|  |  |
| --- | --- |
| **Organization:** Click here to enter text. | **Grant #:** Click here to enter text. |
| **Grant Program:** EHE Wellness [ ]   | **Month/Quarter/Year:**  |
| **Name of Submitter:** Click here to enter text. | **Date of Submission:**  |
| **Program Officer:** Click here to enter text. | **Grant Monitor:** Click here to enter text. |

**SERVICE STATISTICS**

Customer Targets Met: [ ]  YES [ ]  NO

Service Targets Met: [ ]  YES [ ]  NO

CAREWare submission: [ ]  YES [ ]  NO

**If NO to any of the questions above, expand by service category, as needed**

Click here to enter text.

**EXPENDITURES/FISCAL REPORT**

Invoice Submitted: [ ]  YES [ ]  NO

Over- or Under-Spending: [ ]  YES [ ]  NO

**If yes to over- or under-spending, expand by line item in the budget, and include plan to address**

Click here to enter text.

**PROGRAM IMPLEMENTATION PROGRESS TO DATE**

**Types of services and activities directly and referral: Provide a narrative for the sections to which services were provided**

1. **Wellness Coaching Sessions:**
2. **Movement Practices:**
3. **Breath Practices/Meditations:**
4. **Energy Medicine/Acupuncture:**
5. **Body Work/Relaxation:**
6. **Wellness Groups:**

|  |
| --- |
| **Please Complete this section for number of customers served under each funding stream (Living with HIV under HRSA and Status Neutral Customers under CDC section)** |
| **Activity** | **# of Customers - HRSA** | **# of Customers - CDC** |
| **Wellness Coaching Services** |  |  |
| **Movement Services** |  |  |
| **Breath Practices and Meditations** |  |  |
| **Energy Medicine/Acupuncture** |  |  |
| **Body Work/Relaxation** |  |  |
| **Wellness Groups** |  |  |

**CHALLENGES TO SERVICE DELIVERY**

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

Click here to enter text.

**PERSONNEL**

**Any changes in personnel this month? ☐ YES ☐ NO If yes please complete the information below**

**Include contact information (name, title, mailing address, email and telephone) for each new staff person.**

**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**