

## HRSA AIDS Education and Training Centers Participant Information Form (PIF)

**Instructions: This form should be completed once every 12 months by participants of the AIDS Education and Training Centers programs.**

1. **Unique ID number: Enter an email address as a personal identifier.**

\_\_\_\_\_

2. **Today's date:**

|          |          |          |          |          |          |          |          |
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| <b>M</b> | <b>M</b> | <b>D</b> | <b>D</b> | <b>Y</b> | <b>Y</b> | <b>Y</b> | <b>Y</b> |

3. **Your Primary Profession/Discipline (Select one)**

- ☐ Dentist
- ☐ Other Dental Professional
- ☐ Nurse Practitioner/Nurse Professional (prescriber)
- ☐ Nurse Professional (non-prescriber)
- ☐ Midwife
- ☐ Pharmacist
- ☐ Physician
- ☐ Physician Assistant
- ☐ Dietitian or Nutritionist
- ☐ Mental/Behavioral Health Professional
- ☐ Substance Abuse Professional
- ☐ Social Worker or Case Manager
- ☐ Community Health Worker (includes peer educator or navigator)
- ☐ Clergy or Faith-based professional
- ☐ Practice administrator or leader (i.e. chief executive officer, nurse administrator)
- ☐ Other allied health professional (specify, i.e. medical assistant, podiatrist, physical therapist): \_\_\_\_\_
- ☐ Other Public Health Professional
- ☐ Other non-clinical professional (i.e. front desk staff, grant writer -- specify): \_\_\_\_\_

4. **Your Primary Functional Role (Select one)**

- ☐ Administrator
- ☐ Agency Board Member
- ☐ Care Provider/Clinician – can or does prescribe HIV treatment
- ☐ Care Provider/Clinician – cannot or does not prescribe HIV treatment
- ☐ Case Manager
- ☐ HIV tester
- ☐ Client/Patient Educator (includes navigator)
- ☐ Clinical/Medical Assistant
- ☐ Health care organization non-clinical staff (i.e. front desk)
- ☐ Intern/Resident
- ☐ Researcher/Evaluator
- ☐ Student/Graduate Student
- ☐ Teacher/Faculty
- ☐ Other (specify): \_\_\_\_\_

5. **Are you of Hispanic or Latino/a origin?**

☐ Yes      ☐ No

6. **What is your racial background? Select all that apply.**

- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

7. **What is your gender? Select one.**

- ☐ Female
- ☐ Male
- ☐ Transgender, male-to-female
- ☐ Transgender, female-to-male
- ☐ Other gender identity

8. Which of the following characteristics best describe your principal employment setting? (Select one)

- ☐ Academic Health Center
- ☐ Correctional facility
- ☐ Emergency department
- ☐ Federally qualified Health Center
- ☐ Family Planning Clinic
- ☐ HIV or Infectious Diseases Clinic
- ☐ HMO/Managed Care Organization
- ☐ Hospital-Based Clinic
- ☐ Indian Health Services/Tribal Clinic
- ☐ Long-term nursing facility
- ☐ Maternal /child health clinic
- ☐ Mental health clinic
- ☐ STD clinic
- ☐ Substance abuse treatment center
- ☐ Student health clinic
- ☐ Other community-based organization
- ☐ Pharmacy
- ☐ Military or veterans' health facility
- ☐ Other federal health facility
- ☐ Private practice
- ☐ State or local health department
- ☐ Other primary care setting
- ☐ My principal employment setting does not involve the provision care or services to patients/clients (Stop here. You are done with this form.)
- ☐ I am not working (Stop here. You are done with this form.)

9. List the ZIP codes (up to three) where you provide care and services to patients/clients:

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— — — — —  
— — — — —

10. Do you provide HIV prevention counseling and testing services to clients/patients?

- ☐ Yes ☐ No

11. Do you prescribe HIV pre-exposure prophylaxis (PrEP) to clients/patients?

- ☐ Yes ☐ No

12. Do you prescribe antiretroviral therapy (ART) to clients/patients?

- ☐ Yes ☐ No

13. Does your principal employment setting receive Ryan White HIV/AIDS Program funding?

- ☐ Yes ☐ No ☐ Not sure

14. Is HIV care and treatment provided by your principal employment setting?

- ☐ Yes ☐ No

15. Do you have direct interaction with clients/patients?

- ☐ Yes ☐ No (Stop here. You are done with this form.)

16. Do you provide services directly to clients/patients living with HIV?

- ☐ Yes ☐ No (Stop here. You are done with this form.)

17. How many YEARS have you been providing services directly to clients/patients living with HIV (PLWH)? Round up to the nearest whole year. If less than one year, write "01".

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18. Estimate the **NUMBER** of clients/patients living with HIV to whom you provided direct services in the past YEAR:

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For questions 19 through 22, estimate the percentage of your clients/patients living with HIV (PLWH) in the past YEAR.

19. Which of the following best describes the way you provide services to clients/patients living with HIV:

- ☐ Provide behavioral or support services, but no HIV treatment (i.e. case management, counseling, cognitive behavioral therapy, transportation, legal)
- ☐ Provide clinical services to people living with HIV, but no HIV treatment (i.e. nutrition, physical therapy, psychiatry, general primary care)
- ☐ Provide basic HIV care and treatment (novice)
- ☐ Provide intermediate HIV care and treatment
- ☐ Provide advanced HIV care and treatment
- ☐ Provide expert HIV care and treatment, which includes training others and/or clinical consultation

20. Estimate the **PERCENTAGE** of your clients/patients living with HIV (PLWH) in the past YEAR who are racial/ethnic minorities.

- ☐ None
- ☐ 1-24%
- ☐ 25-49%
- ☐ 50-74%
- ☐ ≥75%

21. Estimate the **PERCENTAGE** of your clients/patients living with HIV (PLWH) in the past YEAR with hepatitis B or hepatitis C.

- ☐ None
- ☐ 1-24%
- ☐ 25-49%
- ☐ 50-74%
- ☐ ≥75%

22. Estimate the **PERCENTAGE** of your clients/patients living with HIV (PLWH) in the past YEAR who are receiving antiretroviral therapy.

- ☐ None
- ☐ 1-24%
- ☐ 25-49%
- ☐ 50-74%
- ☐ ≥75%