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

**SERVICE STATISTICS**

**Medical Care Coordination**-

Outpatient Ambulatory Care Services

Customer Targets Met: ☐ YES ☐ NO

Service Targets Met: ☐ YES ☐ NO

Medical Case Management

Customer Targets Met: ☐ YES ☐ NO

Service Targets Met: ☐ YES ☐ NO

Non-Medical Case Management

Customer Targets Met: ☐ YES ☐ NO

Service Targets Met: ☐ YES ☐ NO

Psychosocial Support Services

Customer Targets Met: ☐ YES ☐ NO

Service Targets Met: ☐ YES ☐ NO

**CAREWare submission:**  YES  NO

**EXPENDITURES/FISCAL REPORT**

Invoice Submitted:  YES  NO

Over- or Under-Spending:  YES  NO

**If service targets were not met, please explain?**

Click here to enter text.

**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**

**Please separate program narrative by service categories**

**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**