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

Instructions: This form should be completed or updated at least once every 12 months by participants.

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

_____

Please consistently use this email address for registering for future programs or notify the AIDS Education and Training Center of change.

2. **Today's date:**

M	**M**	**D**	**D**	**Y**	**Y**	**Y**	**Y**

3. **Your Primary Profession/Discipline (Select one)**
   - o Dentist
   - o Other Dental Professional
   - o Nurse Practitioner/Nurse Professional (Prescriber)
   - o Nurse Professional (Non-Prescriber)
   - o Midwife
   - o Pharmacist
   - o Physician
   - o Physician Assistant
   - o Dietitian or Nutritionist
   - o Mental/Behavioral Health Professional
   - o Substance Use Disorder Professional
   - o Social Worker or Case Manager
   - o Community Health Worker (Includes Peer Educator Or Navigator)
   - o Clergy or Faith-Based Professional
   - o Practice Administrator or Leader (i.e., Chief Executive Officer, Nurse Administrator)
   - o Other Allied Health Professional (Specify, i.e., Medical Assistant, Physical Therapist-- Specify): _____
   - o Other Public Health Professional
   - o Other Non-Clinical Professional (i.e., Front Desk Staff, Grant Writer -- Specify): _____
   - o Other Clinical Professional (i.e., Podiatry, Chiropractor, Alternative Medicine Specialist, Wellness Specialist, Etc. -- Specify): _

4. **Your Primary Functional Role (Select one)**
   - o Administrator
   - o Agency Board Member
   - o Care Provider/Clinician – Prescribes HIV Treatment
   - o Care Provider/Clinician – Does Not Prescribe HIV Treatment
   - o Case Manager
   - o HIV Tester
   - o Client Educator (Includes Navigator)
   - o Clinical/Medical Assistant
   - o Health Care Organization Non-Clinical Staff (i.e., Front Desk)
   - o Intern/Resident
   - o Researcher/Evaluator
   - o Student/Graduate Student
   - o Teacher/Faculty
   - o City, Local, State Government Employee
   - o Federal Government Employee
   - o Other (Specify): _____

5. **Are you of Hispanic or Latinx origin?**

○Yes ○No ○Choose Not to Disclose

6. **What is your racial background? Select all that apply.**
   - o American Indian / Alaska Native
   - o Asian
   - o Black or African American
   - o Native Hawaiian or Other Pacific Islander
   - o White
   - o Choose Not to Disclose
   - o Other, Please Specify: _____

7. **What best describes your gender identity? Select one.**
   - o Man
   - o Woman
   - o Transgender Man
   - o Transgender Woman
   - o Other Gender Identity
   - o Choose Not to Disclose

8. **Which of the following characteristics best describe your principal employment setting? (Select one)**
   - o Academic Health Center
   - o Correctional Facility
   - o Emergency Department
   - o Federally Qualified Health Center
   - o Family Planning Clinic
   - o HIV or Infectious Diseases Clinic
   - o HMO/Managed Care Organization
   - o Hospital-Based Clinic
   - o Indian Health Services/Tribal Clinic
   - o Long-Term Nursing Facility
   - o Maternal /Child Health Clinic
   - o Mental Health Clinic
   - o STD Clinic
   - o Substance Use Treatment Center
   - o Student Health Clinic
   - o Other Community-Based Organization
   - o Pharmacy
   - o Military or Veterans' Health Facility
   - o Other Federal Health Facility
   - o Private Practice
   - o State or Local Health Department
   - o Dental Health Facility
   - o Other Primary Care Setting
   - o Principal Employment Setting Does Not Involve Direct Provision of Care or Services (Stop Here,
   - o 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 clients:**

   _ _ _ _ _
   _ _ _ _ _
   _ _ _ _ _

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

○Yes ○No

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

○Yes ○No

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

○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?**

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

16. **Do you provide services directly to <u>clients with HIV?</u>**

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

17. **How many <u>YEARS</u> have you been providing services directly to clients with HIV? Round up to the nearest whole year. If less than one year, write "01".**

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

19. **Which of the following best describes the way you provide services to clients with HIV:**
    - o Behavioral or Support Services, but not Antiretroviral Therapy (I.E. Case Management, Counseling, Cognitive Behavioral Therapy, Transportation, Legal)
    - o Clinical Services to People With HIV, but not Antiretroviral Therapy (I.E. Nutrition, Physical Therapy, Psychiatry, General Primary Care)
    - o Basic HIV Care and Treatment (Novice)
    - o Intermediate HIV Care and Treatment
    - o Advanced HIV Care and Treatment
    - o Expert HIV Care and Treatment, including Training Others and/or Clinical Consultation

For questions 20 through 22, estimate the percentage of your clients with HIV in the past YEAR.

20. **Estimate the PERCENTAGE of your clients with HIV in the past YEAR who are racial and ethnic minorities:**
    - o None
    - o 1-24%
    - o 25-49%
    - o 50-74%
    - o ≥75%

21. **Estimate the PERCENTAGE of your clients with HIV in the past YEAR with hepatitis B or hepatitis C:**
    - o None
    - o 1-24%
    - o 25-49%
    - o 50-74%
    - o ≥75%

22. **Estimate the PERCENTAGE of your clients with HIV in the past YEAR who are receiving antiretroviral therapy:**
    - o None
    - o 1-24%
    - o 25-49%
    - o 50-74%
    - o ≥75%