|  |  |
| --- | --- |
| Organization**: Click here to enter text.** | Grant #: **Click here to enter text.** |
| Grant Program: **Ryan White 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. |

**MONTHLY PERFORMANCE SUMMARY**

Total Customers Served This Month: **(Positive: \_\_\_\_\_ PrEP-Eligible: \_\_\_)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service Area** | **Positive Customers** | | | |  | **PrEP- Eligible Customers** | | | |
| **Customer Targets Met** | | **Service Units Met** | |  | **Customer Targets Met** | | **Service Units Met** | |
| **Y** | **N** | **Y** | **N** |  | **Y** | **N** | **Y** | **N** |
| **Health Education Risk Reduction** |  |  |  |  |  |  |  |  |  |
| **Medical Case Management** |  |  |  |  |  |  |  |  |  |
| **Medical Transportation** |  |  |  |  |  |  |  |  |  |
| **Mental Health** |  |  |  |  |  |  |  |  |  |
| **Non-Medical Case Management** |  |  |  |  |  |  |  |  |  |
| **Outpatient Ambulatory Health Services** |  |  |  |  |  |  |  |  |  |
| **Psychosocial Support Services** |  |  |  |  |  |  |  |  |  |

If service targets were not met, please explain?

Click here to enter text.

**CAREWare submission:** ☐ YES ☐ NO

**EXPENDITURES/FISCAL REPORT**

Invoice Submitted: ☐ YES ☐ NO

Over- or Under-Spending: ☐ YES ☐ NO

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

Click here to enter text.

**PROGRAM IMPLEMENTATION PROGRESS TO DATE**

Please separate the program narrative by service categories and describe activities provided for

positive **and** PrEP-eligible customers.

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, email, and telephone) for each new staff person.

**REMEDIATION / CORRECTIVE ACTION**

Include updates regarding any open remediation/corrective actions, as needed.

**TECHNICAL ASSISTANCE**

Describe requests for technical assistance, if any.

**HIV CASE REPORTS**

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

Were any of these seroconversions? If yes, how many?

**ADDITIONAL INFORMATION**

Report on any additional significant information not already included in this report.