addition, care services are intended to provide support for family members and the loved ones of those who are infected with the Human Immunodeficiency Virus (HIV). Services usually consist of helping the individual in maintaining their self worth, independence, and human dignity while living with AIDS.

AIDS case management services consists of performing a needs assessment and developing, implementing, and monitoring a service/care plan as well as arranging for or referring a client to needed services. Such services, to which clients may be referred or which are arranged for clients, can be any services needed for activities of daily living, caring for HIV/AIDS infected individuals, and alleviation of psychological and social consequences of infection. Case management services require a thorough needs assessment and the development and monitoring of a formal services plan for the client.
  - b. Education:

Education consists of activities aimed at changing knowledge, attitudes, and behaviors of individuals or groups for the purpose of motivating them to avoid contracting or transmitting HIV or alleviating anxiety about transmission and effects of the virus. Education is further defined as activities geared to increasing knowledge and skills of those who perform services for the HIV infected or their friends, families or significant others. Education activities normally consist of presentations, consultations, training, instruction, outreach, hotline operations, and media efforts.
- .02 All agencies under contract with the City of Philadelphia through AACO must submit monthly financial status reports. The purpose of the procedures package is to effectively and efficiently process requests for payment from each contract agency. The package indicated what types of reports were required, information to be included in each report and examples of how each report should look.
- .03 In order for an agency to invoice AACO (City of Philadelphia) for the expenditure of funds allocated through a contract, the submission of a cover letter, an invoice, a monthly budget performance report, and a personnel roster is required. Authorized advance payments must be requested in a letter. Additional information may also be required. Actual requirements for the preceding documents are detailed as follows:

## SECTION 6100 (cont.)

Invoices may differ in format but must include all of the following:

- a) date submitted;
- b) period of service for which invoice is being submitted for;
- c) contract number;
- d) contract name;
- e) current period's expenses (as categorized in the contract budget.)

(Exhibit 1) Monthly Budget Performance Reports must accompany each invoice. This report identifies expenditures in the categories listed on the AACO approved line item budget form and must show current month and year-to-date expenses as well as total budget and the total amount remaining for each line item of the budget. Each column (current month, year-to-date, annual budget, budget amount remaining) must be totaled. Revenue offsetting program/contract costs must be indicated and subtracted from total expenses in all columns.

(Exhibit 2) Personnel Rosters must also accompany each invoice. Each roster must identify names of personnel being charged to a specific program/contract as well as expenditures for each position title. Columns showing current month and year-to-date expenses as well as total budget and total amount remaining for each position must be included and each column must be totaled.

Advance Payments allow for a percentage of the total contract to be paid upon conformation of the contract and must be requested in the form of a letter on Agency/Corporate letterhead. All of the following must be included in each letter:

- a) contract name;
- b) contract number;
- c) signature of authorized corporate official;
- d) percentage of the contract total requested and the amount.

## Section 6120 - Federal CFDA Numbers/Other Regulations

.01 The following Federal CFDA numbers are applicable to AACO Programs:

Program	CFDA No.
AIDS Surveillance and Seroprevalence Grant	93.118, 93.944
AIDS Prevention Project	93.940
HIV Emergency Relief Grant (Formula) (Ryan White)	93.915
HIV Emergency Relief Grant (Supplemental) (Ryan White)	93.914
HIV Early Intervention Project	93.918
HIV Early Intervention Services Network Demonstration Project	93.118

## **Section 6130 - Program Compliance Procedures**

- .01 As discussed in Sections 300 and 500 of this Audit Guide, each City of Philadelphia Department program has specific auditing requirements. These requirements are in addition to those areas of audit specified in Sections 300 and 500 of this Guide. The audit requirements listed on the following pages are not all inclusive and do not represent an audit program for conducting a financial and compliance audit of the program(s). The audit requirements listed are presented as highlights of areas of special interest to the Department. Any deficiencies noted as a result of the procedures are to be disclosed in the Schedule of Findings and Questioned Costs.

### **Program Description and Personal Data Questionnaire**

- .02 The AIDS Agency Services Unit monitors and evaluates programs and direct services for persons with HIV infection. These services include, but are not limited to, AIDS education, support, case management, housing, and HIV counseling and testing. Epidemiology and miscellaneous service contracts are also the responsibility of this unit. All agencies are required to report to their respective AACO program analyst on the progress of the services being rendered.
- .03 Each service is different in nature and requires specific reporting procedures to be followed; however, there are a few reports which AACO requires all contract agencies to submit. These reports include a Position Description and Personal Data Questionnaire (PDPDQ) (Exhibit 3) and monthly statistical and narrative reports. At this time, the PDPDQ is the only standardized form relevant to all AACO contract agencies. Each Agency is required to submit this form to AACO within six months of the contract effective date for all personnel funded by the contract. New staff are required to fill the questionnaires out at the time of their hiring and the agency must submit the forms within thirty (30) days of the hiring date.
- .04 Audit procedures are to include a determination that the PDPDQ is on file at the Organization and that the reporting and filing requirements described above have been met

### **Aids Care Services**

- .05 AACO has many contracts with agencies whose services are provided directly to those individuals who are HIV positive and/or have been diagnosed as having AIDS. Care services help individuals maintain their self worth, independence and dignity while living with AIDS. Such services include, but are not limited to primary care, dental, skilled nursing, transportation, homemaker services, respite care, case management and other required services. Quarterly narrative reports (see Exhibit 7) must contain specific information. In addition to the reporting requirements, the resultant auditing procedure is also stipulated.
- Skilled nursing agencies are required to submit in their monthly reports statistics reflecting the number of Medicaid waivers completed per month. The auditor should determine, on a test basis, that reports include this information and are in compliance with the contract service provisions.
  - Agencies providing homemaker services must include in their monthly reports statistics reflecting the number of clients served each month and the number of hours provided per client per month. Minimum and maximum numbers of clients and hours are provided in the contract service provisions. The auditor should determine, on a test basis, that reports include this information and are in compliance with the provisions.
  - Agencies providing transportation services must include statistics reflecting the number of trips taken per month and the number of clients transported per month in each monthly report. As with homemaker services, minimum and maximum numbers of trips to be taken and clients to be transported are provided in the contract service provisions. The auditor should determine, on a test basis, that reports include this information and are in compliance with the provisions.
- .06 AIDS Case Management services consist of thorough assessments of clients' needs and the development and monitoring of a formal services plan for each client. Agencies providing this type of service assign case managers who aid clients with their daily living needs. These needs vary with each client; therefore, documentation of services provided is extremely important.

- .07 AACO's analytical staff must be able to make their programmatic decisions based on monthly reports from provider agencies. These reports are similar in format to other services' monthly reports; however, more specific information is required. Although no standardized forms are available to agencies at the present time, AACO program staff are in the process of developing a standardized statistical form to be included in future contracts. Nonetheless, statistical information regarding number of clients seen per month, per case manager, is important to AACO.
- .08 Currently, all case management service providers are required to keep a file on each client served. Each client case record file should contain the following list of documents:

### **Assessment Form**

- Data Entry Form
  - Case Management - Client Agreement Form
  - Authorization to obtain release of information.
  - Surveillance letters:
    - (a) To physician
    - (b) To AACO Surveillance Unit.
  - Agency Consent Form
  - Buddy Agreement Form
  - Buddy Program Work Sheet
  - Treatment Care Plan
  - Physician Release Form
  - Case Management Activities Log
  - Progress Notes Form
- .09 The auditor should determine on a test basis that:
- The statistical information reported by the organization to AACO on the monthly statistical reports are traceable to, and in agreement with, supporting records.
  - Client files contain the information required under Section 6130.21.

### **Counseling and Testing Services**

- .10 The counseling and testing programs are required to provide AACO with a monthly report (Exhibit 4) which includes various statistical, programmatic, and staffing information.
- .11 The auditor should determine, on a test basis, that the:
- Statistical information included on the report is traceable to records maintained by the Organization to support the report submitted to AACO. The statistical information needed to be verified by the auditor includes number of individuals pre-tested, number of individuals counseled and not tested, number of individuals tested, and number of individuals post-tested. The source document to be used in verifying the above information is included in Exhibit 4.

### **HIV Prevention: Education and Risk Reduction**

- .12 The education and risk reduction programs are required to provide AACO with a monthly report (Exhibit 5) which includes various statistical, programmatic, and staffing information.
- .13 The auditor should determine, on a test basis that the statistical information included on the report is traceable to records maintained by the organization to support the report(s) submitted to AACO.
- .14 For hotline services, all calls received must be documented on a hotline call record form (Exhibit 6). This is a standardized form which must be completed by a counselor during each telephone conversation.
- .15 The auditor should determine, on a test basis, that the hotline call record forms are utilized and maintained on file at the organization.

## **AIDS Education**

- .16 Other than the Position Description and Personal Data Questionnaire (PDPDQ) which all providers must submit to AACO, AIDS Education Programs must submit a monthly statistical report with narratives within ten working days after the end of each month. These reports document the various education activities performed by each agency. There are no format requirements; however, each report should include the same information regarding the activities conducted during the report period, projected activities for subsequent periods, problems encountered and how they were solved, and supporting statistical data for quantifiable information.
- .17 Each agency is required to track participant attendance for all presentations, workshops, consultations, trainings, and instructions. Attendance sheets are the responsibility of the agency and may be in whatever format they choose to follow; however, participants' names, instructors'/educators' names, and the date of the activity must be included on the form.
- .18 Before and after each educational activity, the instructor/educator must test the knowledge of each participant. This is done through a standardized test which the agency or AACO has developed. Each test, although very often the same, must be presented as two separate distinguishable tests. The first test should be labeled "Pre-test" and the second test should be labeled "Post-test."
- .19 The monthly statistical/narrative report should include a summary of the above information.
- .20 The auditor should determine, on a test basis, the counseling and testing services, that:
  - Statistical information reported corresponds with supporting documents/records maintained at the Organization.
  - Attendance records are utilized and kept on file for participants attending presentations, workshops, consultations, training and instruction.

## **Section 6140 - Financial Compliance Procedures**

### **Revenues:**

- .01 Program-funding is the most common method employed by AACO to fund its provider agencies. This method allows AACO to fund a provider agency's actual eligible expenditures for a provider agency's service(s), offsetting these expenses by anticipated revenues to be received directly by the provider, and establishing the remaining deficit as its authorized level of funding (allocation). Reimbursement is affected on a "last-dollar-in" basis and is based upon actual eligible expenses incurred less actual revenue generated, up to the maximum contract funding.
- .02 Audit procedures should include the following:
  - Does the Agency have a system in place to adequately account for all applicable income received or earned by the agency and that such income was properly reported to AACO.
  - Determine that billings to AACO and reimbursement from AACO are net of other non-AACO revenue.

## **Section 6150 - Supplemental Financial Schedules and Reports**

- .01 The organization's audit report must include the following supplemental financial schedule for each City of Philadelphia contract with \$300,000 or more of expenditures in addition to the financial statements as specified in Sections 400 and 500 of this Audit Guide. A designation has been made for the supplemental schedule required for a "single audit" report (Section 400) on a "program audit" report (Section 500). The auditor will be required to issue an opinion on the Supplemental Schedules listed below as specified in Section 400 of this Audit Guide.

Supplemental Financial Schedule	Section Ref. to Sample Format	Single Audit Report	Program Audit Report
- Schedule of Program Expenditures and Program Revenue (1)	6150.02	Yes	No (2)

**Explanatory Notes:**

(1) The schedule must reflect the categorization of expenditures by the AACO budget with the organization.

(2) The categories of expenditures provided on the program audit financial statement should coincide with the categories of expenditures on the AACO budget.

**Section 6150.02**

**ABC NOT-FOR-PROFIT CORPORATION  
AACO CONTRACT NUMBER XX-XXXX  
STATEMENT OF PROGRAM EXPENDITURES AND PROGRAM REVENUE  
FOR THE YEAR ENDED JUNE 30, 19XX**

**Expenditures**

Personnel:	
Salaries	\$ XXX,XXX
Fringe benefits	XX,XXX
Total personnel expenditures	\$ XXX,XXX

**Operating**

Occupancy	XX,XXX
Renovation	X,XXX
Communications	XXX
Office Supplies	XXX
Education/Program supplies	X,XXX
Travel	X,XXX
Contract Services	X,XXX
Insurance	X,XXX
Condoms	X,XXX
Total operating expenditures	XX,XXX

**Equipment:**

Purchase	XX,XXX
Lease/rental	X,XXX
Repairs	X,XXX
Total equipment expenditures	XX,XXX
Total direct expenditures	XXX,XXX
Administration	XX,XXX
Total expenditures	XXX,XXX
Program Revenue	(X,XXX)
Net AACO funded expenditures	\$ XXX,XXX

**AACO - EXHIBITS  
TABLE OF CONTENTS**

EXHIBIT	DESCRIPTION
1	Monthly Budget Performance Report
2	Personnel Roster
3	Position Description and Personal Data Questionnaire
4	Counseling and Testing Package
5	Education and Risk Reduction Package
6	Hotline Call Record Form
7	Aids Care Services/Ryan White Package

Exhibit 2

AIDS AGENCY XYZ  
CONTRACT XX-XXXX

	Budget		Per Contract	Budget	Remaining
	August Billings	Cumulative Billings			
Personnel Service (by position):					
Prog. Coord.					
B. Smith	\$ 3,333		\$ 6,666	\$ 40,000	\$ 33,334
Counselor					
J. Jones	2,500	5,000	30,000	25,000	
Educator					
A. Carter	2,667	5,334	32,000	26,666	
Secretary					
M. Cuyler (hired 7/15/XX)			1,625	2,437	19,500 17,063
Educator					
C. Jackson (term. 7/31/XX)			-0-	2,667	32,000 29,333
D. Kelly (hired 8/1/XX)	2,667		2,667	-0-	(2,667)
Counselor					
G. Martin	2,500	5,000	30,000	25,000	
Counselor					
F. Berk	2,500	5,000	30,000	25,000	
Education					
Vacant	-0-	-0-	32,000	32,000	
Phlebotomist					
N. Mill (hired 8/10/XX)			718	718	21,500 20,782
Total	\$ 18,510	\$ 35,489	\$ 267,000	\$ 231,511	

ATTACHMENT C  
Exhibit 3

Position Description and Personal Data Questionnaire City of Philadelphia Aids Activities Coordinating Office  
Personnel Action Plan

1. Position Number
2. Request for personnel action on Existing position New Incumbent New Position (Explain) Position (Explain) Conversion
3. Last Name First Mi
4. Agency
5. Service, division, unit 6. Total working hrs per week in agcy. 7. No. working hrs. chgd to county prog.
8. Requested "Pap" title 9. Usual working title 10. Annual salary (for total hrs. worked, #6)
11. Describe types of work you do during working hours on County Program. Use separate paragraph for each kind of work and explain in detail. List your duties in order of importance, showing estimate of time spent on each duty by percentage, fractions, days or hours in "Time" column. Special or occasional duties should be last.

Time Work Performed

(Continue on additional sheets)

**Exhibit 1****BUDGET STATEMENT  
AIDS AGENCY XYZ  
COUNSELING SERVICES  
(CONTRACT XX-XXXX)  
AUGUST, 19XX**

	August	Year To-Date	Total Budget	Budget Remaining
<b>Expenses</b>				
Personnel:				
Salaries	\$ 18,510	\$ 35,489	\$ 267,000	\$ 231,511
Benefits	2,124	4,072	30,638	26,566
Other	-0-	-0-	300	300
Sub-total personnel	20,634	39,561	297,938	258,377
<b>Operating:</b>				
Occupancy	3,045	6,090	36,540	30,450
Renovation	-0-	-0-	-0-	-0-
Communications	1,245	1,900	8,700	6,800
Office Supplies	603	603	2,500	1,897
Education/ Program supplies	262	524	1,750	1,226
Travel	174	348	2,784	2,436
Contract Services	-0-	-0-	-0-	-0-
Insurance	85	170	1,025	855
Condoms	150	250	1,500	1,250
Sub-total operating	5,564	9,885	54,799	44,914
<b>Equipment:</b>				
Purchase	-0-	-0-	3,000	3,000
Lease/rental	39	78	468	390
Repairs	-0-	-0-	500	500
Sub-total equipment	39	78	3,968	3,890
Subtotal direct	26,237	49,524	356,705	307,181
Administration	933	1,874	13,500	11,626
Sub-total	27,170	51,398	370,205	318,807
Revenue	(500)	(1,000)	(7,121)	(6,121)
Grand total	\$ 26,670	\$ 50,398	\$ 363,084	\$ 312,686

**Exhibit 4**

**Attachment B  
PATIENT FOLLOW-UP/PARTNER NOTIFICATION FORM**

Check One:

Patient Follow-Up  
Date Tested

Partner Notification  
Date Interviewed

Name: _____		Alias/Nickname: _____	
Address: _____ _____		DOB: _____	
		Age: _____	
		Sex: _____	
Work Address/Hangouts: _____ _____		Marital Status: _____	
		Work Hours: _____	
Home Phone #: _____		Work Phone#: _____	
Exposure Information: <input type="checkbox"/> Sex <input type="checkbox"/> Needle Sharing <input type="checkbox"/> Other		First: _____	
		Last: _____                      Freq: _____	

Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other	Skin Complexion: _____
Facial Hair:    Beard                      Moustache                      Height: _____	Weight: _____
Identifying Information: (i.e. scars/tattoos)                      Hair Color: _____	Glasses: _____

Reporting Agency: _____	Site #: _____	Date: _____
Counselor: _____	Phone Number: _____	

Submit to:            Kevin F. Green  
Program Administrator, Counseling & Testing  
500 S. Broad St. 3rd Floor  
Philadelphia, PA 19146



**Exhibit 4 (Cont.)**

**Pretest Counseling/Observation  
Counselor Observation**

**Page 2**

10. Client was provided information on the following:

	Counselor	Video/Pamphlet	Not Provided
a. Purpose of the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Meaning of results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. AIDS prognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Value of testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Condom use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please provide examples for questions #11-16.**

11. How well did the counselor provide information at a level of comprehension which was consistent with the client's age and learning skills? Explain.
  
12. How well did the counselor provide/demonstrate culturally competent messages, (e.g., provided in a style and format respectful of cultural norms)? Explain.
  
13. How linguistically appropriate was the counselor with the client, (e.g., presented in a dialect and terminology consistent with the clients native language and style of communication)? Explain.
  
14. How do clients schedule appointments to return for results at the time of the pretest session?
  
15. How well did the counselor reinforce the importance of returning for test results/counseling? Explain.
  
16. What and when is related paperwork completed by the counselor? Explain.

**Exhibit 4 (Cont.)**

**Counselor Observation**  
**Page 3**

**Observational Comments**

## Exhibit 4 (Cont.)

### COUNSELOR OBSERVATION

#### Post-Test Counseling

1. How long did the observed post-test counseling session last?
2. Did the counselor(s) introduce her/himself and explain the purpose of the session?  
Yes                      No
3. Did the counselors(s) use open-ended questions? (Give examples)  
Yes                      No
4. Did the counselor(s) ascertain if a personal risk reduction plan was established in the pretest session?  
Yes                      No
5. If yes to #4, did the counselor (check if "yes"):
  - a. reinforce successful efforts?
  - b. discuss failed efforts?
  - c. provide additional coaching on risks remaining?
6. If no plan had previously been established, did the counselor (check if "Yes"):
  - a. Negotiate a personalized, incremental risk reduction plan with the client(s), i.e. tailored to the behaviors, circumstances and special needs of the client(s) during the posttest session?
  - b. Deliver global prevention messages independent of the clients personal risk behaviors and circumstances?
  - c. Fail to discuss risk reduction in the post-test session?

If a risk reduction plan was discussed, was it revised or updated in the record or review in any subsequent retesting sessions?

Yes                      No

7. Did the counselor (s) (check if "yes")

Routinely recommend retesting at 3-6 months?

Recommend retesting if unsafe behaviors occurred within the last three months or should occur in the future?

Not discuss retesting?

**Exhibit 4 (Cont.)**

**Post-test Counseling/Observation  
Counselor Observation  
Page 2**

**OBSERVATIONAL COMMENTS (IF ANY):**

**Exhibit 4 (Cont.)**

**Attachment E**

City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit

**PREVENTION COUNSELING  
PROGRAM PROGRESS REPORT AGENCY**

Program/Activity

Report Period

Contract Period

AACO Funding for this Program

Funding Source

Report Submitted by

**Section I – Goals**

A.

- 1.
- 2.
- 3.
- 4.

B.

- 1.
- 2.
- 3.
- 4.

**Exhibit 4 (Cont.)**

**Section II – Progress in Meeting Goals**

A.

	Number Prevention Counseled	Number Counseled/ Not Tested	Number Tested	Number of Result Sessions	Number of Counselor/s Hours Worked
Site No.					
Site No.					
Site No.					
Site No.					
Site No.					
Totals					

B.

1.

a.

b.

2.

a.

b.

3.

a.

b.

## **Exhibit 4 (Cont.)**

### **Section III Accomplishments**

A. Programmatic

B. Administrative

C. Fiscal

### **Section IV – Challenges**

A. Programmatic

B. Administrative

C. Fiscal

**Exhibit 4 (Cont.)**

**Section V – Plan of Action to Meet Challenges in Section IV**

- A. Programmatic
  
- B. Administrative
  
- C. Fiscal

**Section VI – Collaboration**

*Please footnote all changes that relate to the addition or deletion of agencies with which you hold Letters of Agreement.*

- A. Names of agencies with Letters of Agreement on file and numbers of referrals:

Name	Number
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

- B. Other (specify):

Name	Number
1.	
2.	
3.	
4.	
5.	

**Exhibit 4 (Cont.)**

**EQUIPMENT INVENTORY FORM  
HIV Prevention Services  
AIDS Activities Coordinating Office  
Revised 11/95**

*Any equipment acquired with AACO funds, and a purchase price greater than \$500 should be entered below. This form should be submitted with the monthly invoice as the line item justification for that purchase.*

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

**Exhibit 5  
Attachment B**

**City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit**

**PROGRAM PROGRESS REPORT**

Program/Activity	Report Period
Contract Period	AACO Funding for this Program
Funding Source	Report Submitted by

**Section I – Goals**

A.

B.

- 1.
- 2.
- 3.
- 4.
- 5.

**Section II – Progress in Meeting Goals**

A.

B. Enter goals stated in Section I-B of this report:

**Section III – Accomplishments**

A. Programmatic

B. Administrative

C. Fiscal

**Exhibit 5 (Cont.)**

**INSTRUCTIONAL TEMPLATE  
City of Philadelphia  
Department of Public Health  
AIDS Activities Coordinating Office  
HIV Prevention Services Unit**

**Risk Reduction  
PROGRAM PROGRESS REPORT AGENCY  
(Enter agency name)**

Program/Activity  
(Enter name of program or activity  
for this contract)

Report Period  
(Enter month being reported on)

Contract Period  
(Enter start and end dates)

AACO Funding for this Program  
(Enter dollar amount of contract/s)

Funding Source  
(Enter source, indicate City, State, or  
Federal completing)

Report Submitted by  
(Enter name of individual  
responsible for the report)

**Section I – Goals**

- A. (Enter Section II part A of contract service provisions)
- B. (Enter goals that have been established with AACO Program Analyst)

- 1.
- 2.
- 3.
- 4.
- 5.

**Section II – Progress in Meeting Goals**

- A. (Enter statistics for the month using the table/s provided)

## **Exhibit 5 (Cont.)**

### **Program Progress Report**

B. Enter the goals stated in Section I-B of this report:

1. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)
2. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)
3. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)
4. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)
5. (Enter goal)
  - a. (Enter work statement/s)
  - b. (Enter progress and/or barriers to implementing work statement/s)

### **Section III – Accomplishments**

*(Enter overall accomplishments, excluding statistics mentioned in Section II A and achievements mentioned in Section II B):*

- A. Programmatic
- B. Administrative
- C. Fiscal

### **Section IV-Challenges**

*(Enter overall challenges, excluding difficulties stated in Section II):*

- A. Programmatic
- B. Administrative
- C. Fiscal

## Exhibit 5 (Cont.)

### Section V – Plan of Action to Meet Challenges in Section IV (Enter plan)

- A. Programmatic
- B. Administrative
- C. Fiscal

### Section VI – Collaboration

*(Enter the number of referrals made to agencies of which you hold Letters of Agreement. Agencies with Letters of Agreement should become permanent entries.)*

Please footnote all changes that relate to the addition or deletion of agencies with which you hold Letters of Agreement.

- A. Names of agencies with Letters of Agreement on file and numbers of referrals:

(Enter name of agency)

(Enter number of referrals)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

- B. Other (specify):

(Enter name of agency)

(Enter number of referrals)

- 1.
- 2.
- 3.
- 4.
- 5.

**Exhibit 5 (Cont.)**

**Attachment C  
EQUIPMENT INVENTORY FORM  
HIV Prevention Services  
AIDS Activities Coordinating Office  
Revised 11/95**

*Any equipment acquired with AACO funds, and a purchase price greater than \$500 should be entered below. This form should be submitted with the monthly invoice as the line item justification for that purchase.*

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

	Date Purchased	Equipment Description	Serial Number	Location
1.				
2.				
3.				
4.				
5.				

## Exhibit 6

### HOTLINE CALL RECORD - FY 97

Data entry use only:

Prep By \_\_\_\_\_ Date \_\_\_\_\_ Time: Start \_\_\_\_\_ Finish \_\_\_\_\_

#### CALL MADE BY GENDER

- |                        |                  |
|------------------------|------------------|
| 1. Consumer            | 1. Female        |
| 2. Friend/partner/rel. | 2. Male          |
| 3. Hospital/clinic     | 3. Mixed group   |
| 4. Agency              | 4. Transgendered |
| 5. School              | 5. Unknown       |

#### INSURANCE

1. MA/SSI
2. Military/VA
3. Employer/Private
4. None
5. Unknown

#### RACE/ETHNICITY

1. African-American
2. Caucasian
3. Hispanic/Latino
4. Asian-American/  
Pacific Islander
5. Native American/Aleutian/  
Native Alaskan/Eskimo
6. Other
7. Unknown
8. N/A
9. Refused

#### AGE \_\_\_\_\_

1. Mixed Group
2. Unknown
3. Refused

#### 6. CHOICE Counselor

7. Other

6. N/A

7. Refused

1. Advocacy
2. Call in Spanish
3. Call in other language
4. TTY

PA COUNTY  
CODE \_\_\_\_\_

#### ZIP CODE \_\_\_\_\_

1. Outside of Phila. Metro area
2. Unknown

#### SUBJECT

- |                             |                |                                       |                                 |
|-----------------------------|----------------|---------------------------------------|---------------------------------|
| 1. Abortion                 | M              | Teen Access                           | 8. Financial assistance/MA      |
| 2. Abuse                    | A. Rape        | D. Parental consent                   | 9. Food/shelter                 |
| 3. Adoption                 | B. Incest      | E. Out-of-state                       | 10. General health              |
| 4. Birth control            | C. Life-threat | F. Court-bypass                       | 11. Gyn                         |
| A. Cervical cap             |                | G. Undecided                          | 12. Infertility                 |
| B. Depo Provera             |                |                                       | 13. Healthy Start               |
| C. Diaphragm                |                | Abortion/Prenatal Care/<br>Pregnancy: | 14. HIV/AIDS *                  |
| D. Female condom            |                | H. First trimester                    | 15. Legal/legislative           |
| E. Foam                     |                | I. Second trimester                   | 16. Menstruation cycle          |
| F. IUD                      |                | J. Third trimester                    | 17. Pregnancy/childbirth        |
| G. Male condom              |                | K. Unknown                            | 18. Pregnancy options           |
| H. Norplant                 |                | L. N/A                                | 19. Pregnancy support/parenting |
| I. Pills                    |                |                                       | 20. Pregnancy test/symptoms     |
| J. Post-Coital pill         |                |                                       | 21. Prenatal care               |
| K. Sponge                   |                |                                       | 22. Sexuality                   |
| L. Natural FP/CMBBT         |                |                                       | 23. STD/infection               |
| 5. Counseling/mental health |                |                                       | 24. Sterilization               |
| 6. Drug abuse               |                |                                       | 25. Other                       |
| 7. Education/job training   |                |                                       |                                 |

## HIV/AIDS

Type of Call	Consumer's Status	Consumer's Concerns			
1. Case management	6. Symptoms	A. HIV	1. Blood transfusion/products	6. Pediatric	
2. General Info	7. Testing	B. HIV+asymptomatic	2. Caregiver/partner	7. Sexual	A. F/M
3. Housing	8. Transmission	C. HIV+ symptomatic	3. Casual contact	8. Work related	B. M/M
4. Medical care	9. Treatment	D. AIDS	4. Health care related	9. Other	C. F/F
5. Support/counseling	10. Other	E. Unknown	5. IDU	10. Unknown	D. Unknown
	F. N/A	11. N/A	E. N/A		

## HOW HEARD OF HOTLINE

1. Called before	7. Other outreach/materials	13. SEPTA car card	19. Campaign E
2. Friend/relative/partner	8. Newspaper ad/coverage	14. Healthy Start Campaign	20. Unknown
3. Agency	9. Radio ad/coverage	15. Campaign A	21. Other
4. Hospital/clinic	10. TV ad/coverage	16. Campaign B	22. N/A
5. Private Practitioner	11. Phone book/information	17. Campaign C	
6. CHOICE outreach/ materials	12. School	18. Campaign D	

## NUMBER CALLED

1. 985-3300	5. 1-800-84-TEENS	1. FPC
2. 985-AIDS	6. Other	2. MCH
3. 1-800-985-AIDS	7. Transfer from	
4. 1-800-876-MOMS	8. 1-800-662-6080	

## FUNDING SOURCE

4. AACO	6. Other Non-Funded
5. Ryan White	
3. Abortion/adoption	
7. AIDS Fact Line	

## REFERRAL SUMMARY

**Exhibit 7**

**ATTACHMENT A**

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: \_\_\_\_\_

**Exhibit 7 (Cont.)**

**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.

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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.

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3. 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?

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**Exhibit 7 (Cont.)**

- 4. a) Briefly discuss any significant barriers that your program has experienced in the provision of this service to your clients, problems encountered in delivering services and unmet needs.

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- b) Describe how this program has worked to overcome the barriers indicated above. Also, indicate any actions that were taken or plans formulated to respond to these areas of concern.

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- 5. Describe technical assistance needs this program has identified.

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- 6. Describe any changes in staff funded by this contract during the past quarter (i.e. has anyone been hired, fired, promoted). Indicate if new job titles were created. Provide job descriptions as appropriate.

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- 7. Describe any organizational budget changes in the last quarter that affect the delivery of services in this contract.

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- 8. Discuss trends and share insight regarding demand/needs that affect or may affect the provision of this program's services from your organization's point of view. Provide documentation as appropriate.

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- 9. Indicate any significant programmatic accomplishments/highlights relevant to the quarter.

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10. Indicate the level of involvement and participation of Persons With HIV/AIDS in the design and delivery of Title I funded services both at your agency and with regard to this particular program. Please be as specific as possible (i.e. indicate the number of consumers who are involved in the delivery of Title I services, the number of paid versus volunteer HIV consumer staff, support groups conducted by and for Persons With HIV/AIDS, HIV consumer needs assessments conducted by your agency, etc.). Please indicate how your agency and/or this program documents HIV consumer involvement.

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11. Indicate any mechanisms/ processes in place at your agency which allows for the assessment of Title I funded services by Persons With HIV/AIDS.

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**Exhibit 7 (Cont.)**

**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
  - (02) 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 New 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: Black (Non-Hispanic)	White (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

17. 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

18. 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

19. 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)

**Exhibit 7 (Cont.)**

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

20. 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

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

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

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

**Exhibit 7 (Cont.)**  
**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