|  |  |
| --- | --- |
| **Organization:** Click here to enter text. | **HCA #:** Click here to enter text. |
| **Grant Program:** Part A[x]  | **Month/Year:**  |
| **Name of Submitter:** Click here to enter text. | **Date of Submission:**  |
| **Program Officer:** Click here to enter text. |  |

**SERVICE STATISTICS**

CAREWare submission: [ ]  YES [ ]  NO [ ]  PARTIALLY

**Explain NO or PARTIALLY responses. Expand by service category, as needed.**

Click here to enter text.

Revised CAREWare submission: [ ]  YES [ ]  NO

**Has your organization submitted updated CAREWare data & invoicing from a prior month(s) due to delays in third party payment processing? Explain.**

Click here to enter text.

**EXPENDITURES/FISCAL REPORT**

Invoice Submitted: [ ]  YES [ ]  NO

**Do you anticipate exceeding the funding threshold established in your organization’s Task Order? Explain**

Click here to enter text.

**PROGRAM IMPLEMENTATION PROGRESS TO DATE**

**Types of services and activities**

Click here to enter text.

**CHALLENGES TO SERVICE DELIVERY**

**Describe any challenges to service delivery and include plans for addressing them**

Click here to enter text.

**WAIT LIST**

**Thorough description of any wait list for the service program, including the number of clients, average length of time on wait list, and the longest period of time for any client currently on the list**

**REMEDIATION / CORRECTIVE ACTION**

**Include update regarding any open remediation/corrective actions, as needed**

**TECHNICAL ASSISTANCE**

**Request of technical assistance, if any**

**HIV CASE REPORTS**

**The number of HIV-positive cases reported to the Department of Health during this month**

**ADDITIONAL INFORMATION**

**Any additional information to report**