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| **Organization:** Click here to enter text. | **Grant #:** Click here to enter text. |
| **Grant Program:** Part A[ ]  | **Month /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**

**Fee for Value** Customer Targets Met

Outpatient/Ambulatory Health Services (OAHS) ☐ YES ☐ NO

Medical Case Management (MCM) ☐ YES ☐ NO

Non-Medical Case Management ☐ YES ☐ NO

Medical Nutrition Therapy ☐ YES ☐ NO

Food Bank / Home-Delivered Meals ☐ YES ☐ NO

**Other EMA-Wide Services**

Oral Health Services ☐ YES ☐ NO

Early Intervention Services ☐ YES ☐ NO

Medical Transportation ☐ YES ☐ NO

**Jurisdictional Ryan White Core and Support Services**

***Washington, DC***

Substance Abuse Outpatient Care ☐ YES ☐ NO

Mental Health Services ☐ YES ☐ NO

Home and Community Based Health Services ☐ YES ☐ NO

Psychosocial Support Services ☐ YES ☐ NO

Other Professional Services ☐ YES ☐ NO

***Suburban, MD***

Health Insurance Prem & Cost-Sharing Asst. (HIPCSA) ☐ YES ☐ NO

Outreach Services ☐ YES ☐ NO

Psychosocial Support Services ☐ YES ☐ NO

***Northern Virginia***

Substance Abuse Outpatient Care ☐ YES ☐ NO

Mental Health Services ☐ YES ☐ NO

Psychosocial Support Services ☐ YES ☐ NO

***West Virginia (Jefferson and Berkley Counties)***

Outpatient/Ambulatory Health Services (OAHS) ☐ YES ☐ NO

Mental Health Services ☐ YES ☐ NO

Medical Case Management (MCM) ☐ YES ☐ NO

Oral Health Services ☐ YES ☐ NO

Health Insurance Prem & Cost-Sharing Asst. (HIPCSA) ☐ YES ☐ NO

Medical Nutrition Therapy ☐ YES ☐ NO

Medical Transportation ☐ YES ☐ NO

Outreach Services ☐ YES ☐ NO

Emergency Financial Assistance ☐ YES ☐ NO

**Emergency Financial Assistance (Washington, DC and Suburban, MD)** ☐ YES ☐ NO

**Minority AIDS Initiative (MAI)- Youth Reach (EMA Wide)**

Outpatient/Ambulatory Health Services (OAHS) ☐ YES ☐ NO

Medical Case Management (MCM) ☐ YES ☐ NO

Mental Health Services ☐ YES ☐ NO

Substance Abuse Outpatient Care ☐ YES ☐ NO

Early Intervention Services ☐ YES ☐ NO

Psychosocial Support Services ☐ YES ☐ NO

Non-Medical Case Management ☐ YES ☐ NO

Medical Transportation ☐ 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 category**

 **Provide a narrative response for each criterion below for the overall Part A 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.

**Red Carpet/Rapid ART (OAHS subrecipients ONLY)**

**Describe progress in implementation of Red Carpet and any challenges.**

**Describe progress in implementation of Rapid ART and any challenges.**

**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**