DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration

DC Department of Health – HIV/AIDS, Hepatitis, STD, Tuberculosis Administration:
Care and Treatment Division
RWA Part B Grant Monthly Narrative Report

Organization: Click here to enter text.

Grant #: Click here to enter text.

Grant Program: Part B ☐

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

Outpatient Ambulatory Health 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

Mental Health
Customer Targets Met: ☐ YES ☐ NO
Service Targets Met: ☐ YES ☐ NO

Psychosocial Support
Customer Targets Met: ☐ YES ☐ NO
Service Targets Met: ☐ YES ☐ NO

Health Education and Risk Reduction
Customer Targets Met: ☐ YES ☐ NO
Service Targets Met: ☐ YES ☐ NO

Medical Transportation
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

Provide a narrative response for each section below for the overall Part B program.   1. **Linkage to Care Navigation**   2. **Rapid Initiation of ART/PrEP**   3. **Treatment Adherence and Retention Strategies**   4. **Customer Re-engagement and Recapture Efforts**

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