Appendix 1:

Consumer Survey

Administrator:	
GC #:	
Do not write above this line.	For Office Use Only.

Statewide Coordinated Statement of Need (SCSN) Needs Assessment Client Survey

- "I understand that my completion of this needs assessment client survey is strictly voluntary. If I choose not to complete the survey, it will not affect the services that I receive."
- All information collected through this survey is completely confidential and anonymous.
 Do not put your name on this survey.
- The survey asks for some personal background information (to assist in planning services that respond to your needs). This personal information will never be used to identify you as an individual.
- For each question below, check or write in an answer. There are no right or wrong answers. Please take as much time as you need to answer the question based on your experiences. If you need help filling out the survey, please ask ______ (needs assessment administrator, etc.)
- Filling out this survey should take approximately 45 minutes of your time.

Note: We recognize that this tool does not address the needs of special populations/children living with HIV/AIDS.



PERSONAL PROFILE

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS BY PLACING A CHECK ON THE LINE OR PROVIDING THE REQUESTED INFORMATION (You may need to check more than one box to answer a question).

1.	Who are you completing this survey for?
	Myself (Answer all questions for yourself)
	As the caregiver for someone else who is HIV positive (Answer all questions for the person
	you are caring for.)
2a	. What is your HIV/AIDS status?
	HIV positive with no symptoms
	HIV positive with symptoms
	Living with AIDS
	Don't Know
2b	. Are you currently
	HIV positive and receiving services
	HIV positive and not receiving services
	A caregiver of a person living with HIV/AIDS receiving services
	A caregiver of a person living with HIV/AIDS not receiving services
	Don't Know
3	Are you
٠.	Male
	Female
	Tentate Transgender
	Other:
	(Specify)
	(Specify)
<u>If</u>	you are a female, please answer questions 4 and 5. Otherwise, please go on to question 6.
4	
4.	Are you currently pregnant/have you been pregnant within the past 12 months?
	Yes
	No
	Don't know
5.	If you answered yes to question 4, are you currently receiving or did you receive any medication to
	prevent transmission of HIV from you to your baby?
	Yes
	No
	Don't know

١.	What is your date of birth?
	Month Year
lea	ase answer both questions 7 <u>AND</u> 8 regardless of your racial/ethnic background.
	What do you consider your ethnic background?
	Hispanic/Latino(a)
	Not Hispanic/Latino(a)
	What do you consider your racial background?
	American Indian or Alaska Native
	Asian
	Black or African-American
	Native Hawaiian or other Pacific Islander
	White
	Multi-racial
	Other: (Specify)
	(Specify)
	Which language are you most comfortable speaking? (Please check only one response) English Spanish
	Other:
	(Specify)
)_	What is the highest level of education you completed?
	Grade school or less (8th grade or less)
	Some high school
	High school graduate/GED
	Technical or trade School
	Some college
	Completed college
	Graduate level
	Other:
	(Specify)
	What is the name of the city/town in which you live?
	If you do not live in a city or town, please name the nearest city or town.
	What is the zip code where you live?
	With only one do seed lines? (Cheeke all that are also)
	With whom do you live? (Check all that apply) I live alone
	Partner/wife/husband
	Other adult family member or relative
	Adult friend/roommate
	Children (minor)
	Other: (Specify)
	(Specify)

14.	Is anyone in your household other than you con Yes	urrently living with H	IV?
	No		
	Don't Know		
15.	Please indicate the number of dependent child	dren in your household	d.
	One child		
	Two children		
	Three children		
	Four or more children		
16.	Do any of the children have HIV?		
	Yes		
	No		
	Don't Know		
	Not Applicable		
1 /.	Please check the one best description of whe places you have lived over the past year.	The you live now. In the	,
		Where I live now (Check only one)	Other places I have lived in the past year. (Check all that apply)
Ţ	I., / I		
	In an apartment/house that I own/rent		
	At my parent's/relative's apartment/house		
-	•		
-	At my parent's/relative's apartment/house		
-	At my parent's/relative's apartment/house Someone else's apartment/house		
-	At my parent's/relative's apartment/house Someone else's apartment/house In a rooming or boarding house In a "supportive living" facility		
-	At my parent's/relative's apartment/house Someone else's apartment/house In a rooming or boarding house In a "supportive living" facility (Assisted Living Facility)		
-	At my parent's/relative's apartment/house Someone else's apartment/house In a rooming or boarding house In a "supportive living" facility (Assisted Living Facility) In a group home or residence In a half-way house, transitional housing or		
-	At my parent's/relative's apartment/house Someone else's apartment/house In a rooming or boarding house In a "supportive living" facility (Assisted Living Facility) In a group home or residence In a half-way house, transitional housing or treatment facility (drug or psychiatric)		
	At my parent's/relative's apartment/house Someone else's apartment/house In a rooming or boarding house In a "supportive living" facility (Assisted Living Facility) In a group home or residence In a half-way house, transitional housing or treatment facility (drug or psychiatric) Skilled nursing home		
- - - - - - -	At my parent's/relative's apartment/house Someone else's apartment/house In a rooming or boarding house In a "supportive living" facility (Assisted Living Facility) In a group home or residence In a half-way house, transitional housing or treatment facility (drug or psychiatric) Skilled nursing home Homeless (on the street/in car)		
-	At my parent's/relative's apartment/house Someone else's apartment/house In a rooming or boarding house In a "supportive living" facility (Assisted Living Facility) In a group home or residence In a half-way house, transitional housing or treatment facility (drug or psychiatric) Skilled nursing home Homeless (on the street/in car) Homeless shelter		
- - - - - - - -	At my parent's/relative's apartment/house Someone else's apartment/house In a rooming or boarding house In a "supportive living" facility (Assisted Living Facility) In a group home or residence In a half-way house, transitional housing or treatment facility (drug or psychiatric) Skilled nursing home Homeless (on the street/in car) Homeless shelter Battered women's shelter		
-	At my parent's/relative's apartment/house Someone else's apartment/house In a rooming or boarding house In a "supportive living" facility (Assisted Living Facility) In a group home or residence In a half-way house, transitional housing or treatment facility (drug or psychiatric) Skilled nursing home Homeless (on the street/in car) Homeless shelter Battered women's shelter Battered men's shelter		

(Specify)

Other:

18a.	your HIV? (Check all that apply)
	I don't have a safe and private room
	I don't have a bed to sleep in
	I don't have a place to store my medications
	I don't have a telephone where someone can call me
	I don't have enough food to eat
	I don't have money to pay for rent
	I'm afraid of others knowing I am HIV-positive
	I can't get away from drugs in the neighborhood
	Other
	(specify)
	None of the Above
18b.	What is the amount that you pay out of pocket each month for rent or mortgage payments? Only include rent or mortgage payments and not utilities or expenses.
	Not applicable, I do not pay mortgage or rent
	Less than \$100
	\$101-200
	\$201-300
	\$301-400
	\$401-500
	\$501-600
	More than \$600
18c.	Does the government or another organization currently pay or help pay for your housing?
	No, I don't get any help with my housing.
	I am not sure if I am getting help paying for my housing.
	Yes, Check all that apply:
	I have a Section 8 certificate or voucher.
	I get help to pay my rent from HOPWA (Housing Opportunities for Persons with AIDS).
	I live in subsidized or public housing.
	I live in a home for people living with HIV infection or AIDS.
	I am getting help paying for my housing, but I don't know what it is called.
	I am getting another kind of help paying for my housing.

18d.	Are you on any waiting lists for government or other help to pay or pay for a part of your housing costs? (Check all that apply)
	No, I am not on any waiting lists for help paying for my housing.
	I am not sure if I am on any waiting lists for help paying for my housing.
	Yes, Check all that apply:
	I am waiting for a Section 8 certificate or voucher. For how long?
	I am waiting to get help to pay my rent from HOPWA (Housing Opportunities for Persons with AIDS). For how long?
	I am waiting for subsidized or public housing.
	I am on a waiting list, but I am not sure what kind.
	I have been waiting for another kind of help paying for my housing.
	No Don't Know If yes, what caused the trouble? (Check all that apply)
	Alcohol or drug use
	Participation in a methadone maintenance program Montal illness
	Mental illness
	Immigration status Bad credit
	Criminal record I didn't have enough money for security deposit, first and last months' rent.
	I had no transportation to search for housing
	I had trouble getting housing for a different reason: Specify:
18f	Please indicate the condition of the following parts of your housing:

	Good Condition	Poor Condition	Don't Know	Not Applicable
Air conditioning				
Doors				
Electrical system				
Heating system				
Kitchen appliances				
Plumbing				
Safety features (locks, alarms, smoke detectors, etc.)				
Windows				

19. Have you been in jail or prison during the past year?	
Yes No	
If "Yes," please answer questions 19a and 19b. If "No," go to question 20a.	
19a. Do any of the following stop you from getting HIV services?	
I have been unable to find a place to live after being released from jail/prison	
I have been unable to get HIV medications after being released from jail/prison	
I have been unable to get case management	
Getting free services has been a problem, such as welfare, food stamps, financial assistance	
I am having trouble staying away from drugs	
I am having trouble finding friends who I can trust	
Other:(Specify)	
None of the Above	
19b. Did you get enough information about finding housing when you were released?	
Yes	
No	
20a. Which one of these describes your current job (work) situation? (Check only one)	
Working full-time job	
Working part-time job	
Working part time on disability	
Not working	
If not working, answer question 20b. If working, go to question 21.	
20b. If you are not currently working (have no job), why not? (Check only one)	
Student	
Looking for a job	
Retired	
Disabled	
Other:	
(Specify)	

21.	What is your yearly income?
	(Specify amount)
21a	. How many people are supported by this income?
	$\frac{1}{2}$
	$\frac{}{}$ 2 $\frac{}{}$ 3
	3
	Other: (Specify)
	(Specify)
	INSURANCE AND BENEFITS
22	D 1 1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
22.	Do you have health insurance that covers your HIV/AIDS medical care? Yes
	No
	110
	If yes, what kind of health insurance do you have? (Check only one. If you have more than one
	check the one that pays first.) *This could be either your insurance or someone else's if you
	are covered on their plan.
	Insurance through work
	COBRA (continuation of insurance paid through your last employer)
	Private insurance, not through work
	Medicare
	Medicaid
	Other: (Specify)
	(Specify)
23.	Are you taking HIV/AIDS drugs/medications?
	Yes
	No
	If yes, what program pays for them? (Check all that apply)
	Local drug assistance program
	State drug assistance program (TDH/ADAP)
	Private Insurance
	Medicaid
	Other:
	(Specify)

23a.	. If you are taking non-HIV medications, do you have difficulties paying for them?
	Yes
	No
	Not applicable, I am not taking any non-HIV medications.
24.	J J (11 0)
	Hospital/Hospital Clinic
	Emergency Room (ER)
	HIV specialty clinic (a public clinic that serves only HIV clients) Private Physician's Office/Clinic
	Public Health or Community Clinic (open to everyone regardless of HIV status)
	VA Hospital/Clinic
	Other:
	Other:(Specify)
25.	Do you have any mental or physical disabilities? (Not including HIV/AIDS) Yes
	No
	100
	If yes, what types of disabilities do you have?
26.	Have you been unable to get needed HIV services because of any of the following circumstances
	or disabilities?
	Yes, Check all that apply:
	Wheelchair bound
	Hard of hearing or deaf
	Visually impaired (not correctable by eyeglasses)
	Blind
	Mentally impaired
	Chemical dependency (alcohol, street drugs)
	Other:
	Other: (Specify)
	No
26a.	. In the past 12 months, how many medical appointments have you missed because of
	transportation problems? (Check only one)
	None
	1-5
	More than 5

PERSONAL HEALTH AND WELLNESS

27.	Have you been tested for HIV infection during the past two years? Yes
	No
	es, how many times have you been tested at each of the sites listed? ase indicate the NUMBER of times: Community site (counseling/testing center, public clinic)
	City/county health department Health fair, bar, or other place of entertainment Home test Hospital clinic Hospital emergency room Military Jail or prison Private physician's office Other: (Specify)
28.	What year did you first test positive for HIV? Indicate Year
29.	How did you find out you were HIV positive?
	When I requested a test for HIV
	When I donated blood
	When I went to the hospital or emergency room for something else
	Recommended by my healthcare provider as part of a physical exam or doctor's visit (For women) As part of care while pregnant
	When I was in jail or prison
	Other: (Specify)
	(Specify)
30.	At the time of your HIV diagnosis, were you referred for any of the following services? (Check all that apply) Medical care related to the HIV diagnosis
	Medical care for a condition other than HIV
	Substance abuse counseling service
	Mental health services (other than substance abuse counseling)
	If pregnant, for OB/GYN care
	Health/HIV education class
	No, I was not referred for services
	Other:
	(Specify)

	Immediately
	Within 6 months
	Within a year
	Longer than 1 year
	I have not gotten medical care for HIV
	0.1
	Other(Specify)
nswer q	uestions 32 & 32a if you waited 1 year or more before receiving medical care related to F
	nestion 33 if you received medical care within 1 year OR if you have never received
<u>eaicai c</u>	are related to HIV.
	ANSWER QUESTIONS 32 & 32A <u>IF YOU WAITED 1 YEAR OR MORE</u> BEFORE RECEIVING MEDICAL CARE RELATED TO HIV
-	did not seek medical care within one year of your diagnosis, please indicate your reasons.
(Che	ck all that apply)
	No one told me that I needed to get medical care
	My doctor or nurse told me that I did not need medical care at that time
_	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick
	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good
	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me
_	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care
_	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care I did not want to receive medical care
_	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care
	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care I did not want to receive medical care I used alternative therapies (herbs, vitamins, acupuncture, massage therapy, or other
_	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care I did not want to receive medical care I used alternative therapies (herbs, vitamins, acupuncture, massage therapy, or other non-traditional medicine) Financial reasons Other
	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care I did not want to receive medical care I used alternative therapies (herbs, vitamins, acupuncture, massage therapy, or other non-traditional medicine) Financial reasons
	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care I did not want to receive medical care I used alternative therapies (herbs, vitamins, acupuncture, massage therapy, or other non-traditional medicine) Financial reasons Other (Specify) any of the following stop you from receiving care after your diagnosis?
 a. Did	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care I did not want to receive medical care I used alternative therapies (herbs, vitamins, acupuncture, massage therapy, or other non-traditional medicine) Financial reasons Other (Specify) any of the following stop you from receiving care after your diagnosis? cek all that apply)
 a. Did	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care I did not want to receive medical care I used alternative therapies (herbs, vitamins, acupuncture, massage therapy, or other non-traditional medicine) Financial reasons Other (Specify) any of the following stop you from receiving care after your diagnosis? ack all that apply) I was worried that someone would force me to take medication
	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care I did not want to receive medical care I used alternative therapies (herbs, vitamins, acupuncture, massage therapy, or other non-traditional medicine) Financial reasons Other (Specify) any of the following stop you from receiving care after your diagnosis? and that apply) I was worried that someone would force me to take medication I was actively using (street drugs, alcohol) so it wasn't important
 a. Did	My doctor or nurse told me that I did not need medical care at that time I did not believe that I needed medical care then, because I was not sick I did not believe that medical care would do me any good I did not find a doctor or nurse whom I wanted to treat me I did not know where to go for medical care I did not want to receive medical care I used alternative therapies (herbs, vitamins, acupuncture, massage therapy, or other non-traditional medicine) Financial reasons Other (Specify) any of the following stop you from receiving care after your diagnosis? ack all that apply) I was worried that someone would force me to take medication

None of the above

I was worried someone might find out about my HIV status if I went there

The people at the agency didn't speak my language

33. Hav	ye you received any of the following within the last 12 months? (Check all that apply) CD4 tests
	Anti-retroviral medication
	Viral load tests
	No, I have not received these tests or medications
	1vo, I have not received these tests of medications
If wo	u have not received any of the tests or medications above answer questions 24 and 24a
· ·	u <u>have not</u> received any of the tests or medications above, answer questions 34 and 34a.
If yo	u <u>have</u> , go to question 34b.
	ANSWER QUESTION 34 AND 34A IF YOU HAVE NOT RECEIVED
	ANY OF THE TESTS OR MEDICATIONS
	LISTED IN QUESTION 33 <u>WITHIN THE LAST 12 MONTHS</u> .
	has been more than 12 months since you received HIV-related medical care from a doctor or se, please indicate your reasons (Check all that apply)
IIdi	My doctor or nurse told me I do not currently need medical care
	I do not believe that I need medical care currently, because I am not sick
	I do not believe that medical care would do me any good
_	I have not found a doctor or nurse whom I want to treat me
_	I do not know where to go for medical care
_	I do not want to receive medical care
_	I use alternative therapies (herbs, vitamins, acupuncture, massage therapy, or other non-traditional medicine)
	Financial reasons
	Other
	(Specify)
1	licate if any of the following has kept you from receiving HIV-related medical care from a etor or nurse.
	I was worried that someone would force me to take medication
	I was actively using (street drugs, alcohol) so it wasn't important
	It was too hard to get there (transportation)
	They were not open when I could get there (convenient hours)
	I was worried someone might find out about my HIV status if I went there
	The people at the agency didn't speak my language
	None of the above

	Agencies' hours of operation
	No way to get there (Transportation)
	I don't have a way to pay for it
	No help in taking care of my children
	Everybody else's needs come first
	I'm worried about my partner finding out I am positive
	I'm worried about my children finding out I am positive
	I'm worried about my partner abusing me
	People don't understand my culture
	I don't feel welcome
	Information for reading is not in my language
	I can't get services because of immigrant/legal status
	Other:
	Other: (Specify)
	Other:(Specify) None of the above
infecti	Past 12 months, have you received medical care for any of the following conditions or ons listed below: Yes, Check all that apply: STDs (such as Syphilis, Gonorrhea, Chlamydia, etc.) Hepatitis C Hepatitis A or B TB (tuberculosis) Mental Disorder (such as Depression, Dementia, Anxiety)
infecti	Past 12 months, have you received medical care for any of the following conditions or ons listed below: Yes, Check all that apply: STDs (such as Syphilis, Gonorrhea, Chlamydia, etc.) Hepatitis C Hepatitis A or B TB (tuberculosis) Mental Disorder (such as Depression, Dementia, Anxiety)
infecti	past 12 months, have you received medical care for any of the following conditions or ons listed below: Yes, Check all that apply: STDs (such as Syphilis, Gonorrhea, Chlamydia, etc.) Hepatitis C Hepatitis A or B TB (tuberculosis) Mental Disorder (such as Depression, Dementia, Anxiety) Heart Disease
infecti	Past 12 months, have you received medical care for any of the following conditions or ons listed below: Yes, Check all that apply: STDs (such as Syphilis, Gonorrhea, Chlamydia, etc.) Hepatitis C Hepatitis A or B TB (tuberculosis) Mental Disorder (such as Depression, Dementia, Anxiety)
infecti	Past 12 months, have you received medical care for any of the following conditions or ons listed below: Yes, Check all that apply: STDs (such as Syphilis, Gonorrhea, Chlamydia, etc.) Hepatitis C Hepatitis A or B TB (tuberculosis) Mental Disorder (such as Depression, Dementia, Anxiety) Heart Disease High Blood Pressure
infecti	past 12 months, have you received medical care for any of the following conditions or ons listed below: Yes, Check all that apply: STDs (such as Syphilis, Gonorrhea, Chlamydia, etc.) Hepatitis C Hepatitis A or B TB (tuberculosis) Mental Disorder (such as Depression, Dementia, Anxiety) Heart Disease High Blood Pressure Diabetes

35.	Have you been told by the doctor, nurse, or other health care team member that you have AIDS?
	Yes
	No
	Prefer not to answer
	If yes, what year were you told you had AIDS? Indicate Year:
	Year
36.	How do you think you were infected by HIV? (Check all that apply)
	Having sex with a man
	Having sex with a woman
	Sharing needles
	Trading sex for drugs/money
	Blood products/Transfusion
	Perinatal transmission (born with it or infected at birth)
	Other:
	(Specify)
	Don't know
	I prefer not to answer
37.	Are you taking any of the following medications?
31.	
	No
	Yes, Check all that apply:
	Antiretrovirals and/or protease inhibitors that work against the virus
	Antibiotics (such as Bactrim) that fight off infections
	Antifungal (such as Diflucan) that are for body rashes or thrush
	Steroids which help you with your appetite or build weight
	Antidepressants for depression or anxiety
	Herbal treatments
	Nutritional supplements
	Other:
	(Specify)

38. Are you currently taking any prescription medicines for your HIV infection?
Yes
No
Huas have often de vou miss a desa of proscribed LIIV medication?
If yes, how often do you miss a dose of prescribed HIV medication? Never
Rarely (no more than once a week)
Some of the time (one to four times a week)
Often (five or more times a week)
If you miss any doses of your prescribed HIV medication, answer question 39.
if you miss any doses of your prescribed fire medication, answer question 33.
If you never miss any doses of HIV medication OR if you do not take HIV medication, go to
question 40.
20 Whan and a mattale and mattale and mattale and a district and a
39. When you do not take your prescribed HIV medication as directed, which of the following are the reason(s) for not taking your medication? (Check all that may apply)
Side effects
Difficult schedule
Medication didn't work
Could not afford it
Just did not want to take them
Forgot to take them
I started feeling better
There were too many pills to take
There was a language problem. The pill bottles were not labeled in my language.
Did not understand how to take it.
Other:
(Specify)
(**************************************
40. Have your doctors, nurses or other health care professionals talked to you about participating in
clinical trials for HIV/AIDS medications?
Yes
No
Don't Know
41a. Do you have a history of using IV drugs?
Yes
No
41h Are you currently an IV drug user?
41b. Are you currently an IV drug user? Yes
No

	Do you have a history of using other street drugs? (cocaine, inhalants, poppers, etc.) Yes
	No
42b.	Are you currently using other street drugs? Yes No
eithei	u are currently using or have a history of using IV or street drugs (if you answered "Yes" to r question 41a, 41b, 42a, or 42b), please answer question 42c. t, go to question 43.
42c.	Do you need any of the following? (Check all that may apply)
	Inpatient detox programs
	Residential treatment programs
	Methadone Maintenance treatment
	Outpatient treatment programs
	Immediate admission to programs when you're ready
	miniculate admission to programs when you re ready
	Information about what services are available
	Information about what services are available
	Information about what services are available Information about where to go for treatment Free treatment
	Information about what services are available Information about where to go for treatment Free treatment Transportation to treatment
	Information about what services are available Information about where to go for treatment Free treatment Transportation to treatment An understanding counselor
	Information about what services are available Information about where to go for treatment Free treatment Transportation to treatment
	Information about what services are available Information about where to go for treatment Free treatment Transportation to treatment An understanding counselor

- 43. Please fill out the following tables related to HIV/AIDS Services. The administrator will provide you with a sheet that gives a description of each service category. **Please do not hesitate to ask for assistance in completing this table.** For each of the services listed in the left column, please place a check in the appropriate box to tell us the following:
 - a. Do you believe the service is available to you? AVAILABILITY
 - **b.** Have you ever used the service? **USE**
 - c. Can you get the service? ACCESSIBILITY
 - **d.** Do you currently need the service? **CURRENT NEED**
 - e. What keeps you from getting the service? BARRIERS

The following are examples of possible barriers to receiving services:

- Information Barriers I didn't have the information I needed about the service that it existed, where to get it, how to qualify, etc
- Personal or Cultural Barriers I was not comfortable with the agency staff. They didn't speak my language or support my cultural beliefs.
- **Service Delivery System Barriers** There was no agency that provided the service I needed. I didn't qualify for services because of income, residence, age, etc. I had no insurance.
- *Access/Availability Barriers* The services available were too far from my home or work. Services were not open at the hours I could get there. There was no childcare. Waiting times for appointments or to see the person I needed to see were too long.

	Doc	es it ex	ist?	Do you	use it?		Can you	u get it?	•	Do you	need it?	What	t keeps	you fro	m getti	ng it?	
	Availability			J	Use		Access				Current Need		Barriers				
	Is this service		Have you used this		How easy was it for you to get					currently	I = Information						
	avai	lable to	you?	service in the		this service?				s service,	P/C = 1	Personal o	or Cultur	al			
Services	Y- Yes			37 37		E - Easy			_	dless of	SD = Service Delivery						
~ 61 11668	N- No DK- Don't Know			37.37		Somewha	it hard			r you are ving it?	A = Access/Availability						
					H - Hard receiving NA - Have not used or tried to				NA =		NA = Not applicable/no barriers						
					get this service						Check	all that	t apply				
	V	N	DK	W	N	E	SWH		NA	Y	NI	T	P/C	SD	·	NA	
	Y	11	DΚ	Y	IN	L	SWII	Н	NA	Y	N	1	P/C	SD	A	NA	
Ambulatory Outpatient Medical Care																	
Primary Care																	
Vision Care																	
OB / GYN																	
Pediatric																	

	Doc	es it ex	ist?	Do you	use it?		Can you	u get it?	?	Do you	need it?	Wha	t keeps	you fro	m getti	ng it?
	Availability Is this service available to you? Y- Yes N- No DK- Don't Know			Use		Aco	cess		Curre	nt Need			Barrier	S		
Services			Have you used this service in the last 12 months? Y- Yes N- No		this service? E - Easy SWH - Somewhat hard H - Hard NA - Have not used or tried to get this service				Do you currently need this service, regardless of whether you are receiving it?		I = Information P/C = Personal or Cultural SD = Service Delivery A = Access/Availability NA = Not applicable/no barriers Check all that apply					
	Y	N	DK	Y	N	E	SWH	Н	NA	Y	N	I	P/C	SD	A	NA
Buddy/Companion Services																
Case Management																
Medical Case Management																
Child Care																
Child Welfare Services																
Client Advocacy																
Day or Respite Care (Adult)																
Drug Reimbursement																
Early Intervention Services																
Emergency Financial Assistance:																
Household Items																
Utility Assistance																
In-home support																
Food:																
Food Bank																
Home Delivered Meals																
Nutritional Supplements																
Health Education/Risk Reduction (HE/RR)																

	Do	es it ex	ist?	Do you	use it?		Can you	u get it?	?	Do you	need it?	Wha	t keeps	you fro	m getti	ng it?	
	Availability			Ţ	J se		Acc	cess		Curre	nt Need]	Barrier	S		
Services	available to you? Y- Yes			service in the last 12 months? Y- Yes N- No		How easy was it for you to get this service? E - Easy SWH - Somewhat hard				Do you currently need this service, regardless of whether you are receiving it?		I = Information P/C = Personal or Cultural SD = Service Delivery					
	N- No DK- Don't Know		H - Hard NA - Have not used or tried to get this service			A = Access/Availability NA = Not applicable/no barriers Check all that apply											
	Y	N	DK	Y	N	E	SWH	Н	NA	Y	N	I	P/C	SD	A	NA	
Health Insurance																	
Home Health Care																	
Hospice Services																	
Housing Assistance																	
Rental Assistance																	
Shelter Vouchers																	
Housing Related Services																	
Legal Services																	
Mental Health Services																	
Psychological/psychiatric treatment and counseling services																	
Support Groups																	
Nutritional Counseling																	
Oral Health (Dental)																	
Other Support Services (Translation, interpretation)																	
Outreach Services																	
Permanency Planning																	
Psychosocial Support Services (Counseling/Peer Support)																	

	Do	es it ex	ist?	Do you	use it?		Can yo	u get it?		Do you	need it?	Wha	t keeps	you fro	m getti	ng it?
	Availability Is this service available to you? Y- Yes N- No DK- Don't Know			N- No		this service? E - Easy SWH - Somewhat hard H - Hard NA - Have not used or tried to				Current Need Do you currently need this service, regardless of whether you are receiving it?		Barriers I = Information P/C = Personal or Cultural SD = Service Delivery A = Access/Availability NA = Not applicable/no barriers Check all that apply				
Services																
	Y	N	DK	Y	N	get this service E SWH H NA				Y	N					NA
Referral	-	11	DIX	_	11	L	SWII		1 1/2 %		11	-	170	SD	11	1 17 1
Rehabilitation Services																
Physical Therapy																
Speech Pathology																
Low Vision Training																
Substance Abuse Services:																
Outpatient treatment																
Residential treatment																
Transportation:																
Van Transportation																
Gas/Taxi Vouchers																
Bus passes																
Treatment Adherence Services																

44. Please list or describe any servi-	ce you ne	eed that is	not availabl	e.*		
						_
						_
						_
						_
*Note: Your concerns will be consider prevent your providers from responde			_		2	y.
	PR	REVENT	ION			
give will be used in planning HIV/AIDS. This personal info an individual. All information and anonymous . 45. Using the scale below, please in	ormatior collecte	n cannot ed throug	and will h this sur	not be uvey is co	sed to identify you mpletely confidenti	as al
sex with the following people:	Never				Regularly	
A man who is a regular partner:		2	3	4		
A man who is a casual partner:	1	2	3	4	5	
			2	1	5	
A woman who is a regular partne	er:1	2		+		

47.	If you have had <i>vaginal or anal sex</i> with a casual partner , how often do you and your partner use a condom or other barrier when having sex? (Check only one)
	Always
	Usually
	Sometimes
	Rarely
	Never
	Not applicable, I do not have sex with a casual partner
48.	If you have had <i>oral sex</i> with any partner , how often do you and your partner use a condom or other barrier when having sex? (Check only one)
	Always
	Usually
	Sometimes
	Rarely Never
	Never
	Not applicable
49.	If you do not always use a condom or other barriers when having sex, please indicate why. (Check all that apply)
	You don't like using condoms or barriers
	Condoms or barriers are not always available
	Your partner does not like using condoms or barriers
	You want to have a baby
	You are sometimes high or buzzed on drugs or alcohol during sex
	You really don't know how to talk about condoms or barriers
	It's not really sex with condoms or barriers
	You thought that you were HIV negative
	You thought that your partner was HIV negative
	You don't care
	Other:
	(Specify)

Thank you for the time that you have taken to complete the survey. Your answers will provide invaluable information for the planning and delivery of services to your community. Please give your completed survey to your administrator.

Information to Help You Complete the Client Survey

Juestion 37: A	re you taking any of the following medications?
No	
Yes, (Check all that apply:
A	Antiretrovirals and/or protease inhibitors that work against the virus
A	Antibiotics (such as Bactrim) that fight off infections
A	Antifungal (such as Diflucan) that are for body rashes or thrush
S	Steroids which help you with your appetite or build weight
A	Antidepressants for depression or anxiety
F	Herbal treatments
N	Nutritional supplements
	Other:
	(Specify)

MEDICATION EXAMPLES:

MEDICATION EXAMPLES:					
<u>Anti-retrovirals</u>	Antibiotics	Antifungals	<u>Anti-</u>	<u>Steroids</u>	
			<u>depressants</u>		
Fusion Inhibitors:	Amoxicillin	Diflucan	Amitriptyline	Anadrol	
Enfuvirtide (Fuzeon, T-20)	Ampicillin	Fluconazole	Celexa	Clenbuterol	
	Bactrim	Ketaconazole	Desipramine	Deca Durabolin	
Non Nucleoside Reverse Transcriptase	Flagyl	Sporanox	Effexor	Dianabol	
Inhibitors (NNRTIs)	Biaxin		Lexapro	Dihydrotestosterone	
Delavirdine (Rescriptor)	Cipro		Luvox	Finaject	
Efavirenz (Sustiva)	Clarithromycin		Nardil	Growth Hormone	
Nevirapine (Viramune)	Cleocin		Nortriptyline	IGF	
	Clindamycin		Paxil	Primobolan	
Nucleoside Reverse Transcriptase	Doxycyclin		Remeron	Sustanol	
Inhibitors (NRTIs)	Erythromycin		Serzone	Testosterone	
Abacavir (Ziagen)	Keflex		Trazadone		
Abacavir+Lamivudine+Zidovudine	Minocycline		Wellbutrin		
(Trizivir)	Tetracycline		Zoloft		
Didanosine (Videx, ddl)	Vibramicin				
Emtricitabine (Emtriva, FTC)	Zithromax				
Lamivudine (Epivir, 3TC)					
Lamivudine+Zidovudine					
(Combivir)					
Stavudine (Zerit, d4T)					
Tenofovir DF (Viread)					
Zalcitabine (Hivid, ddC)					
Zidovudine (Retrovir, AZT, ZDV)					
Protease Inhibitors (PIs)					
Amprenavir (Agenerase)					
Atazanavir (Reyataz)					
Fosamprenavir (Lexiva, 908)					
Indinavir (Crixivan)					
Lopinavir+Ritonavir (Kaletra)					
Nelfinavir (Viracept)					
Ritonavir (Norvir)					
Saquinavir (Fortovase, Invirase)					
,	<u> </u>		<u> </u>	l	

Question 43: Please fill out the following tables related to HIV/AIDS Services. The administrator will provide you with a sheet that gives a description of each service category. **Please do not hesitate to ask for assistance in completing this table.** For each of the services listed in the left column, please place a check in the appropriate box to tell us the following:

- **f.** Do you believe the service is available to you? **AVAILABILITY**
- g. Have you ever used the service? USE
- h. Can you get the service? ACCESSIBILITY
- i. Do you currently need the service? CURRENT NEED
- j. What keeps you from getting the service? BARRIERS

The following are examples of possible barriers to receiving services:

Information Barriers (I):

- I didn't have the information I needed about the service.
- I didn't know that it existed.
- I didn't know where to get it.
- I didn't know if I qualified for it.
- I didn't know if I would have to pay or not.

Personal or Cultural Barriers (P/C):

- I was not comfortable with the agency staff.
- They didn't speak my language
- They didn't know about or support my cultural beliefs.

Service Delivery System Barriers (SD):

- There was no agency that provided the service I needed.
- I didn't qualify for services because of income, residence, age, etc.
- I had no insurance.
- No one told me what information I had to take with me to sign up for the service.

Access/Availability Barriers (A):

- The services were too far from my home or work.
- I had no way to get there.
- Services were not open at the hours I could get there.
- There was no childcare.
- Waiting times for appointments or to see the person I needed to see were too long.

2004 HRSA SERVICE CATEGORY DEFINITIONS

AMBULATORY/OUTPATIENT MEDICAL CARE is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary Medical Care for the Treatment of HIV Infection includes the provision of care that is consistent with the Public Health Service's Treatment Guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

BUDDY/COMPANION SERVICE is an activity provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

CASE MANAGEMENT SERVICES are a range of client-centered services that links clients with health care, psychosocial and other services. Ensures timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include: (1) initial assessment of service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of services required to implement the plan and client monitoring to assess the efficacy of the plan, and (4) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.

CHILDCARE SERVICES are the provision of care for the children of clients who are HIV-positive while the clients are attending medical or other appointments or attending Title-related meetings, groups, or training. NOTE: This does not include daycare while client is at work.

CHILD WELFARE SERVICES include family preservation/unification, foster care, parenting education, and other child welfare services. Services designed to prevent the break-up of a family and to reunite family members. Foster care assistance to place children under the age of 21 years, whose parents are unable to care for them, in temporary or permanent homes and to sponsor programs for foster families. Other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of HIV-positive children about risks and complications, care-giving needs, and developmental and emotional needs of children.

CLIENT ADVOCACY Is the provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.

DAY OR RESPITE is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client.

DRUG REIMBURSEMENT PROGRAM is an ongoing service/program to pay for approved pharmaceuticals and/or medications for persons with no other payment source. See State-ADAP and Local/Consortium Drug Reimbursement Program.

EARLY INTERVENTION SERVICES FOR TITLES I AND II are a combination of services that include outreach, HIV counseling, testing, referral and provision of outpatient medical care and supportive services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care.

EMERGENCY FINANCIAL ASSISTANCE is the provision of short-term payment for essential utilities and for medication assistance when other resources are not available. *In Home Support* is the provision of vouchers to provide in-home support services for HIV/AIDS infected individuals, which must include, but is not limited to, the performance of household and personal tasks.

FOOD BANK/HOME-DELIVERED MEALS involves the provision of actual food, meals, or nutritional supplements. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

HEALTH EDUCATION/RISK REDUCTION is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information, including information dissemination about medical and psychosocial support services and counseling, to help clients with HIV improve their health status.

HEALTH INSURANCE is a program of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

HOME HEALTH PROFESSIONAL CARE is the provision of services in the home by licensed health care workers, such as nurses.

HOME HEALTH SPECIALIZED CARE is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.

HOSPICE SERVICES are provided through Home Based Hospice Care, including nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting. And services provided through Residential Hospice Care, including room, board, nursing care, counseling, physician services, palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

HOUSING ASSISTANCE is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of CARE Act funds for short-term or emergency housing must be linked to medical and/or healthcare or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

HOUSING RELATED SERVICES include assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed.

LEGAL SERVICES the provision of services to individuals with respect to powers of attorney, do not resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

LOCAL/CONSORTIUM DRUG REIMBURSEMENT PROGRAM is established, operated, and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or broaden eligibility beyond that established by a State-operated Title II or other State-funded Drug Reimbursement Program. Medications include prescription drugs provided through ADAP to prolong life or prevent the deterioration of health. This definition does not include medications that are dispensed or administered during the course of a regular medical visit or that are considered part of the service visit. If medications are paid for and dispensed as part of an Emergency Financial Assistance Program, they should be reported as such.

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

NUTRITIONAL COUNSELING is the provision of nutrition education and/or counseling by a licensed registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

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

OUTREACH SERVICES include programs which have as their principal purpose identification of people with HIV disease so that they may become aware of, and may be enrolled in, care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with state and local HIV-prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

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

PSYCHOSOCIAL SUPPORT SERVICES are the provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, and play), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse or nutritional counseling that are provided to clients, family and household members, and/or other caregivers and focused on HIV-related problems.

REFERRAL FOR HEALTH CARE/SUPPORTIVE SERVICES is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.

REFERRAL TO CLINICAL RESEARCH is the provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research involves studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an IRB that initially approves and periodically reviews the research.

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

STATE-ADMINISTERED AIDS DRUG ASSISTANCE PROGRAM (ADAP), authorized under Title II of the CARE Act, provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

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

SUBSTANCE ABUSE SERVICES - RESIDENTIAL are the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) provided in an inpatient health service setting (short-term).

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

TREATMENT ADHERENCE SERVICES provide counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Appendix 2:

Profile of Provider Capacity

JOINT NEEDS ASSESSMENT GROUP (NAG)

2223 West Loop South, Suite 240, Houston, TX 77027 Phone: 713-572-3724 Fax: 713-572-3740

April 26, 2004

Dear Executive Director:

In conjunction with the Texas Statewide Coordinated Statement of Need, the Houston area HIV/AIDS planning bodies are required to conduct a comprehensive needs assessment that examines needs, gaps and availability regarding services for people living with HIV and AIDS in the region. This information is used to determine service priorities, make funding decisions and prepare upcoming federal grant applications. I am writing to ask for your help with this needs assessment by completing the enclosed provider survey.

The provider survey asks detailed information about your agency, your HIV positive clients/patients and resources directed to the care and services for these clients. We are required to compare our funding with other sources of service funding in the region, and therefore, are asking for some financial information about services you provide for people living with HIV disease. Please be assured that any financial information provided will be aggregated by service, and your agency's financial information will not be individually identified.

Also, we understand that the survey appears long, but please be aware that the second half, printed on green paper is only to be completed by agencies providing HIV prevention services. Other agencies may disregard this section.

We would appreciate it if you would complete this survey <u>before May 21, 2004</u> and mail or fax it to the attention of Lynn Schultz, Office of Support for the Ryan White Planning Council, at the above address and fax number.

Thank you for taking the time to assist the Houston Area Ryan White Planning Bodies with this very important project. If you have any questions, please contact the consultant for this project, Lynn Schultz with New Solutions, Inc. at 770-569-5107 or 800-497-3063.

Sincerely,

Ken Malone

Co-Chair Representing Title I

Kun Malme

Houston Area HIV/AIDS Needs Assessment

Tam Kiehnhoff

Co-Chair Representing Title II

Tam Kehnhoff

Houston Area HIV/AIDS Needs Assessment

	ame of Agency:						
Pr	imary Location:						
	STREET ADDRESS						
	CITY	STATE	ZIP				
	TELEPHONE	FAX	EMAIL				
	CONTACT PERSON AND TITLE						
1.	Service delivery hours: (Chec	Service delivery hours: (Check all that apply)					
	Weekdays		Weekends				
	☐ Morning/Afternoon		☐ Weekend Mornings				
	☐ Evenings		☐ Weekend Afternoons				
	☐ Nights		☐ Weekend Evenings				
			☐ Weekend Nights				
2.	For which communities does y (Check all that apply) Defined by Population Large City (1,000,000+ Medium City (250,000 Small City (50,000 - 25) Small Town (5,000 - 50) Rural (<5,000)	-) - 1,000,000) 50,000)	HIV/AIDS care-related services? Defined by Environment Inner City/Urban Suburban Rural				
3.	describe your agency, choose AIDS service organ Public Health clinic	Other and describe your action or an action or an action or an action (not AII) octor octor or that includes HIV/eatment facility	OS-specific) AIDS services				

4.	Please enter the year that your agency first began providing HIV/AIDS care-related services:			
5.	Average waiting time for initial appointment:			
6.	Average waiting time for follow-up appointment:			
7.	Do you target a particular population? O No O Yes, check all that apply in each section below			
	a. Race/Ethnicity Hispanic/Latino American Indian/Alaska Native Asian Black/African-American Native Hawaiian/Pacific Islander White Other (Please Specify): b. Gender Male Female Transgender Other (Please Specify):	c. Age Group Under 2 2-12 13-24 25-44 45-64 65+ All of the Above d. Sexual Orientation Heterosexual Gay Lesbian Bisexual All of the Above		
8.	For the most recent calendar year (JanDec.) prior to this survey, please estimate: a. Total number of patient/clients served: b. The total number of HIV/AIDS patients/clients you served over this time period: c. The number of your patients/clients over this time period who are HIV-positive but have not be diagnosed with AIDS: d. The number of your patients/clients over this time period who are HIV-positive and have been diagnosed with AIDS:			

E	thnic Background	Number of Clients	Number who are HIV-Positive
a. F	Hispanic or Latino		
b. N	Not Hispanic or Latino		
Ra	acial Background	Number of Clients	Number Who are HIV-Positive
	American Indian or Alaska Native		
d. A	Asian		
e. E	Black or African American		
	Native Hawaiian or Pacific Islander		
g. V	White		
G	Sender	Number of Clients	Number Who are HIV-Positive
h. F	Female		
i. N	Male		
ј. Т	Transgender		

10. How are the costs of HIV client services covered?

		Check all that apply	Amount of funding
a.	Ryan White CARE Act (Title I)		\$
b.	Ryan White CARE Act (Title II)		\$
c.	Ryan White CARE Act (Title III)		\$
d.	Ryan White CARE Act (Title IV)		\$
e.	Other Ryan White Funding		\$
f.	HOPWA		\$
g.	CDC		\$
h.	TDH—Services Grants		\$
i.	TCADA		\$
j.	Medicaid		\$
k.	Medicare		\$
1.	Private Insurance		\$
m.	Client Fees		\$
n.	Foundations		\$
o.	Corporate Contributions		\$
p.	Individual Contributions		\$
q.	United Way		\$
r.	Houston City/County Grant		\$
s.	Endowment		\$
t.	Other	_ 🗖	\$

11. Please answer the following for <u>ALL YOUR FUNDING SOURCES COMBINED</u>:

HEALTH CARE SERVICES	Estimate the <u>TOTAL NUMBER</u> of HIV+ persons who received this service <u>FOR ALL FUNDING</u> <u>SOURCES</u> during the most recent calendar year (JanDec.). (Count each person only ONCE in each Total.*)	How much did you spend <u>TOTAL</u> on each service for HIV+ persons <u>FOR ALL</u> <u>FUNDING SOURCES</u> during the most recent calendar year (JanDec.)?		
AMBULATORY/OUTPATIENT MEDICAL CARE	Total Persons*	\$ Total of Below		
Primary Care		\$		
Vision Care		\$		
OB/GYN Care		\$		
Pediatric Care		\$		
Infectious Disease Care		\$		
Other:		\$		
Other:		\$		
Other:		\$		
DRUG REIMBURSEMENT	Total Persons*	\$ Total of Below		
Local Drug Related Reimbursement		\$		
Medications		\$		
Other		\$		
HEALTH INSURANCE	Total Persons*	\$ Total		
HOME HEALTH CARE	Total Persons*	\$ Total		
ORAL HEALTH (Dental)	Total Persons*	\$ Total		
HOSPICE SERVICES	Total Persons*	\$ Total		
MENTAL HEALTH SERVICES	Total Persons*	\$ Total of Below		
Psychological		\$		
Psychiatric Services		\$		
Professional Counseling		\$		
NUTRITIONAL COUNSELING	Total Persons*	\$ Total		
REHABILITATION SERVICES	Total Persons*	\$ Total		
SUBSTANCE ABUSE SERVICES	Total Persons*	\$ Total of Below		
Outpatient		\$		
Residential		\$		
Other:		\$		
MEDICAL CARE/MEDICATION ADHERENCE	Total Persons*	\$ Total of Below		
Counseling		\$		
Other:		\$		

^{*}Where there are subcategories, the Total may be less than the sum of the subcategories because the same person may receive multiple services.

APPENDIX 2: Provider Survey Page A-36

${\tt QUESTION\,\#11\,CONTINUED\,-\,Please\,\,answer\,\,the\,\,following\,\,for\,\,} \underline{{\tt ALL\,\,YOUR\,\,FUNDING\,\,SOURCES\,\,COMBINED:}}$

who received this service FOR ALL FUNDING SOURCES during the most recent calendar year (JanDec.). who received this service FOR ALL FUNDING ALL FUNDING most recent	rou spend <u>TOTAL</u> on HIV+ persons <u>FOR</u> SOURCES during the
(JanDec.). most recer	SOURCES during the
(C . 1 1 OYGE: 1 T . 14)	nt calendar year
	nDec.)?
CHILD CARE SERVICESTotal Persons* \$Total	al
CHILD WELFARE SERVICESTotal Persons* \$Total	al
BUDDY/COMPANION SERVICESTotal Persons* \$Total	al
CASE MANAGEMENTTotal Persons* \$Total	al
Medical Case Management	\$
Social Case Management	\$
CLIENT ADVOCACYTotal Persons* \$Total	al
PSYCHOSOCIAL SUPPORT SERVICESTotal Persons* \$Total	al
DAY/RESPITE CARE FOR ADULTSTotal Persons* \$Total	al
EARLY INTERVENTION SERVICESTotal Persons* \$Total	al
EMERGENCY FINANCIAL SERVICESTotal Persons* \$Total	al
FOOD BANK/HOME DELIVERED MEALS/NUTRITIONAL SUPPLEMENTS Total Persons* STotal	al of Below
Food Bank	\$
Home Delivered Meals	\$
Nutritional Supplements	\$
HEALTH EDUCATION/RISKTotal Persons* \$Total	al
HOUSING ASSISTANCETotal Persons* \$Total	al
HOUSING RELATED SERVICESTotal Persons* \$Total	al
LEGAL SERVICESTotal Persons* \$Total	al
OUTREACH SERVICESTotal Persons* \$Total	al
PERMANENCY PLANNINGTotal Persons* \$Total	al
REFERRAL TO HEALTHTotal Persons* \$Total	al
TRANSPORTATIONTotal Persons* \$Total	al
OTHER SUPPORT SERVICESTotal Persons* \$Total	al of Below
List: \$	
List: \$	
List: \$	
Total Persons*	

12. <u>OTHER FUNDING:</u> How much funding **OTHER THAN RYAN WHITE** did you spend on each service for HIV+ persons during the most recent calendar year (Jan-Dec)?

HEALTH CARE SERVICES	HOPWA	SAMHSA	TCADA	CDC	TDH – Services Grants
AMBULATORY/OUTPATIENT MEDICAL CARE	\$ Total of Belo	ow \$ Total of Below	\$Total of Below	\$ Total of Below	\$ Total of Below
Primary Care	\$	\$	\$	\$	\$
Vision Care	\$	\$	\$	\$	\$
OB/GYN Care	\$	\$	\$	\$	\$
Pediatric Care	\$	\$	\$	\$	\$
Infectious Disease Care	\$	\$	\$	\$	\$
Other:	\$	\$	\$	\$	\$
Other:	\$	\$	\$	\$	\$
Other:	\$	\$	\$	\$	\$
DRUG REIMBURSEMENT	\$ Total of Belo	ow \$ Total of Below	\$ Total of Below	\$ Total of Below	\$ Total of Below
Local Drug Related Reimbursement	\$	\$	\$	\$	\$
Medications	\$	\$	\$	\$	\$
Other	\$	\$	\$	\$	\$
HEALTH INSURANCE	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
HOME HEALTH CARE	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
ORAL HEALTH (Dental)	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
HOSPICE SERVICES	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
MENTAL HEALTH SERVICES	\$ Total of Belo	ow \$ Total of Below	\$ Total of Below	\$ Total of Below	\$ Total of Below
Psychological	\$	\$	\$	\$	\$
Psychiatric Services	\$	\$	\$	\$	\$
Professional Counseling	\$	\$	\$	\$	\$
NUTRITIONAL COUNSELING	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
REHABILITATION SERVICES	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
SUBSTANCE ABUSE SERVICES	\$ Total of Belo	ow \$ Total of Below	\$ Total of Below	\$ Total of Below	\$ Total of Below
Outpatient	\$	\$	\$	\$	\$
Residential	\$	\$	\$	\$	\$
Other:	\$	\$	\$	\$	\$
MEDICAL CARE/MEDICATION ADHERENCE	\$Total of Belo		\$Total of Below	\$ Total of Below	\$ Total of Below
Counseling	\$	\$	\$	\$	\$
Other:	\$	\$	\$	\$	\$

QUESTION #12 CONTINUED –

<u>OTHER FUNDING:</u> How much funding **OTHER THAN RYAN WHITE** did you spend on each service for HIV+ persons during the most recent calendar year (Jan-Dec)?

SUPPORT SERVICES	HOPWA	SAMHSA	TCADA	CDC	TDH – Services Grants
CHILD CARE SERVICES	\$ Total				
CHILD WELFARE SERVICES	\$ Total				
BUDDY/COMPANION SERVICES	\$ Total	\$ Total	\$ Total	\$Total	\$ Total
CASE MANAGEMENT	\$ Total of Below				
Medical Case Management	\$	\$	\$	\$	\$
Social Case Management	\$	\$	\$	\$	\$
CLIENT ADVOCACY	\$ Total				
PSYCHOSOCIAL SUPPORT SERVICES	\$ Total				
DAY/RESPITE CARE FOR ADULTS	\$ Total				
EARLY INTERVENTION SERVICES	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
EMERGENCY FINANCIAL SERVICES	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
FOOD BANK/HOME DELIVERED MEALS/NUTRITIONAL SUPPLEMENTS	\$ Total of Below				
Food Bank	\$	\$	\$	\$	\$
Home Delivered Meals	\$	\$	\$	\$	\$
Nutritional Supplements	\$	\$	\$	\$	\$
HEALTH EDUCATION/RISK	\$ Total				
HOUSING ASSISTANCE	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
HOUSING RELATED SERVICES	\$ Total				
LEGAL SERVICES	\$ Total				
OUTREACH SERVICES	\$ Total				
PERMANENCY PLANNING	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
REFERRAL TO HEALTH	\$ Total				
TRANSPORTATION	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
OTHER SUPPORT SERVICES	\$ Total of Below				
List:	\$	\$	\$	\$	\$
List:	\$	\$	\$	\$	\$
List:	\$	\$	\$	\$	\$
CHILD CARE SERVICES	\$ Total				
CHILD WELFARE SERVICES	\$ Total	\$ Total	\$ Total	\$ Total	\$ Total
BUDDY/COMPANION SERVICES	\$ Total				

APPENDIX 2: Provider Survey Page A-39 13. Under **TOTAL** # **FTE STAFF**, write the total number of full time equivalent staff you have for each position listed. For example: If you had 5 half-time/part-time case managers that would equal 2.5 FTE case managers. Consultants being paid directly by your agency are considered paid staff.

Under **TOTAL** # **NON-PAID STAFF**, write the total number of full time equivalent non-paid staff whom your agency does not pay for each position. For example if you had 5 half time case managers that would equal 2.5 FTE case managers. Non-paid staff includes: doctors with whom you have formal service agreements but are employed outside of your agency, volunteers, interns, etc.

Under **Annual Continuing Education Credits**, indicate whether staff (paid and non-paid) regularly complete Continuing Education Credits (CECs).

Continuing Education Cleans (CECs).		T	
SERVICE CATEGORY	TOTAL # FTE PAID Staff	TOTAL # FTE NON- PAID Staff	Do you Require Annual Continuing Education? (Circle One)
Ambulatory/Outpatient/Medical Care			
Physicians & Physician Extenders			Yes No
RNs, LVNs, Medical Assistants			Yes No
Other Medical Care Staff			Yes No
Case Management			
Medical Case Managers - LMSW degree or higher			Yes No
Other Medical Case Managers			Yes No
Social Case Managers - LMSW degree or higher			Yes No
Other Social Case Managers			Yes No
Linkage Workers			Yes No
Home Health Care			
Licensed Care Givers			Yes No
Other Patient Care Staff			Yes No
Hospice Services			
Licensed Care Givers			Yes No
Other Patient Care Staff			Yes No
Mental Health			
Psychiatrists			Yes No
Counselors – LMSW or LPC or ACP			Yes No
Other Counselors			Yes No
Outreach			
Outreach workers providing prevention activities			Yes No
Outreach workers identifying HIV+ persons &			Yes No
linking them with the care system			105 110
Oral Health			
. Dentists			Yes No
Oral Hygienists, Dental Assistants			Yes No
Rehabilitation			
Licensed Care Givers			Yes No
Other Patient Care Staff			Yes No
Substance Abuse			
Psychiatrists			Yes No
Counselors meeting TCADA eligibility requirements			Yes No
Other Counselors			Yes No

	portant change (other than funding) you would suggest to improve lease identify which special population you are discussing.
Special Population	Suggestions for Change
needs of special populations. Please	e identify which special population you are discussing.
	pproaches you are currently using or will consider using to meet the identify which special population you are discussing. Strategies/Approaches
needs of special populations. Please	e identify which special population you are discussing.
needs of special populations. Please	e identify which special population you are discussing.
needs of special populations. Please	e identify which special population you are discussing.
needs of special populations. Please	e identify which special population you are discussing.
needs of special populations. Please	e identify which special population you are discussing.
needs of special populations. Please	e identify which special population you are discussing.
needs of special populations. Please	e identify which special population you are discussing.
needs of special populations. Please	e identify which special population you are discussing.

1.	
2.	
3.	
4.	
5.	
٥.	
3. Whi	ich of the following services would help you to better serve your clients/patients living with HIV?
3. Whi	reck all that apply) Training in working with people from other cultures
8. Whi (Ch	Training in working with people from other cultures Training to learn other languages
8. Whi (Ch	reck all that apply) Training in working with people from other cultures
8. Whi	Training in working with people from other cultures Training to learn other languages Opportunities for networking among providers to share information on HIV/AIDS care and available
3. Whi	Training in working with people from other cultures Training to learn other languages Opportunities for networking among providers to share information on HIV/AIDS care and available resources Training to gain additional experience/knowledge about providing HIV care, such as antiretroviral treatments, dealing with opportunistic infections, and monitoring and explaining a patient's health
3. Whi	Training in working with people from other cultures Training to learn other languages Opportunities for networking among providers to share information on HIV/AIDS care and available resources Training to gain additional experience/knowledge about providing HIV care, such as antiretroviral treatments, dealing with opportunistic infections, and monitoring and explaining a patient's health status Providing services in a more convenient manner (such as better office hours, quicker appointments

COORDINATION, COLLABORATION, AND PLANNING

	es your agency have any HIV-Specific commitm signed Memoranda of Understanding (MOUs) w	nent letters, letters of collaboration, binding agreement
O :	No	vitil other agencies in the area?
0	Yes. If so, what types of organizations? Chec l	k all that apply
	☐ Non HIV Social Service Provider	☐ Daycare
	☐ Civic Organization	☐ Homeless Service Provider
	☐ Church	☐ Prison/Jail
	☐ Substance Abuse Treatment Facility	☐ Refugee/Immigrant Service Provider
	☐ Mental Health Provider	☐ STD Clinic
	☐ TB Testing/Treatment Provider	☐ AIDS Service Organization (ASO)
	_	☐ HIV Testing Site
	Other (Specify)	Inv resting site
		do to help your agency better coordinate services with
oth	er providers in the area?	
21. If y	your agency refers HIV/AIDS clients to other age	encies, do you have a way of tracking referrals?
•	No	
O	Yes, Check all that apply:	
	☐ Computer tracking	
	☐ Paper-based	
	☐ Other	
	(Specify)	
22 4	a van ar gamaana fram vanr aganay a mambar a	form of the following?
_	e you or someone from your agency a member o	of any of the following?
0	No Yes Check all that apply	
O	Yes, Check all that apply:	
	☐ Title I Planning Council	
	☐ Title II Area Assembly	
	☐ Title III/IV Consumer Committee	
	☐ HIV Prevention Community Planning Gro	-
		plan for HIV-related services (e.g., Community
	Advisory Boards)	
	Other (Specify)	
	(Specily)	

		-		ovide name and conf	tact information.	
						_
24. Is th	nere a	anything else you	would like to add	that might be helpfu	ul to local HIV Services Plannin	g Bodies
25. Do O	No Yes	have multiple services. If Yes, please g	ive us the followin		t all of your locations:	_
		=				
					Zip	
			eted at this locati			
		Hours of operati	on for services at	this location:		
	b.	Secondary Serv Address:				
					Zip	
		Services offered	at this location:			
		Populations targ	eted at this locati	on:		
		Hours of operati	on for services at	this location:		

IF YOU PROVIDE PREVENTION SERVICES,



...Please continue to the next section.

IF YOU DO NOT PROVIDE PREVENTION SERVICES,

...You have completed the survey.



Thank you so much for your valuable time completing this survey! Please return your completed survey to:

Ryan White Planning Council ATTN: LYNN SCHULTZ 2223 West Loop South, Suite 240 Houston, TX 77027

Or fax to: 713-572-3740

HIV PREVENTION SERVICES

1.	Do you provide prevention services?
	O No, we don't offer HIV prevention services.
	• Yes, we offer HIV prevention services
[If	yes, please complete the rest of this section]
2.	Please check all of the following CDC service categories that your organization provides: Routinely Recommended HIV Testing as Part of Regular Medical Care Services Rapid Testing in Non-Clinical Settings Routine HIV Testing of Inmates in Correctional Facilities HIV Partner Counseling and Referral Services Prevention Interventions with Persons Living with HIV Prevention in Medical Care Settings Achieving Universal HIV Testing of Pregnant Women
3.	Where are your HIV prevention services provided? (Check all that apply) Schools and colleges Workplaces Churches/Religious sites Street outreach Barber shops/Beauty parlors Homes Housing projects Prisons/Jails Drug rehabilitation centers Shelters Hospitals/Clinics Bars/Clubs Urban sites Rural sites Public sex environments Other
	(Specify)

4.	Who funds your HIV prevention programs?
	Federal
	□ CDC
	□ SAMHSA
	☐ Other Federal
	State
	☐ TDH
	☐ TCADA
	☐ Other State
	□ County
	☐ City
	□ Non-government sources

5. What HIV prevention services do you provide to the following populations? Please indicate the number of people you served during the calendar year prior to this survey (Jan.-Dec.).

	Individual Level Intervention (ILI)	Small Group Level Intervention (GLI)	Community Level Intervention (CLI)	Prevention Counseling & Partner Elicitation	Outreach	Condom Distribution	Posters/ Brochures	Total Number Served During the Calendar Year Prior to this Survey (JanDec.)
MEN WHO HAVE SEX WITH	MEN						'	
American Indian/Alaskan Native								
Asian								
Black/African American/African Descent								
Hispanic								
Native Hawaiian/Pacific Islander								
White								
WOMEN								
American Indian/Alaskan Native								
Asian								
Black/African American/African Descent								
Hispanic								
Native Hawaiian/Pacific Islander								
White								
TRANSGENDER								
American Indian/Alaskan Native								
Asian								
Black/African American/African Descent								
Hispanic								
Native Hawaiian/Pacific Islander								
White								

	Individual Level Intervention (ILI)	Small Group Level Intervention (GLI)	Community Level Intervention (CLI)	Prevention Counseling & Partner Elicitation	Outreach	Condom Distribution	Posters/ Brochures	Total Number Served During the Calendar Year Prior to this Survey (JanDec.)
INJECTING DRUG USERS								
American Indian/Alaskan Native males								
American Indian/Alaskan Native females								
American Indian/Alaskan Native transgender								
Asian males								
Asian females								
Asian transgender								
Black/African American/African Descent males								
Black/African American/African Descent females								
Black/African American/African Descent transgender								
Hispanic males								
Hispanic females								
Hispanic transgender								
Native Hawaiian/Pacific Islander males								
Native Hawaiian/Pacific Islander females								
Native Hawaiian/Pacific Islander transgender								
White males								
White females								
White transgender								

	Individual Level Intervention (ILI)	Small Group Level Intervention (GLI)	Community Level Intervention (CLI)	Prevention Counseling & Partner Elicitation	Outreach	Condom Distribution	Posters/ Brochures	Total Number Served During the Calendar Year Prior to this Survey (JanDec.)
SUBSTANCE USERS								
American Indian/Alaskan Native males								
American Indian/Alaskan Native females								
American Indian/Alaskan Native transgender								
Asian males								
Asian females								
Asian transgender								
Black/African American/African Descent males								
Black/African American/African Descent females								
Black/African American/African Descent transgender								
Hispanic males								
Hispanic females								
Hispanic transgender								
Native Hawaiian/Pacific Islander males								
Native Hawaiian/Pacific Islander females								
Native Hawaiian/Pacific Islander transgender								
White males								
White females								
White transgender								

	Individual Level Intervention (ILI)	Small Group Level Intervention (GLI)	Community Level Intervention (CLI)	Prevention Counseling & Partner Elicitation	Outreach	Condom Distribution	Posters/ Brochures	Total Number Served During the Calendar Year Prior to this Survey (JanDec.)
YOUTH/ADOLESCENTS (AGE	E 13-24)							
American Indian/Alaskan Native males								
American Indian/Alaskan Native females								
American Indian/Alaskan Native transgender								
Asian males								
Asian females								
Asian transgender								
Black/African American/African Descent males								
Black/African American/African Descent females								
Black/African American/African Descent transgender								
Hispanic males								
Hispanic females								
Hispanic transgender								
Native Hawaiian/Pacific Islander males								
Native Hawaiian/Pacific Islander females								
Native Hawaiian/Pacific Islander transgender								
White males								
White females								
White transgender								

	Individual Level Intervention (ILI)	Small Group Level Intervention (GLI)	Community Level Intervention (CLI)	Prevention Counseling & Partner Elicitation	Outreach	Condom Distribution	Posters/ Brochures	Total Number Served During the Calendar Year Prior to this Survey (JanDec.)
INCARCERATED/RECENTLY F	RELEASED							
American Indian/Alaskan Native males								
American Indian/Alaskan Native females								
American Indian/Alaskan Native transgender								
Asian males								
Asian females								
Asian transgender								
Black/African American/African Descent males								
Black/African American/African Descent females								
Black/African American/African Descent transgender								
Hispanic males								
Hispanic females								
Hispanic transgender								
Native Hawaiian/Pacific Islander males								
Native Hawaiian/Pacific Islander females								
Native Hawaiian/Pacific Islander transgender								
White males								
White females								
White transgender								

	Individual Level Intervention (ILI)	Small Group Level Intervention (GLI)	Community Level Intervention (CLI)	Prevention Counseling & Partner Elicitation	Outreach	Condom Distribution	Posters/ Brochures	Total Number Served During the Calendar Year Prior to this Survey (JanDec.)
SEX WORKERS								
American Indian/Alaskan Native males								
American Indian/Alaskan Native females								
American Indian/Alaskan Native transgender								
Asian males								
Asian females								
Asian transgender								
Black/African American/African Descent males								
Black/African American/African Descent females								
Black/African American/African Descent transgender								
Hispanic males								
Hispanic females								
Hispanic transgender								
Native Hawaiian/Pacific Islander males								
Native Hawaiian/Pacific Islander females								
Native Hawaiian/Pacific Islander transgender								
White males								
White females								
White transgender								

	Individual Level Intervention (ILI)	Small Group Level Intervention (GLI)	Community Level Intervention (CLI)	Prevention Counseling & Partner Elicitation	Outreach	Condom Distribution	Posters/ Brochures	Total Number Served During the Calendar Year Prior to this Survey (JanDec.)
HIV POSITIVE								
American Indian/Alaskan Native males								
American Indian/Alaskan Native females								
American Indian/Alaskan Native transgender								
Asian males								
Asian females								
Asian transgender								
Black/African American/African Descent males								
Black/African American/African Descent females								
Black/African American/African Descent transgender								
Hispanic males								
Hispanic females								
Hispanic transgender								
Native Hawaiian/Pacific Islander males								
Native Hawaiian/Pacific Islander females								
Native Hawaiian/Pacific Islander transgender								
White males								
White females								
White transgender								

Appendix 3:

Focus Group Recruitment



Ryan White Comprehensive Needs Assessment Focus Groups with People Living with HIV/AIDS

We Need Your Help with Focus Group Recruitment!

As part of the 2004 Comprehensive Needs Assessment, we will be conducting nine focus groups with people living with HIV disease. The groups will include:

- Substance users, including injecting drug users
- Recent Hispanic/Latino immigrants
- Young men of color who have sex with men
- Young white/Anglo men who have sex with men
- People recently released from jail or prison
- African-American women of childbearing age (13 to 44 years)
- African-American men
- Homeless

The groups will be held during the weeks of June 14 and 21, so we appreciate your prompt attention to this. We need to have all applications by June 10.

Please help us by posting the attached flyers at your agency and distributing applications to people who qualify to participate. Please help your clients by faxing their completed applications to:

Gary Jerkins FUUSA 3402 Dowling, Suite 210G Houston, Texas 77004 713-942-9333 (phone) 713-942-8915 (fax)

If the client does not want to fax the information, the applications can be mailed or delivered to FUUSA.

Thank you for your ongoing help with this important needs assessment!



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SPEAK OUT - GET PAID

Are you interested in participating in a focus group for People with HIV/AIDS?

Please ask your Provider for an application and fill it out now.

If you are selected and complete the group, you will receive a

\$25 gift certificate!

Groups will be held in mid-June.

This study is part of the Comprehensive HIV Needs Assessment, which is a collaborative project of the Ryan White Planning Council, State of Texas Assembly Group East (STAGE), Houston Regional HIV/AIDS Resource Group, Harris 🜣 County Hospital District, Harris County Public Health & Environmental Services - HIV Services Department, City of 🖈 🖈 Houston HIV Prevention Community Planning Group (CPG), Housing Opportunities for Persons with AIDS (HOPWA), 🖈 ★ Coalition for the Homeless of Houston/Harris County and the East Texas Community Planning Group.



FOCUS GROUP PARTICIPANT APPLICATION

In order to be eligible, you will need to answer all questions.

NAME									
Home Phone	Other Phone								
Age	e Gender								
Race/Ethnicity (Please check all tha	at apply)								
African-American White/Ang	glo Hispanic Other (Specify)								
Are you HIV positive? Yes	No What year were you diagnosed with	ith HIV?							
Do you work of a Ryan White funded	agency or are you on the Planning Council?	Yes 🗌	No 🗌						
Are you available to participate in a g	roup during the week of June 14, 2004?	Yes 🗌	No 🗌						
Are you available to participate in a g	roup during the week of June 21, 2004?	Yes 🗌	No 🗌						
Background Information—Check t	he boxes that help describe you								
☐ Man who has sex with men	☐ Substance/Injection Drug User (nov	w or within 1	ast year)						
Heterosexual/Straight	Recently released from Jail/Prison								
☐ Speaking/Fluent in English	Spanish Speaking/Fluent in Spanish	1							
☐ Male Hispanic Immigrant Year	of Immigration								
Female Hispanic Immigrant Yes	ar of Immigration								
Will you need child care? Yes	No Will you need transportation?	Yes [No						
Please specify any special needs									

REMINDER: In order to assure that everyone has an equal chance to participate in the study, the names of all applicants will be sorted by the groups for which they are eligible and 12 names will be drawn at random for each group. *NOT EVERYONE WILL BE SELECTED*. Individuals who are selected and who participate in a group will be given a \$25 gift certificate in appreciation for their involvement. If you are selected for a group, you will be notified by phone by *Friday June 11, 2004*.

THANK YOU FOR YOUR INTEREST! WHEN YOU HAVE COMPLETED THE FORM, PLEASE RETURN IT TO YOUR PROVIDER

This study is part of the Comprehensive HIV Needs Assessment, which is a collaborative project of the Ryan White Planning Council, State of Texas Assembly Group East (STAGE), Houston Regional HIV/AIDS Resource Group, Harris County Hospital District, Harris County Public Health & Environmental Services - HIV Services Department, City of Houston HIV Prevention Community Planning Group (CPG), Housing Opportunities for Persons with AIDS (HOPWA), Coalition for the Homeless of Houston/Harris County and the East Texas Community Planning Group.

Appendix 4:

Participating Providers

LIST OF SURVEY SITES

AIDS Foundation Houston (AFH)

AFH - A Friendly Haven

AFH - Arrow Project

AFH - Stone Soup

Bering Omega Community Services Adult Day Care

Bering Support Network

Body Positive

Brentwood Community Foundation

City of Houston Sunnyside Multiservice Center

Covenant House Texas

Donald R. Watkins Memorial Foundation

Family Services of Greater Houston

Fort Bend Family Health Center

Harris County Social Services

Houston Area Community Services (HACS)

HACS - Joseph-Hines Clinic

Houston Area Women's Center

Montrose Clinic

Montrose Counseling

SEARCH

St. Hope Foundation

Thomas Street Clinic (Harris County Hospital District)

University of Texas Health Science Center Department of Pediatrics

PROVIDER SURVEY PARTICIPANTS

AIDS Coalition of Coastal Texas, Inc.

AIDS Foundation Houston, Inc.

AIDS Housing Coalition Houston, DBA-W. Heights House

AVES, Inc.

Accessible Signs (Sign Language Accessible Interpreters)

Alliance for Multicultural Community Services

PARTICIPATING PROVIDERS

The Assistance Fund

Baylor College of Medicine, Pediatrics

Baylor College of Medicine, Teen Health Clinic

Bayside Community Hospital and Clinic

Bering Omega Community Services

Better Business Bureau of Greater Houston

Brazos Place

Bread of Life

Career and Recovery Resources Inc.

Catholic Charities

Center for AIDS: Hope and Remembrance Project

DePelchin Children's Center

Design Industries Foundation Fighting AIDS (DIFFA)

Donald R. Watkins Memorial Foundation

Eleos Center, Inc.

Families Under Urban and Social Attack

Family Outreach Clear Lake/Bay Area

Family Services of Greater Houston

FamilyTime Foundation, Inc.

Fort Bend County Clinical Health Services

Fort Bend Family Health Center

Greater Houston Area Chapter American Red Cross

Gulf Coast Community Services Association

Harris County Hospital District

Harris County Sheriff's Office

Harris County Social Services

Hospice Care Team, Inc.

Housing Corporation of Greater Houston

Houston Allied Health Careers

Houston Area Women's Center

Houston Challenge Foundation

Houston GLBT Community Center - Positive Art Workshop

Houston Area Community Services (HACS)

Houston Humane Society

Houston Veteran's Administration Medical Center

Houston Volunteer Lawyers Program

Interfaith CarePartners

Intergroup Association, Inc.

PARTICIPATING PROVIDERS

Kenneth C. Lambert Funeral Consultant

Lazarus House

Local Infant Formula for Emergencies, Inc.

Love Inc. of Baytown

Lutheran Social Services of the South

Memorial Hermann Healthcare System

Mendez Counseling

Metropolitan Multi-Service Center

Montgomery County Emergency Assistance, Inc.

Montrose Clinic

Montrose Counseling Center

NAACP Houston Branch

New Horizon Family Center

Nonprofit Consulting Services

Northeast Assistance Ministries

North Channel Assistance Ministries

Nuclear Imaging of TX

Open Door Mission

Palmer Drub Abuse Program

People with AIDS Coalition-Houston

Planned Parenthood of Houston & SE TX

The Right Step Behavioral Care, Inc.

St. Hope Foundation

St. John Vianney Parish Social Ministries

Salvation Army

Sisters Inspiring Sisters

Southeast Texas Legal Clinic

Twelve Oaks Pharmacy

United Way of the TX Gulf Coast

University Eye Institute

University of Texas Health Science Center

University of Texas Harris County Psychiatric Center

Visiting Nurse Association of Houston

Walker County Maternal and Child Health Center

West Houston Assistance Ministries

YWCA of Houston