



FAX COVER SHEET

Early Advocacy and Care for HIV

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Date:

1/26/93

Fax Number:

To:

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From:

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Comments:

Total number of pages (including transmittal sheet):

13



AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92

CONTRACT AGENCY: <u>NTFAP</u>	QUARTER: (check one) <u>SPRING</u> <u>(J-MAR)</u> <u>X SUMMER</u> <u>(A-JUN)</u> <u>FALL</u> <u>(J-SEPT)</u> <u>WINTER</u> <u>(O-DEC)</u>
PROGRAM: <u>EACH - Treatment Advocacy</u>	REPORT COMPLETED(date):
CONTRACT NUMBER:	AGENCY CONTACT PERSON:
FUNDING SOURCE: <u>CARE</u>	PHONE NUMBER:
TERM OF CONTRACT: <u>5/1/92-4/30/92</u>	AO PGM.MGR.:

I. UNITS OF SERVICE(UOS)

Calendar Quarter

Contract
Period-to-Date

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) Total/Qtr. (A3) Number of New Individuals Served/Qtr.(A2) Contract Period to date (unduplicated clients)

B. GENDER

(1) 7 Male (3) Other (include transgender)
(2) 1 Female (9) Unknown

C. SEXUAL ORIENTATION

(1) 7 Gay Male (3) Bisexual (5) Declines to state (9) Unknown
(2) 1 Lesbian (4) Heterosexual (6) Unsure

D. AGE

(1) 12 YRS. or Less (4) 8 25-29 YRS. (7) 50-59 YRS.
(2) 13-17 YRS. (5) 30-39 YRS. (8) 60 YRS. or More
(3) 18-24 YRS. (6) 40-49 YRS. (9) Unknown

E. ETHNICITY

(10) 2 White/European American (50) American Indian, Alaskan Native
(20) 5 African American (60) Other..Specify
(30) 1 Latino/a (99) Unknown
(40) Asian/Pacific Islander

F. LIVING SITUATION

(1) Alone (6) Non-relatives/Shared Expenses (99) Unknown
(2) Dependent Children (7) Non-relatives/No Shared Expenses
(3) Spouse/Signif. Other (8) Homeless
(4) Parent or Guardian (10) Institutionalized
(5) Other Relatives (11) Incarcerated

N/A
G. GROSS MONTHLY INCOME
(before taxes, for individual client, not for household)

- (1) _____ \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
(2) _____ \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) _____ Full Time (35 or more hrs. per week) (3) 7 Not Employed
(2) 1 Part Time (less than 35 hrs. per week) (9) _____ Unknown

N/A
I. MEDICAL INSURANCE STATUS

- (1) _____ Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
(2) _____ Kaiser (6) _____ Other Public Insurance
(3) _____ MediCal/Medicaid (7) _____ Uninsured
(4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) X Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) _____ Private Practice (incl. other HMOs)
(2) _____ Kaiser
(3) _____ Community Health Center
(4) _____ Hospital Outpatient Clinic
(5) _____ Emergency Room
(6) _____ VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) 8 No Primary Health Care Provider
(9) _____ Unknown

L. HIV STATUS

- (1) 8 HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
(2) _____ Disabling HIV/ARC (9) _____ Unknown
(3) _____ AIDS

N/A
M. SPECIAL POPULATIONS

- (1) _____ Injection Drug User (IDU) (4) _____ Mental Illness
(2) _____ Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
(3) _____ AIDS Dementia (6) _____ None of the above

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92CONTRACT AGENCY: NTFAP/EACHQUARTER: (check one) ☐ SPRING (J-MAR) ☐ SUMMER (A-JUN) ☒ FALL (J-SEPT) ☐ WINTER (O-DEC)PROGRAM: Treatment Advocacy

REPORT COMPLETED (date):

CONTRACT NUMBER:

AGENCY CONTACT PERSON:

FUNDING SOURCE: CARE

PHONE NUMBER:

TERM OF CONTRACT:

AO PGM.MGR.:

I. UNITS OF SERVICE(UOS)

Calendar Quarter

Contract
Period-to-Date

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 8 Total/Qtr.

(A3) _____ Number of New Individuals Served/Qtr.

(A2) _____ Contract Period to date (unduplicated clients)

B. GENDER

(1) 8 Male

(3) _____ Other (include transgender)

(2) _____ Female

(9) _____ Unknown

C. SEXUAL ORIENTATION

(1) 7 Gay Male

(3) _____ Bisexual

(5) _____ Declines to state

(9) _____ Unknown

(2) _____ Lesbian

(4) 1 Heterosexual

(6) _____ Unsure

D. AGE

(1) _____ 12 YRS. or Less

(4) 8 25-29 YRS.

(7) _____ 50-59 YRS.

(2) _____ 13-17 YRS.

(5) _____ 30-39 YRS.

(8) _____ 60 YRS. or More

(3) _____ 18-24 YRS.

(6) _____ 40-49 YRS.

(9) _____ Unknown

E. ETHNICITY

(10) 1 White/European American

(50) _____ American Indian, Alaskan Native

(20) 6 African American

(60) _____ Other..Specify

(30) _____ Latino/a

(99) _____ Unknown

(40) 1 Asian/Pacific IslanderF. LIVING SITUATION N/A

(1) _____ Alone

(6) _____ Non-relatives/Shared Expenses

(99) _____ Unknown

(2) _____ Dependent Children

(7) _____ Non-relatives/No Shared Expenses

(3) _____ Spouse/Signif. Other

(8) _____ Homeless

(4) _____ Parent or Guardian

(10) _____ Institutionalized

(5) _____ Other Relatives

(11) _____ Incarcerated

G. GROSS MONTHLY INCOME

(before taxes, for individual client, not for household)

- (1) 8 \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
(2) _____ \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) _____ Full Time (35 or more hrs. per week) (3) 6 Not Employed
(2) _____ Part Time (less than 35 hrs. per week) (9) 2 Unknown

I. MEDICAL INSURANCE STATUS

N/A

- (1) _____ Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
(2) _____ Kaiser (6) _____ Other Public Insurance
(3) _____ MediCal/Medicaid (7) _____ Uninsured
(4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) X Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

N/A

- (1) _____ Private Practice (incl. other HMOs)
(2) _____ Kaiser
(3) _____ Community Health Center
(4) _____ Hospital Outpatient Clinic
(5) _____ Emergency Room
(6) _____ VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) _____ No Primary Health Care Provider
(9) _____ Unknown

L. HIV STATUS

- (1) 8 HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
(2) _____ Disabling HIV/ARC (9) _____ Unknown
(3) _____ AIDS

M. SPECIAL POPULATIONS

- (1) _____ Injection Drug User (IDU) (4) _____ Mental Illness
(2) _____ Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
(3) _____ AIDS Dementia (6) 8 None of the above

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92CONTRACT AGENCY: NTFAP/EACHQUARTER: WINTER
(check one) — SPRING — SUMMER — FALL X WINTER
(J-MAR) (A-JUN) (J-SEPT) (O-DEC)PROGRAM: Treatment Advocacy

REPORT COMPLETED (date):

CONTRACT NUMBER:

AGENCY CONTACT PERSON:

FUNDING SOURCE: CARE

PHONE NUMBER:

TERM OF CONTRACT:

AO PGM.MGR.:

I. UNITS OF SERVICE(UOS)

Calendar Quarter

Contract
Period-to-Date

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 8 Total/Qtr.(A3) Number of New Individuals Served/Qtr.(A2) Contract Period to date (unduplicated clients)

B. GENDER

(1) 8 Male(3) Other (include transgender)(2) Female(9) Unknown

C. SEXUAL ORIENTATION

(1) 8 Gay Male(3) Bisexual(5) Declines to state(9) Unknown(2) Lesbian(4) Heterosexual(6) Unsure

D. AGE

(1) 12 YRS. or Less(4) 25-29 YRS.(7) 50-59 YRS.(2) 13-17 YRS.(5) 8 30-39 YRS.(8) 60 YRS. or More(3) 18-24 YRS.(6) 40-49 YRS.(9) Unknown

E. ETHNICITY

(10) White/European American(50) American Indian, Alaskan Native(20) 8 African American(60) Other..Specify(30) Latino/a(99) Unknown(40) Asian/Pacific Islander

F. LIVING SITUATION

(1) 4 Alone(6) Non-relatives/Shared Expenses(99) Unknown(2) Dependent Children(7) Non-relatives/No Shared Expenses(3) Spouse/Signif. Other(8) 4 Homeless(4) Parent or Guardian(10) Institutionalized(5) Other Relatives(11) Incarcerated

G. GROSS MONTHLY INCOME

(before taxes, for individual client, not for household)

- (1) 7 \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
(2) 1 \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) 8 Full Time (35 or more hrs. per week) (3) _____ Not Employed
(2) _____ Part Time (less than 35 hrs. per week) (9) _____ Unknown

I. MEDICAL INSURANCE STATUS

- (1) 1 Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
(2) 1 Kaiser (6) 1 Other Public Insurance
(3) 1 MediCal/Medicaid (7) 4 Uninsured
(4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) X Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) 1 Private Practice (incl. other HMOs)
(2) 1 Kaiser
(3) 1 Community Health Center
(4) 1 Hospital Outpatient Clinic
(5) 1 Emergency Room
(6) _____ VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) 3 No Primary Health Care Provider
(9) _____ Unknown

L. HIV STATUS

- (1) 8 HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
(2) _____ Disabling HIV/ARC (9) _____ Unknown
(3) _____ AIDS

M. SPECIAL POPULATIONS

- (1) 1 Injection Drug User (IDU) (4) _____ Mental Illness
(2) 1 Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
(3) _____ AIDS Dementia (6) 6 None of the above

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92

CONTRACT AGENCY: <u>NTFAP / EACH</u>	QUARTER: (check one) <u>X</u> SUMMER (A-JUN) <u>X</u> SPRING (J-MAR) <u>X</u> FALL (J-SEPT) <u>X</u> WINTER (O-DEC) <u>X</u>
PROGRAM: <u>Community Events</u>	REPORT COMPLETED(date): _____
CONTRACT NUMBER: _____	AGENCY CONTACT PERSON: _____
FUNDING SOURCE: <u>CARE</u>	PHONE NUMBER: _____
TERM OF CONTRACT: _____	AO PGM.MGR.: _____

I. UNITS OF SERVICE(UOS)

Calendar Quarter	Contract Period-to-Date
_____	_____

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 24 Total/Qtr. (A3) _____ Number of New Individuals Served/Qtr.
 (A2) _____ Contract Period to date (unduplicated clients)

B. GENDER

(1) 24 Male (3) _____ Other (include transgender)
 (2) _____ Female (9) _____ Unknown

C. SEXUAL ORIENTATION

(1) 19 Gay Male (3) 5 Bisexual (5) _____ Declines to state (9) _____ Unknown
 (2) _____ Lesbian (4) _____ Heterosexual (6) _____ Unsure

D. AGE

(1) _____ 12 YRS. or Less (4) _____ 25-29 YRS. (7) _____ 50-59 YRS.
 (2) _____ 13-17 YRS. (5) _____ 30-39 YRS. (8) _____ 60 YRS. or More
 (3) _____ 18-24 YRS. (6) _____ 40-49 YRS. (9) _____ Unknown

E. ETHNICITY

(10) 4 White/European American (50) _____ American Indian, Alaskan Native
 (20) 18 African American (60) _____ Other..Specify
 (30) 2 Latino/a (99) _____ Unknown
 (40) _____ Asian/Pacific Islander

F. LIVING SITUATION

(1) _____ Alone (6) _____ Non-relatives/Shared Expenses (99) _____ Unknown
 (2) _____ Dependent Children (7) _____ Non-relatives/No Shared Expenses
 (3) _____ Spouse/Signif. Other (8) _____ Homeless
 (4) _____ Parent or Guardian (10) _____ Institutionalized
 (5) _____ Other Relatives (11) _____ Incarcerated

G. GROSS MONTHLY INCOME

(before taxes, for individual client, not for household)

- (1) _____ \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
 (2) _____ \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) 4 Full Time (35 or more hrs. per week) (3) 10 Not Employed
 (2) 4 Part Time (less than 35 hrs. per week) (9) 6 Unknown

I. MEDICAL INSURANCE STATUS

- (1) _____ Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
 (2) _____ Kaiser (6) _____ Other Public Insurance
 (3) _____ MediCal/Medicaid (7) _____ Uninsured
 (4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) X Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) _____ Private Practice (incl. other HMOs)
 (2) _____ Kaiser
 (3) _____ Community Health Center
 (4) _____ Hospital Outpatient Clinic
 (5) _____ Emergency Room
 (6) _____ VA, Military Hospital Outpatient Clinic or Indian Health Service
 (7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
 (8) _____ No Primary Health Care Provider
 (9) _____ Unknown

L. HIV STATUS

- (1) 24 HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
 (2) _____ Disabling HIV/ARC (9) _____ Unknown
 (3) _____ AIDS

M. SPECIAL POPULATIONS

- (1) _____ Injection Drug User (IDU) (4) _____ Mental Illness
 (2) _____ Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
 (3) _____ AIDS Dementia (6) _____ None of the above

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92

CONTRACT AGENCY:

NIFAP/EACH

QUARTER:

(check one)

— SPRING

(J-MAR)

— SUMMER

(A-JUN)

☒ FALL

(J-SEPT)

— WINTER

(O-DEC)

PROGRAM:

Community Events

REPORT COMPLETED(date):

CONTRACT NUMBER:

AGENCY CONTACT PERSON:

FUNDING SOURCE:

CARE

PHONE NUMBER:

TERM OF CONTRACT:

AO PGM.MGR.:

I. UNITS OF SERVICE(UOS)

Calendar Quarter

Contract
Period-to-Date

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 24 Total/Qtr.

(A3) _____ Number of New Individuals Served/Qtr.

(A2) _____ Contract Period to date (unduplicated clients)

B. GENDER

(1) 24 Male

(3) _____ Other (include transgender)

(2) _____ Female

(9) _____ Unknown

C. SEXUAL ORIENTATION

(1) 20 Gay Male(3) 1 Bisexual

(5) _____ Declines to state

(9) _____ Unknown

(2) _____ Lesbian

(4) 3 Heterosexual

(6) _____ Unsure

D. AGE

(1) _____ 12 YRS. or Less

(4) 10 25-29 YRS.

(7) _____ 50-59 YRS.

(2) _____ 13-17 YRS.

(5) 10 30-39 YRS.

(8) _____ 60 YRS. or More

(3) 2 18-24 YRS.(6) 2 40-49 YRS.

(9) _____ Unknown

E. ETHNICITY

(10) 6 White/European American(50) 4 American Indian, Alaskan Native(20) 12 African American

(60) _____ Other..Specify

(30) 1 Latino/a

(99) _____ Unknown

(40) 1 Asian/Pacific Islander

F. LIVING SITUATION

(1) 10 Alone(6) 3 Non-relatives/Shared Expenses(99) 2 Unknown

(2) _____ Dependent Children

(7) 3 Non-relatives/No Shared Expenses

(3) _____ Spouse/Signif. Other

(8) 6 Homeless

(4) _____ Parent or Guardian

(10) _____ Institutionalized

(5) _____ Other Relatives

(11) _____ Incarcerated

G. GROSS MONTHLY INCOME

(before taxes, for individual client, not for household)

- (1) 14 \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
(2) 10 \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) 6 Full Time (35 or more hrs. per week) (3) 16 Not Employed
(2) 2 Part Time (less than 35 hrs. per week) (9) _____ Unknown

I. MEDICAL INSURANCE STATUS

- (1) 4 Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
(2) 1 Kaiser (6) 1 Other Public Insurance
(3) _____ MediCal/Medicaid (7) 18 Uninsured
(4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) X Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) 4 Private Practice (incl. other HMOs)
(2) 1 Kaiser
(3) 1 Community Health Center
(4) 4 Hospital Outpatient Clinic
(5) _____ Emergency Room
(6) 2 VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) 12 No Primary Health Care Provider
(9) _____ Unknown

L. HIV STATUS

- (1) 24 HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
(2) _____ Disabling HIV/ARC (9) _____ Unknown
(3) _____ AIDS

M. SPECIAL POPULATIONS

- (1) 5 Injection Drug User (IDU) (4) _____ Mental Illness
(2) 2 Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
(3) _____ AIDS Dementia (6) 17 None of the above

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92

CONTRACT AGENCY: <u>NTFAP/HACH</u>	QUARTER: (check one) <u>WINTER</u> (J-MAR) (A-JUN) (J-SEPT) (O-DEC)
PROGRAM: <u>Community Events</u>	REPORT COMPLETED(date):
CONTRACT NUMBER:	AGENCY CONTACT PERSON:
FUNDING SOURCE: <u>CARE</u>	PHONE NUMBER:
TERM OF CONTRACT:	AO PGM.MGR.:

I. UNITS OF SERVICE(UOS)

Calendar Quarter	Contract Period-to-Date

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 24 Total/Qtr. (A3) _____ Number of New Individuals Served/Qtr.
 (A2) _____ Contract Period to date (unduplicated clients)

B. GENDER

(1) 24 Male (3) _____ Other (include transgender)
 (2) _____ Female (9) _____ Unknown

C. SEXUAL ORIENTATION

(1) 24 Gay Male (3) _____ Bisexual (5) _____ Declines to state (9) _____ Unknown
 (2) _____ Lesbian (4) _____ Heterosexual (6) _____ Unsure

D. AGE

(1) _____ 12 YRS. or Less (4) _____ 25-29 YRS. (7) _____ 50-59 YRS.
 (2) _____ 13-17 YRS. (5) _____ 30-39 YRS. (8) _____ 60 YRS. or More
 (3) _____ 18-24 YRS. (6) _____ 40-49 YRS. (9) _____ Unknown

E. ETHNICITY

(10) 8 White/European American (50) _____ American Indian, Alaskan Native
 (20) 10 African American (60) _____ Other..Specify
 (30) 5 Latino/a (99) _____ Unknown
 (40) 1 Asian/Pacific Islander

F. LIVING SITUATION

(1) _____ Alone (6) _____ Non-relatives/Shared Expenses (99) _____ Unknown
 (2) _____ Dependent Children (7) _____ Non-relatives/No Shared Expenses
 (3) _____ Spouse/Signif. Other (8) _____ Homeless
 (4) _____ Parent or Guardian (10) _____ Institutionalized
 (5) _____ Other Relatives (11) _____ Incarcerated

G. GROSS MONTHLY INCOME

(before taxes, for individual client, not for household)

- (1) _____ \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
 (2) _____ \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) _____ Full Time (35 or more hrs. per week) (3) _____ Not Employed
 (2) _____ Part Time (less than 35 hrs. per week) (9) _____ Unknown

I. MEDICAL INSURANCE STATUS

- (1) _____ Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
 (2) _____ Kaiser (6) _____ Other Public Insurance
 (3) _____ MediCal/Medicaid (7) _____ Uninsured
 (4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) ☒ Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) _____ Private Practice (incl. other HMOs)
 (2) _____ Kaiser
 (3) _____ Community Health Center
 (4) _____ Hospital Outpatient Clinic
 (5) _____ Emergency Room
 (6) _____ VA, Military Hospital Outpatient Clinic or Indian Health Service
 (7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
 (8) _____ No Primary Health Care Provider
 (9) _____ Unknown

L. HIV STATUS

- (1) _____ HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
 (2) _____ Disabling HIV/ARC (9) _____ Unknown
 (3) _____ AIDS

M. SPECIAL POPULATIONS

- (1) _____ Injection Drug User (IDU) (4) _____ Mental Illness
 (2) _____ Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
 (3) _____ AIDS Dementia (6) _____ None of the above

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92-93

CONTRACT AGENCY: NTFAP/EACH

QUARTER: SPRING SUMMER FALL XX WINTER
(check one) (J-MAR) (A-JUN) (J-SEPT) (O-DEC)

PROGRAM: Community Events

REPORT COMPLETED(date): 1/19/93

CONTRACT NUMBER: 83-20317

AGENCY CONTACT PERSON: R. Miller

FUNDING SOURCE: General Funds

PHONE NUMBER: [REDACTED]

TERM OF CONTRACT: 7/1/92-6/30/93

AO PGM.MGR.: R. Zellers

I. UNITS OF SERVICE(UOS)

Calendar Quarter

Contract
Period-to-Date486.0800.80

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 45 Total/Qtr.(A3) 45 Number of New Individuals Served/Qtr.(A2) 298 Contract Period to date (unduplicated clients)

B. GENDER

(1) 45 Male(3) Other (include transgender)(2) Female(9) Unknown

C. SEXUAL ORIENTATION

(1) 45 Gay Male(3) Bisexual(5) Declines to state(9) Unknown(2) Lesbian(4) Heterosexual(6) Unsure

D. AGE

(1) 12 YRS. or Less(4) 25-29 YRS.(7) 50-59 YRS.(2) 13-17 YRS.(5) 30-39 YRS.(8) 60 YRS. or More(3) 18-24 YRS.(6) 40-49 YRS.(9) Unknown

E. ETHNICITY

(10) 13 White/European American(50) American Indian, Alaskan Native(20) 17 African American(60) Other..Specify(30) 6 Latino/a(99) Unknown(40) 10 Asian/Pacific Islander

F. LIVING SITUATION

(1) Alone(6) Non-relatives/Shared Expenses(99) Unknown(2) Dependent Children(7) Non-relatives/No Shared Expenses(3) Spouse/Signif. Other(8) Homeless(4) Parent or Guardian(10) Institutionalized(5) Other Relatives(11) Incarcerated

G. GROSS MONTHLY INCOME

(before taxes, for individual client, not for household)

- (1) _____ \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
(2) _____ \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) _____ Full Time (35 or more hrs. per week) (3) _____ Not Employed
(2) _____ Part Time (less than 35 hrs. per week) (9) _____ Unknown

I. MEDICAL INSURANCE STATUS

- (1) _____ Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
(2) _____ Kaiser (6) _____ Other Public Insurance
(3) _____ MediCal/Medicaid (7) _____ Uninsured
(4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) XX Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) _____ Private Practice (incl. other HMOs)
(2) _____ Kaiser
(3) _____ Community Health Center
(4) _____ Hospital Outpatient Clinic
(5) _____ Emergency Room
(6) _____ VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) _____ No Primary Health Care Provider
(9) _____ Unknown

L. HIV STATUS

- (1) 45 HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
(2) _____ Disabling HIV/ARC (9) _____ Unknown
(3) _____ AIDS

M. SPECIAL POPULATIONS

- (1) _____ Injection Drug User (IDU) (4) _____ Mental Illness
(2) _____ Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
(3) _____ AIDS Dementia (6) _____ None of the above

AIDS OFFICE HEALTH SERVICES BRANCH
QUARTERLY REPORT
PROGRAM EVALUATION UPDATE

JAN 19 1993

Contract Agency: <u>NTFAP/EACH</u>	Quarter: <u>Winter</u>
Program: <u>Community Events</u>	Report Completed (date): <u>1/19/93</u>
Contract Number: <u>83-20317</u>	Agency Contact Person: <u>R. Miller</u>
Funding Source: <u>General Funds</u>	Phone Number: <u>[REDACTED]</u>
Term of Contract: <u>7/1/92-6/30/93</u>	AO Program Manager: <u>R. Zellers</u>

This form should be completed and submitted as part of the Quarterly Report. Please refer to your Contract exhibit or MOU prior to answering questions. Complete this form for each exhibit. If you have questions about this form, contact your program manager.

1. What evaluation procedures have you undertaken during the quarter, and what were their results?

All staff have met individually with the Program Coordinator on a bimonthly basis to review and informally evaluate their progress in fulfilling contractual obligations.

2. What significant program changes have occurred during the quarter (include scope, goals & objectives, timeline, staff, volunteers, etc.)?

Two new Treatment Advocates were hired to fill vacant positions during this quarter. One Treatment Advocate (Asian Pacific Islander) resigned after an initial trial period. A replacement candidate has been interviewed for the position. The decision was made to present three special events in gay bars during the month of May of 1993. This changes the timeline presented in the contract.

3. Describe how the program has succeeded in meeting its goals, quarterly outcome objectives, and timelines.

Once again the EACH Program is moving into the area of over-provision of Units of Service in the Community Events portion of the program. Workshop attendance continues to be limited but many more workshop opportunities are being presented.

4. What types of problems has the program experienced during the quarter, and what steps have been taken towards their resolution?

Demographic reporting for workshop participants continues to be difficult. The self-reporting form has been adapted once again to limit and target the key information needed from the workshop participants.

5. What Quality Assurance (QA) activities took place during the quarter, and what were their results? Describe any changes in program procedures resulting from your QA review.

All Treatment Advocates received training in multicultural sensitivity and in workshop presentation. All Each Staff attended a two-day staff retreat in December geared towards updating and perfecting skills. Staff began the process of doing mock presentation and were evaluated on their presentations.

6. Does your program maintain a waiting list? ☒ YES ☐ NO XXXXX
- A) How long is that list? N/A
- B) What is the average waiting time? N/A

7. Where does your program refer eligible clients who are awaiting services (include those not accepted onto a waiting list)?

EACH clients are referred to services after the initial intake. EACH maintains an extensive referral list for health-related and social services.

8. Systemwide, what gaps in available services have you noted?

None.

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92-93

CONTRACT AGENCY: NTFAP/EACH	QUARTER: ☐ SPRING (J-MAR) ☐ SUMMER (A-JUN) ☐ FALL (J-SEPT) ☒ WINTER (O-DEC)
PROGRAM: Community Events	REPORT COMPLETED(date): 1/19/93
CONTRACT NUMBER: 83-20317	AGENCY CONTACT PERSON: R. Miller
FUNDING SOURCE: General Funds	PHONE NUMBER: [REDACTED]
TERM OF CONTRACT: 7/1/92-6/30/93	AO PGM.MGR.: R. Zellers

I. UNITS OF SERVICE(UOS)	Calendar Quarter	Contract Period-to-Date
	<u>486.0</u>	<u>800.80</u>

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 45 Total/Qtr. (A3) 45 Number of New Individuals Served/Qtr.
 (A2) 298 Contract Period to date (unduplicated clients)

B. GENDER

(1) 45 Male (3) _____ Other (include transgender)
 (2) _____ Female (9) _____ Unknown

C. SEXUAL ORIENTATION

(1) 45 Gay Male (3) _____ Bisexual (5) _____ Declines to state (9) _____ Unknown
 (2) _____ Lesbian (4) _____ Heterosexual (6) _____ Unsure

D. AGE

(1) _____ 12 YRS. or Less (4) _____ 25-29 YRS. (7) _____ 50-59 YRS.
 (2) _____ 13-17 YRS. (5) _____ 30-39 YRS. (8) _____ 60 YRS. or More
 (3) _____ 18-24 YRS. (6) _____ 40-49 YRS. (9) _____ Unknown

E. ETHNICITY

(10) 13 White/European American (50) _____ American Indian, Alaskan Native
 (20) 17 African American (60) _____ Other..Specify
 (30) 6 Latino/a (99) _____ Unknown
 (40) 10 Asian/Pacific Islander

F. LIVING SITUATION

(1) _____ Alone (6) _____ Non-relatives/Shared Expenses (99) _____ Unknown
 (2) _____ Dependent Children (7) _____ Non-relatives/No Shared Expenses
 (3) _____ Spouse/Signif. Other (8) _____ Homeless
 (4) _____ Parent or Guardian (10) _____ Institutionalized
 (5) _____ Other Relatives (11) _____ Incarcerated

R. over
L. OK.

G. GROSS MONTHLY INCOME
(before taxes, for individual client, not for household)

- (1) _____ \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
(2) _____ \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) _____ Full Time (35 or more hrs. per week) (3) _____ Not Employed
(2) _____ Part Time (less than 35 hrs. per week) (9) _____ Unknown

I. MEDICAL INSURANCE STATUS

- (1) _____ Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
(2) _____ Kaiser (6) _____ Other Public Insurance
(3) _____ MediCal/Medicaid (7) _____ Uninsured
(4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) XX Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) _____ Private Practice (incl. other HMOs)
(2) _____ Kaiser
(3) _____ Community Health Center
(4) _____ Hospital Outpatient Clinic
(5) _____ Emergency Room
(6) _____ VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) _____ No Primary Health Care Provider
(9) _____ Unknown

L. HIV STATUS

- (1) 45 HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
(2) _____ Disabling HIV/ARC (9) _____ Unknown
(3) _____ AIDS

M. SPECIAL POPULATIONS

- (1) _____ Injection Drug User (IDU) (4) _____ Mental Illness
(2) _____ Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
(3) _____ AIDS Dementia (6) _____ None of the above

AIDS OFFICE HEALTH SERVICES BRANCH
QUARTERLY REPORT
PROGRAM EVALUATION UPDATE

JAN 19 1993

Contract Agency: NTFAP/EACH Quarter: Winter
Program: Community Events Report Completed (date): 1/19/93
Contract Number: 83-20317 Agency Contact Person: R. Miller
Funding Source: General Funds Phone Number: [REDACTED]
Term of Contract: 7/1/92-6/30/93 AO Program Manager: R. Zellers

This form should be completed and submitted as part of the Quarterly Report. Please refer to your Contract exhibit or MOU prior to answering questions. Complete this form for each exhibit. If you have questions about this form, contact your program manager.

1. What evaluation procedures have you undertaken during the quarter, and what were their results?

All staff have met individually with the Program Coordinator on a bimonthly basis to review and informally evaluate their progress in fulfilling contractual obligations.

2. What significant program changes have occurred during the quarter (include scope, goals & objectives, timeline, staff, volunteers, etc.)?

Two new Treatment Advocates were hired to fill vacant positions during this quarter. One Treatment Advocate (Asian Pacific Islander) resigned after an initial trial period. A replacement candidate has been interviewed for the position. The decision was made to present three special events in gay bars during the month of May of 1993. This changes the timeline presented in the contract.

3. Describe how the program has succeeded in meeting its goals, quarterly outcome objectives, and timelines.

Once again the EACH Program is moving into the area of over-provision of Units of Service in the Community Events portion of the program. Workshop attendance continues to be limited but many more workshop opportunities are being presented.

4. What types of problems has the program experienced during the quarter, and what steps have been taken towards their resolution?

Demographic reporting for workshop participants continues to be difficult. The self-reporting form has been adapted once again to limit and target the key information needed from the workshop participants.

5. What Quality Assurance (QA) activities took place during the quarter, and what were their results? Describe any changes in program procedures resulting from your QA review.

All Treatment Advocates received training in multicultural sensitivity and in workshop presentation. All Each Staff attended a two-day staff retreat in December geared towards updating and perfecting skills. Staff began the process of doing mock presentation and were evaluated on their presentations.

6. Does your program maintain a waiting list? ☒ YES ☐ NO XXXXX

A) How long is that list? N/A

B) What is the average waiting time? N/A

7. Where does your program refer eligible clients who are awaiting services (include those not accepted onto a waiting list)?

EACH clients are referred to services after the initial intake. EACH maintains an extensive referral list for health-related and social services.

8. Systemwide, what gaps in available services have you noted?

None.

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92-93

CONTRACT AGENCY: <u>NTFAP</u>	QUARTER: <u>WINTER</u> (check one) <u>(J-MAR)</u> <u>(A-JUN)</u> <u>(J-SEPT)</u> <u>(O-DEC)</u>
PROGRAM: <u>Treatment Advocacy</u>	REPORT COMPLETED(date): <u>1/19/93</u>
CONTRACT NUMBER: <u>83-17163</u>	AGENCY CONTACT PERSON: <u>R. Miller</u>
FUNDING SOURCE: <u>CARE</u>	PHONE NUMBER: <u>[REDACTED]</u>
TERM OF CONTRACT: <u>5/1/92-4/30/93</u>	AO PGM.MGR.: <u>R. Zellers</u>

I. UNITS OF SERVICE(UOS)

Calendar Quarter

Contract
Period-to-Date702.81064.83

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 225 Total/Qtr.(A3) 75 Number of New Individuals Served/Qtr.(A2) 182 Contract Period to date (unduplicated clients)

B. GENDER

(1) 44 Male(3) Other (include transgender)(2) 1 Female(9) Unknown

C. SEXUAL ORIENTATION

(1) 37 Gay Male(3) 3 Bisexual(5) Declines to state(9) Unknown(2) 1 Lesbian(4) 3 Heterosexual(6) 1 Unsure

D. AGE

(1) 12 YRS. or Less(4) 7 25-29 YRS.(7) 2 50-59 YRS.(2) 13-17 YRS.(5) 22 30-39 YRS.(8) 60 YRS. or More(3) 2 18-24 YRS.(6) 11 40-49 YRS.(9) 1 Unknown

E. ETHNICITY

(10) 15 White/European American(50) 3 American Indian, Alaskan Native(20) 18 African American(60) 1 Other..Specify(30) 7 Latino/a(99) Unknown(40) 2 Asian/Pacific Islander

F. LIVING SITUATION

(1) 23 Alone(6) 2 Non-relatives/Shared Expenses(99) Unknown(2) 1 Dependent Children(7) 1 Non-relatives/No Shared Expenses(3) 3 Spouse/Signif. Other(8) 4 Homeless(4) 1 Parent or Guardian(10) Institutionalized(5) Other Relatives(11) Incarcerated* Needs Gr
on (A1)B. Less
C. Less
D. Less
E. Less
f. Less

G. GROSS MONTHLY INCOME
(before taxes, for individual client, not for household)

(1) 16 \$600 or Below (3) 7 \$ 901 - \$1200 (5) 2 Above \$2400
(2) 12 \$601 - \$900 (4) 7 \$1201 - \$2400 (9) 1 Unknown

H. EMPLOYMENT STATUS

(1) 10 Full Time (35 or more hrs. per week) (3) 30 Not Employed
(2) 4 Part Time (less than 35 hrs. per week) (9) Unknown

I. MEDICAL INSURANCE STATUS

(1) 3 Private Insurance (incl. other HMOs) (5) 2 MediCal/Medicare
(2) 4 Kaiser (6) 1 Other Public Insurance
(3) 5 MediCal/Medicaid (7) 7 Uninsured
(4) 1 Medicare (9) 22 Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

(1) Client Pays (2) xx Client does not Pay (3) No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

(1) 4 Private Practice (incl. other HMOs)
(2) 3 Kaiser
(3) 3 Community Health Center
(4) 7 Hospital Outpatient Clinic
(5) 0 Emergency Room
(6) 1 VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) 4 Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) 5 No Primary Health Care Provider
(9) 19 Unknown

L. HIV STATUS

(1) 25 HIV Positive (not Disabling) (4) Relative, Friend or Partner of HIV Positive
(2) 15 Disabling HIV/ARC (9) Unknown
(3) 4 AIDS

M. SPECIAL POPULATIONS

(1) 6 Injection Drug User (IDU) (4) 1 Mental Illness
(2) 8 Other Substance Abuse (5) 4 Mental Illness and Substance Abuse
(3) 1 AIDS Dementia (6) 24 None of the above

AIDS OFFICE HEALTH SERVICES BRANCH
QUARTERLY REPORT
PROGRAM EVALUATION UPDATE

JAN 19 1993

Contract Agency: <u>NTFAP/EACH</u>	Quarter: <u>Winter</u>
Program: <u>Treatment Advocacy</u>	Report Completed (date): <u>1/19/93</u>
Contract Number: <u>83-17163</u>	Agency Contact Person: <u>R. Miller</u>
Funding Source: <u>CARE</u>	Phone Number: <u>[REDACTED]</u>
Term of Contract: <u>5/1/92-6/30/93</u>	AO Program Manager: <u>R. Zellers</u>

This form should be completed and submitted as part of the Quarterly Report. Please refer to your Contract exhibit or MOU prior to answering questions. Complete this form for each exhibit. If you have questions about this form, contact your program manager.

1. What evaluation procedures have you undertaken during the quarter, and what were their results?

All staff have met individually with the Program Coordinator on a bimonthly basis to review and informally evaluate their progress in fulfilling contractual obligations. All Treatment Advocates were evaluated by the Senior Treatment Advocate in writing to determine future training needs. A list of necessary in-service trainings was produced and is currently being implemented. Two new Treatment Advocates were provided orientation and training for providing one-on-one treatment advocacy.

2. What significant program changes have occurred during the quarter (include scope, goals & objectives, timeline, staff, volunteers, etc.)?

Two new Treatment Advocates were hired to fill vacant positions during this quarter. One Treatment Advocate (Asian Pacific Islander) resigned after an initial trial period. A replacement candidate has been interviewed for the position.

3. Describe how the program has succeeded in meeting its goals, quarterly outcome objectives, and timelines.

Now that the EACH Program has been operating at full staff the Units of Service provision for the Treatment Advocacy portion of the contract has improved dramatically. Nevertheless, it will take some time to fully train the new staff so they will be fully aware of treatment information and policies and procedures. Otherwise the program is doing well in meeting its goals and timelines.

4. What types of problems has the program experienced during the quarter, and what steps have been taken towards their resolution?

The number of individual clients coming in to the program has been low. The hiring and training of new staff, the launching of paid advertisement campaigns, and more active recruitment and outreach should dramatically improve this situation in the remainder of the contract year.

5. What Quality Assurance (QA) activities took place during the quarter, and what were their results? Describe any changes in program procedures resulting from your QA review.

The Universal Precautions were reviewed by all staff. All staff also reviewed the Tb Protocol for the EACH Program and were instructed in compliance with this document.

6. Does your program maintain a waiting list? ☒ YES ☐ NO XXXXX

A) How long is that list? N/A

B) What is the average waiting time? N/A

7. Where does your program refer eligible clients who are awaiting services (include those not accepted onto a waiting list)?

EACH clients are referred to services after the initial intake. EACH maintains an extensive referral list for health-related and social services.

8. Systemwide, what gaps in available services have you noted?

None.

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92-93

CONTRACT AGENCY: <u>NTFAP</u>	QUARTER: <u>—</u> SPRING <u>—</u> SUMMER <u>—</u> FALL <u>XX</u> WINTER (check one) (J-MAR) (A-JUN) (J-SEPT) (O-DEC)
PROGRAM: <u>Treatment Advocacy</u>	REPORT COMPLETED(date): <u>1/19/93</u>
CONTRACT NUMBER: <u>83-17163</u>	AGENCY CONTACT PERSON: <u>R. Miller</u>
FUNDING SOURCE: <u>CARE</u>	PHONE NUMBER: <u>[REDACTED]</u>
TERM OF CONTRACT: <u>5/1/92-4/30/93</u>	AO PGM.MGR.: <u>R. Zellers</u>

I. UNITS OF SERVICE(UOS)	Calendar Quarter	Contract Period-to-Date
	<u>702.8</u>	<u>1064.83</u>

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 225 Total/Qtr. (A3) 75 Number of New Individuals Served/Qtr.
(A2) 182 Contract Period to date (unduplicated clients)

B. GENDER

(1) 44 Male (3) — Other (include transgender)
(2) 1 Female (9) — Unknown

C. SEXUAL ORIENTATION

(1) 37 Gay Male (3) 3 Bisexual (5) — Declines to state (9) — Unknown
(2) 1 Lesbian (4) 3 Heterosexual (6) 1 Unsure

D. AGE

(1) — 12 YRS. or Less (4) 7 25-29 YRS. (7) 2 50-59 YRS.
(2) — 13-17 YRS. (5) 22 30-39 YRS. (8) — 60 YRS. or More
(3) 2 18-24 YRS. (6) 11 40-49 YRS. (9) 1 Unknown

E. ETHNICITY

(10) 15 White/European American (50) 3 American Indian, Alaskan Native
(20) 18 African American (60) 1 Other..Specify
(30) 7 Latino/a (99) — Unknown
(40) 2 Asian/Pacific Islander

F. LIVING SITUATION

(1) 23 Alone (6) 2 Non-relatives/Shared Expenses (99) — Unknown
(2) 1 Dependent Children (7) 1 Non-relatives/No Shared Expenses
(3) 3 Spouse/Signif. Other (8) 4 Homeless
(4) 1 Parent or Guardian (10) — Institutionalized
(5) — Other Relatives (11) — Incarcerated

G. GROSS MONTHLY INCOME

(before taxes, for individual client, not for household)

- (1) 16 \$600 or Below (3) 7 \$ 901 - \$1200 (5) 2 Above \$2400
(2) 12 \$601 - \$900 (4) 7 \$1201 - \$2400 (9) 1 Unknown

H. EMPLOYMENT STATUS

- (1) 10 Full Time (35 or more hrs. per week) (3) 30 Not Employed
(2) 4 Part Time (less than 35 hrs. per week) (9) Unknown

I. MEDICAL INSURANCE STATUS

- (1) 3 Private Insurance (incl. other HMOs) (5) 2 MediCal/Medicare
(2) 4 Kaiser (6) 1 Other Public Insurance
(3) 5 MediCal/Medicaid (7) 7 Uninsured
(4) 1 Medicare (9) 22 Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) Client Pays (2) xx Client does not Pay (3) No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) 4 Private Practice (incl. other HMOs)
(2) 3 Kaiser
(3) 3 Community Health Center
(4) 7 Hospital Outpatient Clinic
(5) 0 Emergency Room
(6) 1 VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) 4 Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) 5 No Primary Health Care Provider
(9) 19 Unknown

L. HIV STATUS

- (1) 25 HIV Positive (not Disabling) (4) Relative, Friend or Partner of HIV Positive
(2) 15 Disabling HIV/ARC (9) Unknown
(3) 4 AIDS

M. SPECIAL POPULATIONS

- (1) 6 Injection Drug User (IDU) (4) 1 Mental Illness
(2) 8 Other Substance Abuse (5) 4 Mental Illness and Substance Abuse
(3) 1 AIDS Dementia (6) 24 None of the above

AIDS OFFICE HEALTH SERVICES BRANCH JAN 19 1993
QUARTERLY REPORT
PROGRAM EVALUATION UPDATE

Contract Agency: <u>NTFAP/EACH</u>	Quarter: <u>Winter</u>
Program: <u>Treatment Advocacy</u>	Report Completed (date): <u>1/19/93</u>
Contract Number: <u>83-17163</u>	Agency Contact Person: <u>R. Miller</u>
Funding Source: <u>CARE</u>	Phone Number: <u>[REDACTED]</u>
Term of Contract: <u>5/1/92-6/30/93</u>	AO Program Manager: <u>R. Zellers</u>

This form should be completed and submitted as part of the Quarterly Report. Please refer to your Contract exhibit or MOU prior to answering questions. Complete this form for each exhibit. If you have questions about this form, contact your program manager.

1. What evaluation procedures have you undertaken during the quarter, and what were their results?

All staff have met individually with the Program Coordinator on a bimonthly basis to review and informally evaluate their progress in fulfilling contractual obligations. All Treatment Advocates were evaluated by the Senior Treatment Advocate in writing to determine future training needs. A list of necessary in-service trainings was produced and is currently being implemented. Two new Treatment Advocates were provided orientation and training for providing one-on-one treatment advocacy.

2. What significant program changes have occurred during the quarter (include scope, goals & objectives, timeline, staff, volunteers, etc.)?

Two new Treatment Advocates were hired to fill vacant positions during this quarter. One Treatment Advocate (Asian Pacific Islander) resigned after an initial trial period. A replacement candidate has been interviewed for the position.

3. Describe how the program has succeeded in meeting its goals, quarterly outcome objectives, and timelines.

Now that the EACH Program has been operating at full staff the Units of Service provision for the Treatment Advocacy portion of the contract has improved dramatically. Nevertheless, it will take some time to fully train the new staff so they will be fully aware of treatment information and policies and procedures. Otherwise the program is doing well in meeting its goals and timelines.

4. What types of problems has the program experienced during the quarter, and what steps have been taken towards their resolution?

The number of individual clients coming in to the program has been low. The hiring and training of new staff, the launching of paid advertisement campaigns, and more active recruitment and outreach should dramatically improve this situation in the remainder of the contract year.

5. What Quality Assurance (QA) activities took place during the quarter, and what were their results? Describe any changes in program procedures resulting from your QA review.

The Universal Precautions were reviewed by all staff. All staff also reviewed the Tb Protocol for the EACH Program and were instructed in compliance with this document.

6. Does your program maintain a waiting list? YES NO XXXXX

- A) How long is that list? N/A
- B) What is the average waiting time? N/A

7. Where does your program refer eligible clients who are awaiting services (include those not accepted onto a waiting list)?

EACH clients are referred to services after the initial intake. EACH maintains an extensive referral list for health-related and social services.

8. Systemwide, what gaps in available services have you noted?

None.

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92-93

CONTRACT AGENCY: Nat'l Task Force AIDS
 PROGRAM: Community Events
 CONTRACT NUMBER: 83-17163
 FUNDING SOURCE: CARE
 TERM OF CONTRACT: 5/1/92-4/30/93

QUARTER: — SPRING — SUMMER — FALL XX WINTER
 (check one) (J-MAR) (A-JUN) (J-SEPT) (O-DEC)
 REPORT COMPLETED(date): 1/19/93
 AGENCY CONTACT PERSON: Randy Miller
 PHONE NUMBER: [REDACTED]
 AO PGM.MGR.: R. Zellers

I. UNITS OF SERVICE(UOS)

Calendar Quarter

Contract
Period-to-Date307524.75

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 45 Total/Qtr. (A3) 45 Number of New Individuals Served/Qtr.
 (A2) 298 Contract Period to date (unduplicated clients)

B. GENDER

(1) — Male (3) — Other (include transgender)
 (2) — Female (9) — Unknown

C. SEXUAL ORIENTATION

(1) 45 Gay Male (3) — Bisexual (5) — Declines to state (9) — Unknown
 (2) — Lesbian (4) — Heterosexual (6) — Unsure

D. AGE

(1) — 12 YRS. or Less (4) — 25-29 YRS. (7) — 50-59 YRS.
 (2) — 13-17 YRS. (5) — 30-39 YRS. (8) — 60 YRS. or More
 (3) — 18-24 YRS. (6) — 40-49 YRS. (9) — Unknown

E. ETHNICITY

(10) 12 White/European American (50) 0 American Indian, Alaskan Native
 (20) 16 African American (60) 0 Other..Specify
 (30) 6 Latino/a (99) 0 Unknown
 (40) 10 Asian/Pacific Islander

F. LIVING SITUATION

(1) — Alone (6) — Non-relatives/Shared Expenses (99) — Unknown
 (2) — Dependent Children (7) — Non-relatives/No Shared Expenses
 (3) — Spouse/Signif. Other (8) — Homeless
 (4) — Parent or Guardian (10) — Institutionalized
 (5) — Other Relatives (11) — Incarcerated

Less
 ①

G. GROSS MONTHLY INCOME
(before taxes, for individual client, not for household)

- (1) _____ \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
(2) _____ \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) _____ Full Time (35 or more hrs. per week) (3) _____ Not Employed
(2) _____ Part Time (less than 35 hrs. per week) (9) _____ Unknown

I. MEDICAL INSURANCE STATUS

- (1) _____ Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
(2) _____ Kaiser (6) _____ Other Public Insurance
(3) _____ MediCal/Medicaid (7) _____ Uninsured
(4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) _____ Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) _____ Private Practice (incl. other HMOs)
(2) _____ Kaiser
(3) _____ Community Health Center
(4) _____ Hospital Outpatient Clinic
(5) _____ Emergency Room
(6) _____ VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) _____ No Primary Health Care Provider
(9) _____ Unknown

L. HIV STATUS

- (1) _____ HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
(2) _____ Disabling HIV/ARC (9) _____ Unknown
(3) _____ AIDS

M. SPECIAL POPULATIONS

- (1) _____ Injection Drug User (IDU) (4) _____ Mental Illness
(2) _____ Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
(3) _____ AIDS Dementia (6) _____ None of the above

AIDS OFFICE HEALTH SERVICES BRANCH
QUARTERLY REPORT
PROGRAM EVALUATION UPDATE

JAN 19 1993

Contract Agency: <u>NTFAP/EACH</u>	Quarter: <u>Winter</u>
Program: <u>Community Events</u>	Report Completed (date): <u>1/19/93</u>
Contract Number: <u>83-17163</u>	Agency Contact Person: <u>R. Miller</u>
Funding Source: <u>CARE</u>	Phone Number: <u>[REDACTED]</u>
Term of Contract: <u>5/1/92-6/30/93</u>	AO Program Manager: <u>R. Zellers</u>

This form should be completed and submitted as part of the Quarterly Report. Please refer to your Contract exhibit or MOU prior to answering questions. Complete this form for each exhibit. If you have questions about this form, contact your program manager.

1. What evaluation procedures have you undertaken during the quarter, and what were their results?

All staff have met individually with the Program Coordinator on a bimonthly basis to review and informally evaluate their progress in fulfilling contractual obligations.

2. What significant program changes have occurred during the quarter (include scope, goals & objectives, timeline, staff, volunteers, etc.)?

Two new Treatment Advocates were hired to fill vacant positions during this quarter. One Treatment Advocate (Asian Pacific Islander) resigned after an initial trial period. A replacement candidate has been interviewed for the position. The decision was made to present three special events in gay bars during the month of May of 1993. This changes the timeline presented in the contract.

3. Describe how the program has succeeded in meeting its goals, quarterly outcome objectives, and timelines.

Once again the EACH Program is moving into the area of over-provision of Units of Service in the Community Events portion of the program. Workshop attendance continues to be limited but many more workshop opportunities are being presented.

4. What types of problems has the program experienced during the quarter, and what steps have been taken towards their resolution?

Demographic reporting for workshop participants continues to be difficult. The self-reporting form has been adapted once again to limit and target the key information needed from the workshop participants.

5. What Quality Assurance (QA) activities took place during the quarter, and what were their results? Describe any changes in program procedures resulting from your QA review.

All Treatment Advocates received training in multicultural sensitivity and in workshop presentation. All Each Staff attended a two-day staff retreat in December geared towards updating and perfecting skills. Staff began the process of doing mock presentation and were evaluated on their presentations.

6. Does your program maintain a waiting list?

YES	NO XXXXX
-----	----------

A) How long is that list? N/A

B) What is the average waiting time? N/A

7. Where does your program refer eligible clients who are awaiting services (include those not accepted onto a waiting list)?

EACH clients are referred to services after the initial intake. EACH maintains an extensive referral list for health-related and social services.

8. Systemwide, what gaps in available services have you noted?

None.

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92-93

CONTRACT AGENCY: <u>Nat'l Task Force AIDS</u>	QUARTER: <u>SPRING</u> <u>SUMMER</u> <u>FALL</u> <u>XX WINTER</u> (check one) (J-MAR) (A-JUN) (J-SEPT) (O-DEC)
PROGRAM: <u>Community Events</u>	REPORT COMPLETED(date): <u>1/19/93</u>
CONTRACT NUMBER: <u>83-17163</u>	AGENCY CONTACT PERSON: <u>Randy Miller</u>
FUNDING SOURCE: <u>CARE</u>	PHONE NUMBER: <u>[REDACTED]</u>
TERM OF CONTRACT: <u>5/1/92-4/30/93</u>	AO PGM.MGR.: <u>R. Zellers</u>

I. UNITS OF SERVICE(UOS)

Calendar Quarter

307Contract
Period-to-Date524.75

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 45 Total/Qtr.(A3) 45 Number of New Individuals Served/Qtr.(A2) 298 Contract Period to date (unduplicated clients)

B. GENDER

(1) Male(3) Other (include transgender)(2) Female(9) Unknown

C. SEXUAL ORIENTATION

(1) 45 Gay Male(3) Bisexual(5) Declines to state(9) Unknown(2) Lesbian(4) Heterosexual(6) Unsure

D. AGE

(1) 12 YRS. or Less(4) 25-29 YRS.(7) 50-59 YRS.(2) 13-17 YRS.(5) 30-39 YRS.(8) 60 YRS. or More(3) 18-24 YRS.(6) 40-49 YRS.(9) Unknown

E. ETHNICITY

(10) 12 White/European American(50) 0 American Indian, Alaskan Native(20) 16 African American(60) 0 Other..Specify(30) 6 Latino/a(99) 0 Unknown(40) 10 Asian/Pacific Islander

F. LIVING SITUATION

(1) Alone(6) Non-relatives/Shared Expenses(99) Unknown(2) Dependent Children(7) Non-relatives/No Shared Expenses(3) Spouse/Signif. Other(8) Homeless(4) Parent or Guardian(10) Institutionalized(5) Other Relatives(11) Incarcerated

G. GROSS MONTHLY INCOME

(before taxes, for individual client, not for household)

- (1) _____ \$600 or Below (3) _____ \$ 901 - \$1200 (5) _____ Above \$2400
(2) _____ \$601 - \$900 (4) _____ \$1201 - \$2400 (9) _____ Unknown

H. EMPLOYMENT STATUS

- (1) _____ Full Time (35 or more hrs. per week) (3) _____ Not Employed
(2) _____ Part Time (less than 35 hrs. per week) (9) _____ Unknown

I. MEDICAL INSURANCE STATUS

- (1) _____ Private Insurance (incl. other HMOs) (5) _____ MediCal/Medicare
(2) _____ Kaiser (6) _____ Other Public Insurance
(3) _____ MediCal/Medicaid (7) _____ Uninsured
(4) _____ Medicare (9) _____ Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) _____ Client Pays (2) _____ Client does not Pay (3) _____ No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) _____ Private Practice (incl. other HMOs)
(2) _____ Kaiser
(3) _____ Community Health Center
(4) _____ Hospital Outpatient Clinic
(5) _____ Emergency Room
(6) _____ VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) _____ Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) _____ No Primary Health Care Provider
(9) _____ Unknown

L. HIV STATUS

- (1) _____ HIV Positive (not Disabling) (4) _____ Relative, Friend or Partner of HIV Positive
(2) _____ Disabling HIV/ARC (9) _____ Unknown
(3) _____ AIDS

M. SPECIAL POPULATIONS

- (1) _____ Injection Drug User (IDU) (4) _____ Mental Illness
(2) _____ Other Substance Abuse (5) _____ Mental Illness and Substance Abuse
(3) _____ AIDS Dementia (6) _____ None of the above

AIDS OFFICE HEALTH SERVICES BRANCH JAN 19 1993
QUARTERLY REPORT
PROGRAM EVALUATION UPDATE

Contract Agency: <u>NTFAP/EACH</u>	Quarter: <u>Winter</u>
Program: <u>Community Events</u>	Report Completed (date): <u>1/19/93</u>
Contract Number: <u>83-17163</u>	Agency Contact Person: <u>R. Miller</u>
Funding Source: <u>CARE</u>	Phone Number: <u>[REDACTED]</u>
Term of Contract: <u>5/1/92-6/30/93</u>	AO Program Manager: <u>R. Zellers</u>

This form should be completed and submitted as part of the Quarterly Report. Please refer to your Contract exhibit or MOU prior to answering questions. Complete this form for each exhibit. If you have questions about this form, contact your program manager.

1. What evaluation procedures have you undertaken during the quarter, and what were their results?

All staff have met individually with the Program Coordinator on a bimonthly basis to review and informally evaluate their progress in fulfilling contractual obligations.

2. What significant program changes have occurred during the quarter (include scope, goals & objectives, timeline, staff, volunteers, etc.)?

Two new Treatment Advocates were hired to fill vacant positions during this quarter. One Treatment Advocate (Asian Pacific Islander) resigned after an initial trial period. A replacement candidate has been interviewed for the position. The decision was made to present three special events in gay bars during the month of May of 1993. This changes the timeline presented in the contract.

3. Describe how the program has succeeded in meeting its goals, quarterly outcome objectives, and timelines.

Once again the EACH Program is moving into the area of over-provision of Units of Service in the Community Events portion of the program. Workshop attendance continues to be limited but many more workshop opportunities are being presented.

4. What types of problems has the program experienced during the quarter, and what steps have been taken towards their resolution?

Demographic reporting for workshop participants continues to be difficult. The self-reporting form has been adapted once again to limit and target the key information needed from the workshop participants.

5. What Quality Assurance (QA) activities took place during the quarter, and what were their results? Describe any changes in program procedures resulting from your QA review.

All Treatment Advocates received training in multicultural sensitivity and in workshop presentation. All Each Staff attended a two-day staff retreat in December geared towards updating and perfecting skills. Staff began the process of doing mock presentation and were evaluated on their presentations.

6. Does your program maintain a waiting list? ☒ YES ☐ NO XXXXX

A) How long is that list? N/A

B) What is the average waiting time? N/A

7. Where does your program refer eligible clients who are awaiting services (include those not accepted onto a waiting list)?

EACH clients are referred to services after the initial intake. EACH maintains an extensive referral list for health-related and social services.

8. Systemwide, what gaps in available services have you noted?

None.

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92-93

CONTRACT AGENCY: NTFAP/EACH
 PROGRAM: Treatment Advocacy
 CONTRACT NUMBER: 83-20317
 FUNDING SOURCE: General Funds
 TERM OF CONTRACT: 7/1/92-6/30/93

QUARTER: — SPRING — SUMMER — FALL XX WINTER
 (check one) (J-MAR) (A-JUN) (J-SEPT) (O-DEC)
 REPORT COMPLETED(date): 1/19/93
 AGENCY CONTACT PERSON: R. Miller
 PHONE NUMBER: [REDACTED]
 AO PGM.MGR.: R. Zellers

I. UNITS OF SERVICE(UOS)

Calendar Quarter

Contract
Period-to-Date855.081264.94

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 226 Total/Ctr.(A3) 75 Number of New Individuals Served/C(A2) 182 Contract Period to date (unduplicated clients)

B. GENDER

(1) 41 Male(3) — Other (include transgender)(2) 1 Female(9) — Unknown

C. SEXUAL ORIENTATION

(1) 37 Gay Male(3) 3 Bisexual(5) — Declines to state(9) — Unknown(2) — Lesbian(4) 2 Heterosexual(6) 1 Unsure

D. AGE

(1) — 12 YRS. or Less(4) 6 25-29 YRS.(7) 2 50-59 YRS.(2) — 13-17 YRS.(5) 21 30-39 YRS.(8) — 60 YRS. or More(3) 1 18-24 YRS.(6) 11 40-49 YRS.(9) 1 Unknown

E. ETHNICITY

(10) 15 White/European American(50) 2 American Indian, Alaskan Native(20) 17 African American(60) — Other...Specify(30) 6 Latino/a(99) — Unknown(40) 1 Asian/Pacific Islander

F. LIVING SITUATION

(1) 22 Alone(6) 2 Non-relatives/Shared Expenses(99) — Unknown(2) 1 Dependent Children(7) 1 Non-relatives/No Shared Expenses(3) 3 Spouse/Signif. Other(8) 3 Homeless(4) 1 Parent or Guardian(10) — Institutionalized(5) — Other Relatives(11) — IncarceratedRandy MillerCalled on 1/20/93Will call back.② Called on 2/26/93for asking to send theCorrection.③ 3/9/93 have themessage at 8:15 AM.b. Less 33c. Less 32d. Less 33e. Less 34f. Less 42

G. GROSS MONTHLY INCOME
(before taxes, for individual client, not for household)

- (1) 15 \$600 or Below (3) 6 \$ 901 - \$1200 (5) 1 Above \$2400
(2) 12 \$601 - \$900 (4) 7 \$1201 - \$2400 (9) 1 Unknown

H. EMPLOYMENT STATUS

- (1) 10 Full Time (35 or more hrs. per week) (3) 30 Not Employed
(2) 3 Part Time (less than 35 hrs. per week) (9) Unknown

I. MEDICAL INSURANCE STATUS

- (1) 2 Private Insurance (incl. other HMOs) (5) 2 MediCal/Medicare
(2) 4 Kaiser (6) 1 Other Public Insurance
(3) 5 MediCal/Medicaid (7) 7 Uninsured
(4) Medicare (9) 21 Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) Client Pays (2) XX Client does not Pay (3) No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) 3 Private Practice (incl. other HMOs)
(2) 2 Kaiser
(3) 2 Community Health Center
(4) 6 Hospital Outpatient Clinic
(5) Emergency Room
(6) 1 VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) 4 Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) 4 No Primary Health Care Provider
(9) 19 Unknown

L. HIV STATUS

- (1) 25 HIV Positive (not Disabling) (4) Relative, Friend or Partner of HIV Positive
(2) 14 Disabling HIV/ARC (9) Unknown
(3) 4 AIDS

M. SPECIAL POPULATIONS

- (1) 6 Injection Drug User (IDU) (4) 1 Mental Illness
(2) 8 Other Substance Abuse (5) 4 Mental Illness and Substance Abuse
(3) AIDS Dementia (6) 24 None of the above

G. Less
H. Less
I. Less
K. Less
L. Less
M. Less



AIDS OFFICE HEALTH SERVICES BRANCH
QUARTERLY REPORT
PROGRAM EVALUATION UPDATE

JAN 19 1993

Contract Agency: <u>NTFAP/EACH</u>	Quarter: <u>Winter</u>
Program: <u>Treatment Advocacy</u>	Report Completed (date): <u>1/19/93</u>
Contract Number: <u>83-202317</u>	Agency Contact Person: <u>R. Miller</u>
Funding Source: <u>General Funds</u>	Phone Number: <u>[REDACTED]</u>
Term of Contract: <u>7/1/92-6/30/93</u>	AO Program Manager: <u>R. Zellers</u>

This form should be completed and submitted as part of the Quarterly Report. Please refer to your Contract exhibit or MOU prior to answering questions. Complete this form for each exhibit. If you have questions about this form, contact your program manager.

1. What evaluation procedures have you undertaken during the quarter, and what were their results?

All staff have met individually with the Program Coordinator on a bimonthly basis to review and informally evaluate their progress in fulfilling contractual obligations. All Treatment Advocates were evaluated by the Senior Treatment Advocate in writing to determine future training needs. A list of necessary in-service trainings was produced and is currently being implemented. Two new Treatment Advocates were provided orientation and training for providing one-on-one treatment advocacy.

2. What significant program changes have occurred during the quarter (include scope, goals & objectives, timeline, staff, volunteers, etc.)?

Two new Treatment Advocates were hired to fill vacant positions during this quarter. One Treatment Advocate (Asian Pacific Islander) resigned after an initial trial period. A replacement candidate has been interviewed for the position.

3. Describe how the program has succeeded in meeting its goals, quarterly outcome objectives, and timelines.

Now that the EACH Program has been operating at full staff the Units of Service provision for the Treatment Advocacy portion of the contract has improved dramatically. Nevertheless, it will take some time to fully train the new staff so they will be fully aware of treatment information and policies and procedures. Otherwise the program is doing well in meeting its goals and timelines.

4. What types of problems has the program experienced during the quarter, and what steps have been taken towards their resolution?

The number of individual clients coming in to the program has been low. The hiring and training of new staff, the launching of paid advertisement campaigns, and more active recruitment and outreach should dramatically improve this situation in the remainder of the contract year.

5. What Quality Assurance (QA) activities took place during the quarter, and what were their results? Describe any changes in program procedures resulting from your QA review.

The Universal Precautions were reviewed by all staff. All staff also reviewed the Tb Protocol for the EACH Program and were instructed in compliance with this document.

6. Does your program maintain a waiting list? ☒ YES ☐ NO XXXXX

A) How long is that list? N/A

B) What is the average waiting time? N/A

7. Where does your program refer eligible clients who are awaiting services (include those not accepted onto a waiting list)?

EACH clients are referred to services after the initial intake. EACH maintains an extensive referral list for health-related and social services.

8. Systemwide, what gaps in available services have you noted?

None.

AIDS OFFICE, HEALTH SERVICES BRANCH

PROGRAM QUARTERLY REPORT

YEAR: 92-93

CONTRACT AGENCY: NTFAP/EACH	QUARTER: <u> </u> SPRING <u> </u> SUMMER <u> </u> FALL <u>XX</u> WINTER (check one) (J-MAR) (A-JUN) (J-SEPT) (O-DEC)
PROGRAM: <u>Treatment Advocacy</u>	REPORT COMPLETED(date): <u>1/19/93</u>
CONTRACT NUMBER: <u>83-20317</u>	AGENCY CONTACT PERSON: <u>R. Miller</u>
FUNDING SOURCE: <u>General Funds</u>	PHONE NUMBER: <u> </u>
TERM OF CONTRACT: <u>7/1/92-6/30/93</u>	AO PGM.MGR.: <u>R. Zellers</u>

I. UNITS OF SERVICE(UOS)

Calendar Quarter

Contract
Period-to-Date855.081264.94

II. CLIENT INFORMATION

(Use actual counts for each item. Do not use percents. The total per category must equal the total number of new clients served.)

A. NUMBER OF CLIENTS SERVED

(A1) 226 Total/Qtr. (A3) 75 Number of New Individuals Served/Qtr.
(A2) 182 Contract Period to date (unduplicated clients)

B. GENDER

(1) 41 Male (3) Other (include transgender)
(2) 1 Female (9) Unknown

C. SEXUAL ORIENTATION

(1) 37 Gay Male (3) 3 Bisexual (5) Declines to state (9) Unknown
(2) Lesbian (4) 2 Heterosexual (6) 1 Unsure

D. AGE

(1) 12 YRS. or Less (4) 6 25-29 YRS. (7) 2 50-59 YRS.
(2) 13-17 YRS. (5) 21 30-39 YRS. (8) 60 YRS. or More
(3) 1 18-24 YRS. (6) 11 40-49 YRS. (9) 1 Unknown

E. ETHNICITY

(10) 15 White/European American (50) 2 American Indian, Alaskan Native
(20) 17 African American (60) Other..Specify
(30) 6 Latino/a (99) Unknown
(40) 1 Asian/Pacific Islander

F. LIVING SITUATION

(1) 22 Alone (6) 2 Non-relatives/Shared Expenses (99) Unknown
(2) 1 Dependent Children (7) 1 Non-relatives/No Shared Expenses
(3) 3 Spouse/Signif. Other (8) 3 Homeless
(4) 1 Parent or Guardian (10) Institutionalized
(5) Other Relatives (11) Incarcerated

G. GROSS MONTHLY INCOME

(before taxes, for individual client, not for household)

- (1) 15 \$600 or Below (3) 6 \$ 901 - \$1200 (5) 1 Above \$2400
(2) 12 \$601 - \$900 (4) 7 \$1201 - \$2400 (9) 1 Unknown

H. EMPLOYMENT STATUS

- (1) 10 Full Time (35 or more hrs. per week) (3) 30 Not Employed
(2) 3 Part Time (less than 35 hrs. per week) (9) Unknown

I. MEDICAL INSURANCE STATUS

- (1) 2 Private Insurance (incl. other HMOs) (5) 2 MediCal/Medicare
(2) 4 Kaiser (6) 1 Other Public Insurance
(3) 5 MediCal/Medicaid (7) 7 Uninsured
(4) Medicare (9) 21 Unknown

J. CLIENT PAYMENT FOR YOUR SERVICE

- (1) Client Pays (2) XX Client does not Pay (3) No Fee for Service

K. PRIMARY HEALTH CARE SOURCE

- (1) 3 Private Practice (incl. other HMOs)
(2) 2 Kaiser
(3) 2 Community Health Center
(4) 6 Hospital Outpatient Clinic
(5) Emergency Room
(6) 1 VA, Military Hospital Outpatient Clinic or Indian Health Service
(7) 4 Other Primary Health Care Provider/Acupuncturist or Chiropractor
(8) 4 No Primary Health Care Provider
(9) 19 Unknown

L. HIV STATUS

- (1) 25 HIV Positive (not Disabling) (4) Relative, Friend or Partner of HIV Positive
(2) 14 Disabling HIV/ARC (9) Unknown
(3) 4 AIDS

M. SPECIAL POPULATIONS

- (1) 6 Injection Drug User (IDU) (4) 1 Mental Illness
(2) 8 Other Substance Abuse (5) 4 Mental Illness and Substance Abuse
(3) AIDS Dementia (6) 24 None of the above

AIDS OFFICE HEALTH SERVICES BRANCH JAN 19 1993
QUARTERLY REPORT
PROGRAM EVALUATION UPDATE

Contract Agency: NTFAP/EACH Quarter: Winter
Program: Treatment Advocacy Report Completed (date): 1/19/93
Contract Number: 83-202317 Agency Contact Person: R. Miller
Funding Source: General Funds Phone Number: [REDACTED]
Term of Contract: 7/1/92-6/30/93 AO Program Manager: R. Zellers

This form should be completed and submitted as part of the Quarterly Report. Please refer to your Contract exhibit or MOU prior to answering questions. Complete this form for each exhibit. If you have questions about this form, contact your program manager.

1. What evaluation procedures have you undertaken during the quarter, and what were their results?

2 ND Copies 2/16/93
All staff have met individually with the Program Manager on a monthly basis to review and informally evaluate their progress. Treatment Advocates were evaluated by the Program Manager on a monthly basis. All Treatment Advocates were evaluated by the Program Manager on a monthly basis. A list of results was produced and is currently being implemented. Two copies were provided for orientation and training for providing one-on-one treatment advocacy. *Waiting to Correction*

2. What significant program changes have occurred during the quarter (include scope, goals & objectives, timeline, staff, volunteers, etc.)?

Two new Treatment Advocates were hired to fill vacant positions during this quarter. One Treatment Advocate (Asian Pacific Islander) resigned after an initial trial period. A replacement candidate has been interviewed for the position.

3. Describe how the program has succeeded in meeting its goals, quarterly outcome objectives, and timelines.

Now that the EACH Program has been operating at full staff the Units of Service provision for the Treatment Advocacy portion of the contract has improved dramatically. Nevertheless, it will take some time to fully train the new staff so they will be fully aware of treatment information and policies and procedures. Otherwise the program is doing well in meeting its goals and timelines.

4. What types of problems has the program experienced during the quarter, and what steps have been taken towards their resolution?

The number of individual clients coming in to the program has been low. The hiring and training of new staff, the launching of paid advertisement campaigns, and more active recruitment and outreach should dramatically improve this situation in the remainder of the contract year.

5. What Quality Assurance (QA) activities took place during the quarter, and what were their results? Describe any changes in program procedures resulting from your QA review.

The Universal Precautions were reviewed by all staff. All staff also reviewed the Tb Protocol for the EACH Program and were instructed in compliance with this document.

6. Does your program maintain a waiting list?

YES	NO XXXXX
-----	----------

A) How long is that list? N/A

B) What is the average waiting time? N/A

7. Where does your program refer eligible clients who are awaiting services (include those not accepted onto a waiting list)?

EACH clients are referred to services after the initial intake. EACH maintains an extensive referral list for health-related and social services.

8. Systemwide, what gaps in available services have you noted?

None.



June 29, 1993

Randy Miller
 Director of Local Programs
 National Task Force on AIDS Prevention
 631 O'Farrell Street
 San Francisco, CA 94109

Dear Randy:

This letter concerns the Quarterly Reports recently resubmitted to the AIDS Office for FY 92-93. There are a number of problems which we need to ask that you correct. As you know, Quarterly Reports are routinely submitted late by the NTFAP and we ask that, in the future, reports be submitted by the fifteenth of the month following the close of the calendar quarter. Because of the funding cycle, there is an additional report covering the month of April for CARE Formula contracts. (Your CARE Quarterly Reports for April 1993 was due on May 15, 1993; kindly submit this report no later than Monday, July 26, 1993.) Quarterly Reports, even when resubmitted, have been incomplete and incorrect. I hope that the following information and instructions will be helpful in clarifying what is needed by the AIDS Office.

COMMUNITY EVENTS

For all Quarterly Reports related to **Community Events** (regardless of funding source), please attach a separate sheet to the back of each report which provides the following information:

- A list of all workshops and special events conducted with the dates, target community, units of service and number of participants;
- All outreach events attended (including type of event, date, length, and number of participants).

With regard to section II Client Information, Number of Client Served, on the statistical part of the Quarterly Report (Units of Service and Client Information): Item A3 (Number of New Individuals Served/Qtr.) should be the number of clients for whom demographics are provided on the remainder of the form. For example, if A3 is 100 individuals, gender should total 100, sexual orientation should total 100, age should total 100, etc. If you do not know the demographics of some clients (e.g., outreach events) you may show them as "unknown" for each demographic characteristic. In this case, reference the demographic characteristic on a separate sheet of paper and give an estimate where possible (e.g., ethnicity). For example, category E, Ethnicity, might appear as follows:

(10)	5 White/European American	(50)	2	American Indian, Alaskan Native
(20)	6 African American	(60)	0	Other..Specify
(30)	3 Latino/a	(99)	8	Unknown
(40)	2 Asian/Pacific Islander			

E. Ethnicity

Estimate of Unknown clients: 2 White/European American; 5 African American; and 1 Latino/a.

AIDS OFFICE

25 VAN NESS AVENUE, SUITE 500
 SAN FRANCISCO, CA 94102 - 6033

415 - 554-9000
 FAX 415 - 431-7547

The narrative part of the Quarterly Report (Question 1 entitled "Program Evaluation Update") should provide a summary of what evaluation activities have taken place **and the results** for the current contract year related to community events, including: (a) feedback from participants; (b) quarterly written staff evaluations of the program; and (c) annual written Management Team evaluation. Question 3 should describe what has been accomplished with respect to specific objectives in the contract and items scheduled to be accomplished on the contract timeline.

INDIVIDUAL TREATMENT ADVOCACY

For all Quarterly Reports related to **Individual Treatment Advocacy** (regardless of funding source), please attach a separate sheet to the back of each report which lists each type of service (e.g., intake & follow-up, brief encounters, and general outreach) with the units of service and number of individuals served (if applicable).

With regard to section II Client Information, Number of Client Served, on the statistical part of the Quarterly Report (Units of Service and Client Information): Item A3 (Number of New Individuals Served/Qtr.) should be the number of clients for whom demographics are provided on the remainder of the form. For example, if A3 is 20 individuals, gender should total 20, sexual orientation should total 20, age should total 20, etc. Demographics should be reported on all clients in all categories (gender, sexual orientation, age, etc.). **Please do not mark categories as "Data Not Available;" this information should be routinely collected by the program.** Clients served through "general outreach" should not be counted as unduplicated clients.

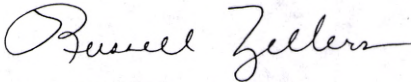
The narrative (Question 1 of the narrative entitled "Program Evaluation Update") should provide a summary of what evaluation activities have taken place **and the results** for the current contract year related to individual treatment advocacy, including: (a) client satisfaction surveys; (b) staff evaluations of the program; and (c) annual written Management Team evaluation. Question 3 should describe what has been accomplished with respect to specific objectives in the contract and items scheduled to be accomplished on the contract timeline.

We are asking that you revise all of your FY 92-93 reports in the following manner: (a) correct the statistical sections, including estimates for "unknown" demographic characteristics; and (b) add separate sheets with a description of educational events or types of individual treatment advocacy services provided. You need not bother with revising the narrative sections of your reports since I have requested this information in summary form under separate letter for purposes of preparing General Fund Monitoring Reports. In future reports, however, please include this specific information on evaluation activities and accomplishment of the objectives and timeline described in the contract.

Kindly make the indicated corrections or additions and submit this material to our office no later than Monday, July 26, 1993. I am enclosing a set of instructions for completing Quarterly Reports in the event that you do not have these available. Please call me at 554-9105 if you need further clarification on any of the reports listed above. David Makofsky can be reached at 554-9107 if you have general questions about the Quarterly Report. David and I would be happy to meet with you concerning data reporting if this would be of help to you or your staff.

Thank you for your assistance in providing the requested information in a timely manner.

Sincerely yours,

A handwritten signature in cursive script that reads "Russell Zellers". The signature is fluid and elegant, with the first name "Russell" and last name "Zellers" clearly distinguishable.

Russell Zellers
Program Manager

cc: Reggie Williams
Sophia Chang
Valerie Dorr
David Makofsky
Stella Cheung