County of San Bernardino
Department of Public Health
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Website: www.iehpc.org

Riverside/San Bernardino California Transitional Grant Area

Maxwell Ohikhuare, MD
Interim County Health Officer Co-Chair

Gregory French
Community Co-Chair

Executive Committee

Thursday, April 10, 2014
9:00am-10:00am

Meeting Location
San Bernardino County Public Health
351 N. Mt. View
Planning Council Conference Room, B15
San Bernardino, CA 92415
(909) 693-0750

These facilities are in compliance with the Americans with Disabilities Act of 1992.

Agenda

Time	Item	Presenter
9:00 am	**1. Call to Order** ▪ Roll Call* ▪ Introductions	G. French
	2. Public Comments[1]	Members of the Public
	3. Members Privilege	PC Members
	4. Approval of Agenda[2]	G. French
	5. Approval of Minutes[2]	G. French
	6. Old Business[2]	Committee Members
	7. New Business[2] 7.1 Approval of Revised Needs Assessment Survey(A-1&2) 7.2 Approve Council Staff to coordinate Evaluation of Administrative Mechanism 7.3 Approve Council to conduct Council Member Self-Assessment	Members of the Public

Time	Item	Presenter
	8. Public Comments[1]	Members of the Public
	9. Members Privilege	PC Members
	10. Review of Action Item	PC Staff
	11. Agenda Setting for Next Meeting TBD	PC Members/ T. Evan
	12. Roll Call*	PC Staff
10:00am	**13. Adjournment**	G. French

[1] Public Comments: Any member of the public may address this meeting on items of interest that relate to the Ryan White CARE Act by completing a speaker slip to indicate their interest in addressing the Planning Council. A three-minute limitation will normally apply to each member of the public who wishes to comment, unless waived by the Chair.
[2] The agenda item may consist of a discussion and a vote. Public comments can be made prior to each Planning Council vote.
* Members must be present at both roll calls to receive credit for meeting attendance.
** Copies can be obtained at the I.E.H.P.C. office and will be available at the meeting.

Requests for special accommodations (e.g., language translation) must be received 72 hours prior to the date of the meeting. Contact PC Support at (909) 693-0750.

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Status on Pilot Testing for 2014 Needs Assessment

At the last Planning Committee on March 13, 2014, members of the committee expressed concerned over the length of the survey tool used in2011. The survey tool that was approved by PC consisted of 171 questions. Consultant and RW Program staff reviewed survey and based on *lessons* learned from the previous needs assessment and *limited resources for this needs assessment, s*urvey was modified to a shorter version that would focus on questions required specifically to assist PC members with their Priority Setting process during PSRA,

The shorter version consists of 66 questions. Since incentives were not available at this time, a small number of HIV consumers were pilot-tested. Five consumers completed the survey in English and three in Spanish. The time consumers took to complete the survey was ranged from 10 minutes to 20 minutes. Most of the consumers completed it fairly quickly. Consumers were asked if the survey was easy to understand and feedback received was that the section on ranking (i.e, *Most* Important) at the end of survey tool was a bit problematic; this seem to be consistent with the2011 N.A. survey. However, because this information is important for priority setting, consultant feels it should be in survey.

In addition to pilot testing, sample size for the *2014 needs assessment* was determined using local epidemiological data reported in the TGA. An estimate of the target population was drawn from the year ending 2012, HIV/AIDS prevalence of 8,518 in the TGA. Epidemiological data for year ending 2013 is not currently available. The sample size estimate was determined using a 95% confidence level and a margin sampling error of plus or minus 10%. Calculations with the HIV/ADS prevalence of 8,518 provided the estimated range for an adequate sample size to be 95 using a confidence interval of 10%.; 163 for a 99% confidence level.

Respectfully,

Janet Velez, MPH

Pilot Test

2014 Needs Assessment Survey

Thank you for completing this survey. The purpose of this needs assessment is to help us develop services and programs to support clients/patients like you.

We appreciate your participation.

Before we start, let me ask you some questions to be sure you qualify to complete this survey:

1. ***Are you at least 18 years old?***

   O **Yes** O **No, PLEASE**

 You DO NOT qualify to take survey.

2. ***Do you live in Riverside or San Bernardino County?***

   O **Yes** O **No, PLEASE**

 You DO NOT qualify to take survey.

3. ***Are you HIV Positive or have ever been diagnosed with AIDS?***

   O **Yes** O **No, PLEASE**

 You DO NOT qualify to take survey.

If you have answered yes to ALL three questions you qualify to take this survey.

We realize some of the questions may be sensitive. **This survey is 100% confidential.** Your HIV/AIDS medical care or access to any other HIV services will not be affected, regardless of whether or not you complete the survey.

This survey will take about 15 minutes to complete.

For Office Use Only:

Date Completed ___/___/___ ***Survey Administrator***___________________________________

Data Entered ___/___/___ ***Initials***_____________

GENERAL INFORMATION

1. **When were you born? ____________________**
   (Month/year)

2. **What county do you live in? (***check ☑one)*
   - ❒ Riverside County
   - ❒ San Bernardino County

3. **What is your zip code?_____________________**

4. **What is your gender?** *(check ☑one)*
   - ❒ Male
   - ❒ Female
   - ❒ Transgender (Male to Female)
   - ❒ Transgender (Female to Male)

5. **What is your race/ethnicity?** (*Choose ☑all that apply*)
   - ❒ African American/Black
   - ❒ Asian
   - ❒ Latino(a)/Hispanic
   - ❒ Native American/ Alaska Native
   - ❒ Pacific Islander /Native Hawaiian
   - ❒ White/Caucasian
   - ❒ Other (specify)________________

6. **Which language do you speak most of the time?***(check ☑one)*
   - ❒ English
   - ❒ Spanish
   - ❒ American Sign Language
   - ❒ Other, Please specify_________________

7. **What is the highest education level you completed?** *(check ☑one)*
   - ❒ 8th Grade or less
   - ❒ Some high school, but did not graduate
   - ❒ High school graduate or GED
   - ❒ Associates Degree
   - ❒ Vocational/technical certification
   - ❒ Some college, but did not graduate
   - ❒ Bachelors Degree
   - ❒ Master's Degree or higher
   - ❒ Other, ________________________

8. **What is your status?** *(check ☑one)*
   - ❒ U.S. citizen
   - ❒ Legal resident, but not a U.S. citizen
   - ❒ Have a visa
   - ❒ Undocumented
   - ❒ Other, specify______________
   - ❒ Don't Know

9. **Including yourself, how many persons live in your household?**
   [**Note:** Include partner, spouse, children, and anyone you are making a home with.]
   ____

10. **What is your total average MONTHLY income?** (i.e., you and other members of household)?
    $________________

GENERAL LIVING

11. **Which best describes your current employment?** *(check ☑one)*
    - ❒ Not working
    - ❒ Not working, but looking for work
    - ❒ Part-time work (<35 hours a week)
    - ❒ Full-time work (35 hours a week or more)
    - ❒ Other, Please specify___________________________________

12. **What is the source of your income?** *(Check ☑ all that apply)*
    - ❒ Job
    - ❒ SSI (Supplemental Security Income)
    - ❒ SSP (State Supplementary Payment)
    - ❒ SSDI (Social Security Disability Income)
    - ❒ CalWorks
    - ❒ General Relief
    - ❒ TANF (Temporary Assistance to Needy Families)
    - ❒ Workers' Compensation
    - ❒ Pension or retirement
    - ❒ Other, Please specify___________ _________________________

13. **<u>In the past 12 months</u>, have you been homeless even once?** *(check ☑one)*
    - ❒ Yes
    - ❒ No

14. **Describe your current living situation?***(check ☑one)*
    - ❒ Living alone
    - ❒ Temporary/transitional housing
    - ❒ Living with roommates
    - ❒ Living with partner/spouse
    - ❒ Living with family member
    - ❒ Homeless
    - ❒ Other, Please specify_________________________

15. **How long have you been in your current living situation?***(check ☑one)*
    - ❒ 0 – 90 days
    - ❒ 91 – 180 days
    - ❒ 181 days to 1 year
    - ❒ More than 1 year
    - ❒ Don't Know

16. **Do you receive any type of financial assistance to pay for your housing?** (*Choose ☑all that apply*)
    - ❒ None
    - ❒ Section 8 (how much?$______________)
    - ❒ HOPWA (how much? $______________)
    - ❒ Roommates share the rent/mortgage (how much? $______________)
    - ❒ Spouse/partner pays the rent/mortgage
    - ❒ Family or another person pays the rent/mortgage
    - ❒ Other (specify)

17. **Do you receive any type of financial assistance to pay for your utilities**? (*Choose ☑all that apply*)
   - ❐ None
   - ❐ Home Energy Assistance Program (HEAP) (how much?$_______________)
   - ❐ Southern California Edison Low-Income Program
   - ❐ The Gas Company Low-Income Program
   - ❐ Other (specify)

18. **In the past 12 months, have you received any help with buying food?** (*Choose ☑all that apply*)
   - ❐ I didn't receive any help
   - ❐ Food Stamps
   - ❐ WIC Assistance
   - ❐ Community/church food bank
   - ❐ Hot meal program
   - ❐ Food voucher
   - ❐ Other, Please specify ___________________________________

ACCESS TO CARE

19. **When did you first test HIV-positive?**

   ____
   (month/year)

20. **What is the most likely way you were infected with HIV?** *(check ☑one)*
   - ❐ Having sex with a man
   - ❐ Having sex with a woman
   - ❐ Having sex with a transgender person
   - ❐ Sharing needles
   - ❐ Transfusion or organ donation
   - ❐ I was born with it
   - ❐ Jail or prison
   - ❐ Other, Please specify_______________________
   - ❐ Don't know

21. **Where were you living at that time?***(check ☑one)*
   - ❐ California (what city?____________________)
   - ❐ Other State
   - ❐ Outside United States

22. **Do you have an <u>AIDS</u> diagnosis?***(check ☑one)*
   - ❐ Yes
   - ❐ No, Please skip to **Question #25**
   - ❐ Don't know, Please skip to **Question #25**

23. **When were you diagnosed with AIDS**? _______________
   (month/year)

24. **Where were you living at that time?** *(check ☑one)*
   - ❐ California (what city?____________________)
   - ❐ Other State
   - ❐ Outside United States

25. **After your HIV diagnosis, how soon did you seek HIV-related medical care?***(check ☑one)*

- ❒ Less than 1 month
- ❒ 1 to 3 months
- ❒ 4 to 6 months
- ❒ 7 months to less than a year
- ❒ One year or more, Please skip to **Question #28**
- ❒ I have not received medical care yet, Please skip to **Question #28**

26. **After your diagnosis, who helped you get medical care?** *(Check ☑One)*

- ❒ HIV testing provider
- ❒ Myself
- ❒ Spouse or Partner
- ❒ Friend/Family member/Neighbor/Priest or Pastor
- ❒ HIV case manager
- ❒ Outreach worker
- ❒ Mental health or substance abuse provider
- ❒ Other, Please specify_________________ _________________________

27. **After your diagnosis, why did you wait more than a year to receive medical care or why have you never received it?** *(Check ☑all that apply)*

- ❒ I did not/do not want to receive HIV-related medical care
- ❒ No one told me that I needed to get HIV-related medical care
- ❒ I did not/do not feel sick
- ❒ I did not/do not know where to go for HIV-related medical care
- ❒ I used/use alternative therapies (e.g., herbs, vitamins, acupuncture)
- ❒ I did not/do not have money or health insurance to pay for medical care
- ❒ I was/am actively using drugs or alcohol or relapsed after my diagnosis
- ❒ No transportation
- ❒ They were not/are not open when I could get there
- ❒ I'm worried someone might find out about my HIV diagnosis
- ❒ I could not find a clinic that spoke my language
- ❒ Other, Please specify____

28. **Do you currently have health insurance?***(check ☑one)*

- ❒ Yes
- ❒ No, Please skip to **Question #33**

29. **What type of insurance do you have?** (*Choose ☑all that apply*)

- ❒ Private health insurance (e.g., Blue Cross, Kaiser Permanente, Health Net)
- ❒ Medicare
- ❒ Medicare Advantage Plan
- ❒ Medi-Cal
- ❒ Healthy Families or Healthy Kid's Program
- ❒ IEHP (Inland Empire Health Plan)
- ❒ The military, CHAMPUS, TriCare, or the Veteran's Administration
- ❒ COBRA
- ❒ CARE HIPP
- ❒ Don't know
- ❒ Other, Please specify____

30. **With my health insurance, I have to pay**…*(Check ☑ all that apply)*
   - ❒ Monthly premium (amount $__________)
   - ❒ Co-payment at the time of my doctor's visit (amount $_______ per visit)
   - ❒ Deductible (amount $__________ before my insurance pays)
   - ❒ Medi-Cal Share of cost (amount $______)
   - ❒ Don't know

31. **I have difficulty paying my**…*(Check ☑ all that apply)*
   - ❒ Monthly premium
   - ❒ Co-payment
   - ❒ Deductible
   - ❒ Medi-Cal Share of cost

32. **How do you pay for your HIV medications**? *(check ☑ all that apply)*
   - ❒ I am not taking any HIV medications
   - ❒ Cash
   - ❒ AIDS Drug Assistance Program (ADAP)
   - ❒ Private health insurance (e.g., Blue Cross, Kaiser Permanente)
   - ❒ Medicare Part D
   - ❒ Medicare Advantage Plan
   - ❒ Medi-Cal
   - ❒ Healthy Families or Healthy Kid's Program
   - ❒ IEHP (Inland Empire Health Plan)
   - ❒ The military, CHAMPUS, TriCare, or the Veteran's Administration
   - ❒ COBRA
   - ❒ Don't know
   - ❒ Other, Please specify____

33. **Is there one place in particular, like a doctor's office or clinic, where you usually go to for care for any sort of medical problem?**
   (check ☑ one)
   - ❒ Yes
   - ❒ No, Please skip to **Question #38**
   - ❒ Don't Know, Please skip to **Question #38**

34. **How many miles do you travel to get to your doctor or healthcare provider for your HIV-related medical care?** *(check ☑ one)*
   - ❒ 1 mile or less
   - ❒ 2-10 miles
   - ❒ More than 10 miles
   - ❒ Don't know

35. **How long does it take to get to your doctor or health care provider for your HIV-related medical care?** *(check ☑ one)*
   - ❒ 0-15 minutes
   - ❒ 16-30 minutes
   - ❒ 31-60 minutes
   - ❒ More than an hour

36. **What type of transportation do you use to get to your doctor or health care provider for your HIV-related medical care?** *(check ☑one)*

- ❒ I walk
- ❒ I ride a bicycle
- ❒ My car or motorcycle
- ❒ I get a ride with someone else
- ❒ Public transportation (i.e., bus)
- ❒ Medical transportation van
- ❒ Taxi
- ❒ Other (specify)

37. **What type of dental insurance do you have? (***check ☑one)*

- ❒ I don't have dental insurance
- ❒ Denti-Cal
- ❒ Private Insurance or HMO (e.g., Delta Dental)
- ❒ Other (please specify_______________)

38. **How many miles do you travel to go to your dentist?***(check ☑one)*

- ❒ I don't have a dentist
- ❒ 1 mile or less
- ❒ 2-10 miles
- ❒ More than 10 miles
- ❒ Don't know

39. **In the past 12 months, has anyone reviewed your eligibility for:** (*Choose ☑all that apply*)

a. Medi-Cal	❒ Yes	❒ No	❒ Don't Know	❒ Not Applicable
b. AIDS Drug Assistance Program (ADAP)	❒ Yes	❒ No	❒ Don't Know	❒ Not Applicable
c. Medically Indigent Services Program (MISP)	❒ Yes	❒ No	❒ Don't Know	❒ Not Applicable
d. Covered California – Insurance Marketplace to purchase health insurance	❒ Yes	❒ No	❒ Don't Know	❒ Not Applicable
e. Financial Programs (e.g., SSI, SSDI, GR)	❒ Yes	❒ No	❒ Don't Know	❒ Not Applicable
f. Food Stamps	❒ Yes	❒ No	❒ Don't Know	❒ Not Applicable

HEALTH, WELL BEING, AND CARE EXPERIENCE

40. **Have you received any of the following in the past 12 months?**
(*Choose ☑all that apply*)

- ❒ CD4 test
- ❒ Viral load test
- ❒ Anti-retroviral medications for HIV
- ❒ No, I have not received these tests or medications in the past 12 months.

41. **How long has it been since you have been to your doctor or healthcare provider for your HIV-related medical care?***(check ☑one)*
    - ❒ Less than 1 year
    - ❒ 1-3 years, Please skip to **Question #44**
    - ❒ More than 3 years, Please skip to **Question #44**
    - ❒ I don't go to the doctor, Please skip to **Question #45**

42. **During the last 12 months, have you missed any HIV-related medical appointments?***(check ☑one)*
    - ❒ Yes, how many?___________- What is the main reason?________________________ __________________________________)
    - ❒ No

43. **In the past 3 years, have you ever stopped seeing your doctor for HIV-related medical care for more than 12 months?***(check ☑one)*
    - ❒ Yes (what is the main reason you stopped?____________________________________)
    - ❒ No

44. **Do you currently take any HIV-related medications?** *(check ☑one)*
    - ❒ Yes, Please skip to **Question #47**
    - ❒ No

45. **Why aren't you taking any HIV-related medications?**
    (Choose ☑all that apply)
    - ❒ The doctor says I don't need them right now
    - ❒ I don't feel sick
    - ❒ I am doing alternative treatment
    - ❒ I can't pay for the medications
    - ❒ My insurance ended
    - ❒ Other, Please specify____

46. **Do you have trouble taking your HIV-related medications as prescribed?** *(check ☑one)*
    - ❒ Yes
    - ❒ No, Please skip to **Question #49**

47. **What is the main reason you are having trouble?***(check ☑one)*
    - ❒ I forget
    - ❒ They make me feel sick
    - ❒ I don't like taking pills
    - ❒ I am drunk or high and don't remember
    - ❒ I am depressed
    - ❒ **I am homeless**
    - ❒ I don't know how to take them
    - ❒ Other, Please specify____________________

48. **When was your last dental check-up?***(check ☑one)*
    - ❒ Within past year
    - ❒ More than 1 year ago
    - ❒ Never been to the dentist
    - ❒ Don't need to go - I have dentures or don't have teeth
    - ❒ Don't remember

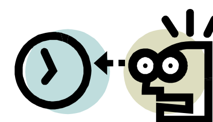
49. **When was the last time you had your teeth cleaned?***(check ☑one)*
- ❒ Within past year
- ❒ More than 1 year ago
- ❒ Never been to the dentist for teeth cleaning
- ❒ Don't need to go - I have dentures
- ❒ Don't remember

50. **When was your last nutrition screening?***(check ☑one)*
- ❒ Within past year
- ❒ More than 1 year ago
- ❒ Never had a nutrition screening
- ❒ Don't remember

51. **Do you currently have or have you been told by a doctor or health professional that you have had any of the following conditions, either now or in the past 12 months?** (*Choose ☑all that apply*)

Health Condition	I **currently** have this condition…	I had this condition in the **past 12 months**…	I am receiving or already received **treatment**
Syphilis	❒	❒	❒
Gonorrhea	❒	❒	❒
Chlamydia	❒	❒	❒
Human papillomavirus (HPV)	❒	❒	❒
Other STD	❒	❒	❒
Hepatitis A	❒	❒	❒
Hepatitis B	❒	❒	❒
Hepatitis C	❒	❒	❒
Tuberculosis	❒	❒	❒
Cancer	❒	❒	❒
Heart Disease	❒	❒	❒
High Blood Pressure	❒	❒	❒
High Blood Cholesterol	❒	❒	❒
Diabetes (Type I or Type II)	❒	❒	❒
Stroke	❒	❒	❒
Sickle Cell Anemia	❒	❒	❒

Not much longer to complete the Survey!



SUBSTANCE USE AND MENTAL HEALTH HISTORY

52. **When did you last use any of the following substances:** Please select ☑ one column for each Substance

Substance	Never Used	Used in Past 30 days	Used in Past 12 months	Used More than 1 year ago
Tobacco	❒	❒	❒	❒
Alcohol	❒	❒	❒	❒
Marijuana (other than medical use)	❒	❒	❒	❒
Crystal Methamphetamine	❒	❒	❒	❒
Heroin	❒	❒	❒	❒
Cocaine/ Crack	❒	❒	❒	❒
LSD/Acid/Other Hallucinogens	❒	❒	❒	❒
Club Drugs (X, G, Special K, etc.)	❒	❒	❒	❒
Other (specify)	❒	❒	❒	❒

53. **In the past 12 months, have you used a needle to inject street drugs?** *(check ☑one)*
    - ❒ Yes
    - ❒ No

54. **Have you ever been told by a doctor or other health care professional that you have any of the following mental health conditions?**
    (*Choose ☑all that apply*)
    - ❒ No, I don't have any mental health conditions
    - ❒ Depressive Disorder
    - ❒ Generalized Anxiety Disorder
    - ❒ Post-Traumatic Stress Disorder
    - ❒ Bipolar Disorder
    - ❒ Schizophrenia
    - ❒ Alzheimer's or Dementia
    - ❒ Other, specify______________

INCARCERATION HISTORY

55. **Have you ever been in jail or prison?** *(check ☑one)*
    - ❒ Yes
    - ❒ No, Please skip to **Question #63**

56. **During the past 3 years, were you in jail or prison for more than 1 month?** *(check ☑one)*
    - ❒ Yes
    - ❒ No, Please skip to **Question #59**

57. **What type of facility were you in?** *(check ☑one)*
    - ❒ Local jail
    - ❒ State prison
    - ❒ Federal prison

- ❒ Juvenile Detention

58. **Did you become HIV positive while incarcerated?***(check ☑one)*
    - ❒ Yes
    - ❒ No

59. **Did you receive HIV-related medical care during incarceration?**
    (check ☑one)
    - ❒ Yes
    - ❒ No (why not?)

60. **After you were released, did you have trouble getting medical care or HIV-related medications?***(check ☑ one)*
    - ❒ Yes
    - ❒ No

61. **What prevented you from getting the medical care or HIV-related medications that you needed?**
    (*Choose ☑ all that apply*)

- ❒ I don't know where to go for help
- ❒ The paperwork is too complicated
- ❒ Services and information are not available in my language
- ❒ I don't have insurance or money to pay for services
- ❒ Attitude of staff
- ❒ The agency or staff lacks skills working with minorities
- ❒ Service is too far away from my home
- ❒ I don't have transportation
- ❒ I can't get an appointment
- ❒ Waiting list is too long
- ❒ The agency overbooks appointments
- ❒ Hours of operation are not convenient
- ❒ No childcare available
- ❒ I've called the agency but no one calls me back
- ❒ Service provider is not caring
- ❒ Service provider has a bad reputation
- ❒ I'm afraid of being seen by my friends/ family/ neighbors
- ❒ I'm afraid that the staff won't keep my privacy
- ❒ I'm afraid of discrimination
- ❒ I'm afraid of being deported
- ❒ I don't want people to think I'm gay
- ❒ I don't trust the staff or agency
- ❒ I perceive racism by the doctor or healthcare provider
- ❒ I perceive racism by the agency or staff
- ❒ There is no one of my race/ethnicity that works at the agency
- ❒ I perceive discrimination because I'm a lesbian/gay/bisexual/transgender person
- ❒ There are no lesbian/gay/bisexual/transgender people that work at the agency
- ❒ I was using alcohol or drugs
- ❒ I was depressed
- ❒ I don't want to be around other sick people
- ❒ Other, Please specify____________________

____

____

Hang in there almost done with survey!

62. **Please identify all of the services that you Need and Use**

Services	**In the last 12 months, did you NEED this service? (Y=Yes; N=No; DK=Don't Know)** *(check ☑ one)*			**In the last 12 months, did you USE this service? (Y=Yes; N=No)** *(check ☑ one)*		**If you need the service but are not using it, why not?**
CORE SERVICES	**Y**	**N**	**DK**	**Y**	**N**	
Visit with a doctor, nurse, or physician assistant to take care of your HIV medical care	❒	❒	❒	❒	❒	
Help to pay for HIV medications	❒	❒	❒	❒	❒	
Visit with a dentist, hygienist, or dental assistant to take care of oral health problems or have teeth cleaned	❒	❒	❒	❒	❒	
Access **Early Intervention Services** which includes counseling and referrals about HIV/AIDS , testing, medical care and other services to help me stay in medical care	❒	❒	❒	❒	❒	
Receive financial assistance such as Health Assistance Premiums to pay your insurance premiums	❒	❒	❒	❒	❒	
Receive financial assistance to help pay your insurance deductible, share of cost, or co-payments.	❒	❒	❒	❒	❒	
Receive home health care services by licensed health care workers such as a nurse.	❒	❒	❒	❒	❒	
Receive home and community-based health care services in your home, including durable medical equipment, home health aides, and personal care services.	❒	❒	❒	❒	❒	

Services	In the last 12 months, did you NEED this service? (Y=Yes; N=No; DK=Don't Know) *(check ☑ one)*			In the last 12 months, did you USE this service? (Y=Yes; N=No) *(check ☑ one)*		If you <u>need</u> the service but <u>are not using</u> it, why not?
CORE SERVICES	**Y**	**N**	**DK**	**Y**	**N**	
Receive hospice services	☐	☐	☐	☐	☐	
Receive mental health services individually or in a group (psychological and psychiatric treatment and counseling) provided by a licensed mental health professional.	☐	☐	☐	☐	☐	
Receive medical nutritional therapy provided by a registered dietician.	☐	☐	☐	☐	☐	
Receive medical nutritional supplements (such as Boost, Ensure, etc.)	☐	☐	☐	☐	☐	
Have session(s) with a medical case manager to help you coordinate your HIV/AIDS **medical** care and help you access other services/benefits.	☐	☐	☐	☐	☐	
Receive education and counseling from a nurse on ways to help you take your HV medications and stay on your HIV treatment.	☐	☐	☐	☐	☐	
Receive individual and/or group outpatient substance abuse treatment or counseling	☐	☐	☐	☐	☐	
Receive referrals for specialty medical care services <u>not</u> related to HIV (e.g., cancer, heart disease, etc)	☐	☐	☐	☐	☐	

63. From the list of core medical services, please choose the service that is **Most Important** for you = **1**
Then select the service that is the next **Most Important** for you = **2**
Then select the service that is the next **Most Important** for you = **3**
Then select the service that is the next **Most Important** for you = **4**
Then select the service that is the next **Most Important** for you = **5**

Most Important	Service
1	
2	
3	
4	
5	

64. **Please identify all of the support services that you Need and Use**

Services	In the last 12 months, did you NEED this service? (Y=Yes; N=No; DK=Don't Know) *(check ☑ one)*			In the last 12 months, did you USE this service? (Y=Yes; N=No) *(check ☑ one)*		If you need the service but are not using it, why not?
SUPPORT SERVICES	**Y**	**N**	**DK**	**Y**	**N**	**DESCRIBE BARRIER**
Receive counseling, information, and/or help to obtain medical, social, community, legal, financial and any other services you might need.	☐	☐	☐	☐	☐	
Receive child care while you attend medical or other HIV-related appointments	☐	☐	☐	☐	☐	
Receive emergency financial assistance to help pay for utilities (i.e., gas, water, electric)	☐	☐	☐	☐	☐	
Receive assistance to pay for food or groceries.	☐	☐	☐	☐	☐	
Receive education or counseling about HIV, HIV transmission, and how to reduce the risk of HIV transmission	☐	☐	☐	☐	☐	
Receive help in finding an affordable place to live	☐	☐	☐	☐	☐	
Receive short-term financial assistance to support emergency, temporary, or transitional housing	☐	☐	☐	☐	☐	
Receive assistance with HIV legal issues (e.g., discrimination, making a will, etc.)	☐	☐	☐	☐	☐	
Receive legal assistance to help you plan for your minor age children or family if you are deceased.	☐	☐	☐	☐	☐	
Receive interpretation or translation services or sign language assistance.	☐	☐	☐	☐	☐	
Receive transportation assistance to help you get to your medical appointments.	☐	☐	☐	☐	☐	

Services	In the last 12 months, did you NEED this service? (Y=Yes; N=No; DK=Don't Know) *(check ☑ one)*			In the last 12 months, did you USE this service? (Y=Yes; N=No) *(check ☑ one)*		If you need the service but are not using it, why not?
SUPPORT SERVICES	**Y**	**N**	**DK**	**Y**	**N**	**DESCRIBE BARRIER**
Participate in emotional support groups for persons living with HIV (may be led by peers or non-clinical staff)	❒	❒	❒	❒	❒	
Receive information or referrals for HIV services from telephone, online, or printed materials	❒	❒	❒	❒	❒	
Receive rehabilitative services such as physical, occupational, or speech therapy	❒	❒	❒	❒	❒	
Receive inpatient substance abuse treatment or counseling where you need to stay overnight for several days.	❒	❒	❒	❒	❒	
Receive counseling or education to help me stay on my HIV medications from peers or non-medical staff.	❒	❒	❒	❒	❒	
Receive information, education, or training from peers and/or agency staff on how you can manage your HIV disease	❒	❒	❒	❒	❒	

65. From the list of support services, please choose the service that is the highest priority for you **Most Important** = **1**

Then select the service that is the next **Most Important** for you = **2**

Then select the service that is the next **Most Important** for you = **3**

Then select the service that is the next **Most Important** for you = **4**

Then select the service that is the next **Most Important** for you = **5**

Most Important	Service
1	
2	
3	
4	
5	

We appreciate the time you took to complete this survey and providing us with important information on how to improve services for you.

Thank you!