Health Education/Risk Reduction Program
2009-2012

Data Collection Procedure Manual

County of Los Angeles
Department of Public Health
Office of AIDS Programs and Policy

Table of Contents

Introduction

Office of AIDS Programs and Policy

The Office of AIDS Programs and Policy (OAPP) coordinates the overall response to HIV/AIDS in Los Angeles County in collaboration with community-based organizations, governmental bodies, advocates and people living with HIV/AIDS. It also sets the standards of care for HIV/AIDS services provided countywide. OAPP articulates and recommends HIV/AIDS-related policies and positions for the consideration of the Department of Public Health and the Los Angeles County Board of Supervisors. It serves as liaison with policy makers, local and national organizations to achieve policy objectives relevant to services for people with HIV/AIDS. OAPP receives funding from the Health Resources and Services Administration (HRSA), the Centers for Diseases Control and Prevention (CDC), the State of California Office of AIDS and the Los Angeles County Department of Public Health. OAPP utilizes fiscal resources to manage approximately 400 contracts within a network of more than 100 community-based organizations and ten County departments in an effort to maximize access to services for persons with HIV/AIDS.

Office of AIDS Programs and Policy Mission

To respond to the HIV/AIDS epidemic in Los Angeles County by preventing its spread, maximizing health and social outcomes, and coordinating effective and efficient targeted services for those at risk for, living with, or affected by HIV.

Overview of the OAPP HIV Health Education/Risk Reduction Procedure Manual

This training manual offers a comprehensive and detailed explanation of data collection and reporting for OAPP-funded HIV Health Education/Risk Reduction (HE/RR) programs. The goal of this manual is to function as a reference for agency staff on the protocol, procedures, requirements, goals and expectations of OAPP-funded HE/RR data collection and data reporting.

Technical Assistance

Office of AIDS Programs and Policy

600 South Commonwealth Ave., 10th Floor
Los Angeles, CA 90005
Office Hours Monday – Friday:
8:00 a.m. - 4:30 p.m.
Tel. number: 213-351-8000

Data Team Contact Information

Title	Name	Phone Number	Email
Planning and Research Division – Data Management			
Chief Research Analyst	Mike Janson, MPH	(213) 351-8355	mjanson@ph.lacounty.gov
Data Manager/Data Collection Liaison	Candice Rivas	(213) 351-8352	crivas@ph.lacounty.gov
Evaluation Specialist	Pamela Ogata	(213) 351-8398	pogata@ph.lacounty.gov
Prevention Services Division – Program Management			
Section Manager	Paulina Zamudio	(213) 351-8059	pzamudio@ph.lacounty.gov
HERR Program Supervisor	Lisa Delgadillo	(213) 351-8092	ldelgadillo@ph.lacounty.gov
Program Manager	Jesse Campos	(213) 351-8367	jcampos@ph.lacounty.gov
Program Manager	Alicia Moody	(213) 351-8189	amoody@ph.lacounty.gov
Program Manager	Maxanna Brooks	(213) 351-8274	mbrooks@ph.lacounty.gov
Program Manager	Kamaria Gray	(213) 351-1145	kgray@ph.lacounty.gov

Contact the following for specific questions about:

- **Data Submission:** Data Manager/Data Collection Liaison (Candice Rivas)
- **Evaluation/Quality Management:** Evaluation Specialist (Pamela Ogata)
- **Monthly Reports:** OAPP Program Manager
- **Quarterly Reports:** OAPP Program Manager
- **Questions on how to complete the forms:** OAPP Program Manager or Warm-line
- **Reimbursement:** OAPP Program Manager

> **IMPORTANT:** When in doubt, first contact your OAPP Program Manager.

November 30, 2009   5

Technical Assistance

Office of AIDS Programs and Policy

600 South Commonwealth Ave., 10th Floor
Los Angeles, CA 90005
Office Hours Monday – Friday:
8:00 a.m. - 4:30 p.m.
Tel. number: 213-351-8000

Data Team Contact Information

Title	Name	Phone Number	Email
Planning and Research Division – Data Management			
Chief Research Analyst	Mike Janson, MPH	(213) 351-8355	mjanson@ph.lacounty.gov
Data Manager/Data Collection Liaison	Candice Rivas	(213) 351-8352	crivas@ph.lacounty.gov
Evaluation Specialist	Pamela Ogata	(213) 351-8398	pogata@ph.lacounty.gov
Prevention Services Division – Program Management			
Section Manager	Paulina Zamudio	(213) 351-8059	pzamudio@ph.lacounty.gov
HERR Program Supervisor	Lisa Delgadillo	(213) 351-8092	ldelgadillo@ph.lacounty.gov
Program Manager	Jesse Campos	(213) 351-8367	jcampos@ph.lacounty.gov
Program Manager	Alicia Moody	(213) 351-8189	amoody@ph.lacounty.gov
Program Manager	Maxanna Brooks	(213) 351-8274	mbrooks@ph.lacounty.gov
Program Manager	Kamaria Gray	(213) 351-1145	kgray@ph.lacounty.gov

Contact the following for specific questions about:

- **Data Submission:** Data Manager/Data Collection Liaison (Candice Rivas)
- **Evaluation/Quality Management:** Evaluation Specialist (Pamela Ogata)
- **Monthly Reports:** OAPP Program Manager
- **Quarterly Reports:** OAPP Program Manager
- **Questions on how to complete the forms:** OAPP Program Manager or Warm-line
- **Reimbursement:** OAPP Program Manager

> **IMPORTANT:** When in doubt, first contact your OAPP Program Manager.

Emergency Contacts

For unanticipated adverse events related to HE/RR data collection activities please contact:

Mike Janson, MPH (mjanson@ph.lacounty.gov, 213 351-8355) or Paulina Zamudio (pzamudio@ph.lacounty.gov, 213 351-8059).

Warm-line Information

Warm-line telephone number: (213) 351-8352

The purpose of the warm-line is to have a dedicated method to provide technical support for HE/RR data reporting issues. OAPP staff will respond to all queries within 24 business hours.

Please include the following information when leaving a detailed message on the data collection warm-line:

1. Caller name and Agency
2. Day and time called
3. Telephone number for where caller can be reached
4. Brief description of the issue or question

HIV Health Education/Risk Reduction

Overview

In 2003, the Institute of Medicine (IOM) called for "evidence based" decision making across all public health sectors. The IOM further recommended that HIV prevention efforts utilize interventions of proven efficacy to avert as many new infections as possible. In response to the IOM, several federal agencies, including the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Service Administration (SAMHSA) and the National Institute of Drug Abuse (NIDA) among others, have emphasized evidence-based interventions as part of their strategic national prevention plans. OAPP supports programs that are rooted in behavioral theory as well as based on evidence as described in the Los Angeles County HIV Prevention Plan: 2009-2013 http://ph.lacounty.gov/aids/PreventionPlan.htm

The delivery of Health Education/Risk Reduction (HE/RR) services is a powerful approach in the prevention of HIV. HE/RR services include outreach to high-risk HIV-negative and HIV-positive persons, interventions delivered to individuals (IDI) and/or groups (IDG), community-level interventions (CLI), structural interventions, and comprehensive risk counseling and services (CRCS). HE/RR also includes health communication and public information programs for targeted at-risk population and the general public.

Effective Interventions

"Evidence-based" or effective interventions are 1) evaluated for efficacy and 2) acceptable to the target audience. Two types of evaluation activities used to measure effectiveness or the success of an intervention are outcome monitoring and outcome evaluation.

Outcome Monitoring

Outcome monitoring is the collection of data about client/participant knowledge, attitudes, beliefs and behaviors (KABBs), and intentions to change behavior before, during and/or after the intervention. Outcome monitoring identifies what components or activities of an intervention are working as expected and which ones are not.[1]

Outcome Evaluation

Outcome evaluation is the collection of data on changes in client/participant KABBs and compares these results to another group of participants not in the intervention. It provides evidence that the intervention is causing the intended changes. It also measures whether or not the program is being delivered as planned.[2]

In addition to understanding if the intervention was successful in changing client/participant knowledge, attitudes, beliefs and/or behaviors, it is also important to

---

[1] Los Angeles County Comprehensive HIV Prevention Plan, 2009-13
[2] Los Angeles County Comprehensive HIV Prevention Plan, 2009-13

assess who participated in the intervention, was the intervention implemented as originally designed, and what barriers did clients/participants experience in accessing the intervention? Two additional evaluation activities that help answer these questions are process monitoring and process evaluation.

Process Monitoring

Process monitoring is the routine documentation of data describing the characteristics of the population served, the services provided, and the resources used to deliver those services. Process monitoring helps both agency staff and OAPP program managers to identify problems with program operations and delivery for program improvement.

Process Evaluation

Process evaluation is the assessment of a program's conformity to its design, program implementation, and the extent to which it reaches its intended audience. Process evaluation assists an agency in knowing whether or not the implementation of the program adheres to the original program, which is especially important if an agency wants to turn their locally developed intervention into an effective behavioral intervention (EBI).

The result of any of the above four evaluation activities is the accumulation of data or information.

Data

Although data and information are collected from individuals, the way data are collected and reported is either aggregate or client-level.

Aggregate-level data
- Information or data are not linked to a specific client/participant. For example, age, race, and gender are collected but it is not possible to determine how many 65 year old, Native American men participated in the intervention. It is possible to count how many 65-year-old individuals participated in the intervention, but you will not know what their race is or what gender they are.

Client-level data
- Information or data are linked to a specific client/participant by some unique identifier (usually it is a client ID).
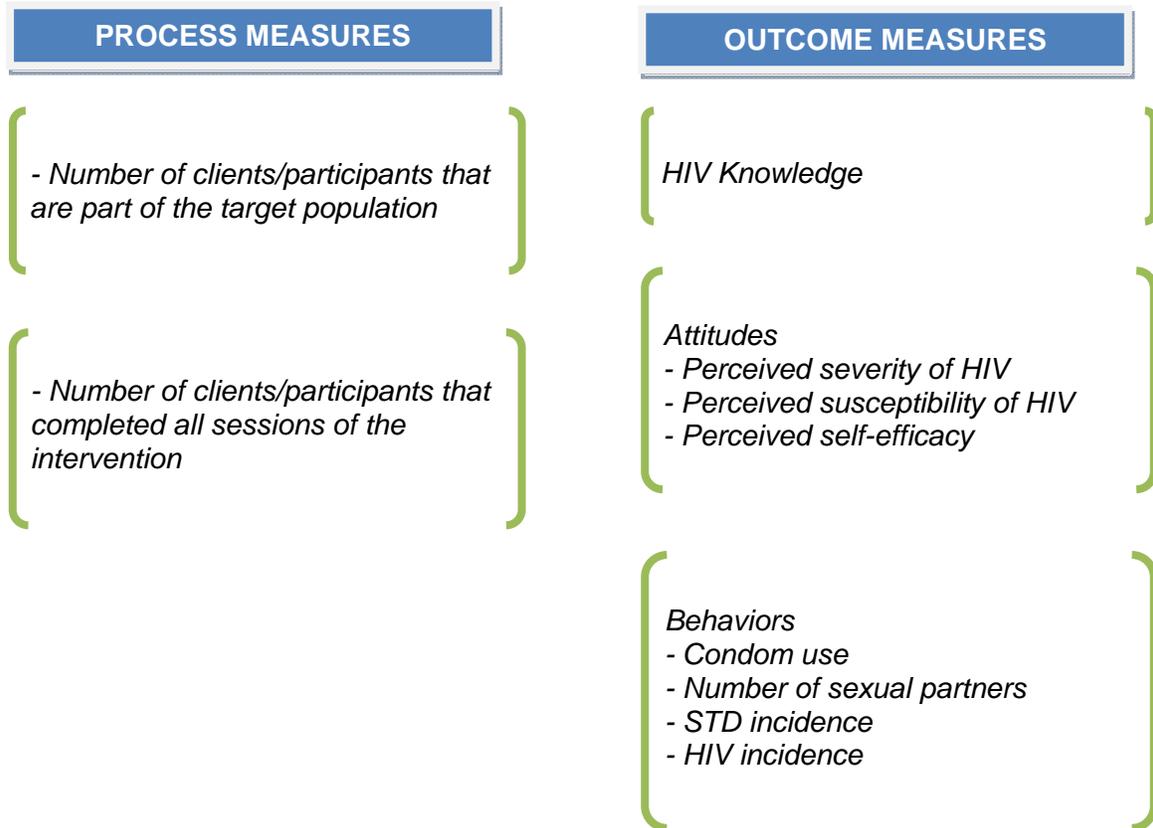- Client-

HE/RR Program Objectives

The objectives of HE/RR prevention services are to:

1. Determine the acceptability of the intervention/program by the target population

2. Determine the effectiveness or success of the intervention or program.

Program objectives are measured by standardized or common process and outcome measures.

PROCESS MEASURES	OUTCOME MEASURES

- Number of clients/participants that are part of the target population

HIV Knowledge

- Number of clients/participants that completed all sessions of the intervention

Attitudes
- Perceived severity of HIV
- Perceived susceptibility of HIV
- Perceived self-efficacy

Behaviors
- Condom use
- Number of sexual partners
*- STD incidence*
- HIV incidence

Data Collection, Submission Process, and Procedures

STEPS TO SUCCESSFUL DATA SUBMISSION

1. **Produce Data Collection Forms**
   - Original HE/RR data collection forms and cover sheet can be obtained from an **OAPP Program Manager** or online at http://ph.lacounty.gov/aids/Contractors.htm.

   - Print one copy on an ink jet or laser printer (this will be the original). When printing the PDF file, under the **"Print"** dialogue box, you must choose **"None"** under the heading **"Page Scaling", so** that the copy matches the dime**nsions** originally set when **creating the** form. If this option is not chosen, the printed copy of the form will actually be smaller than it should be, increasing the chances that the scanning software may be unable to read the data (see below).
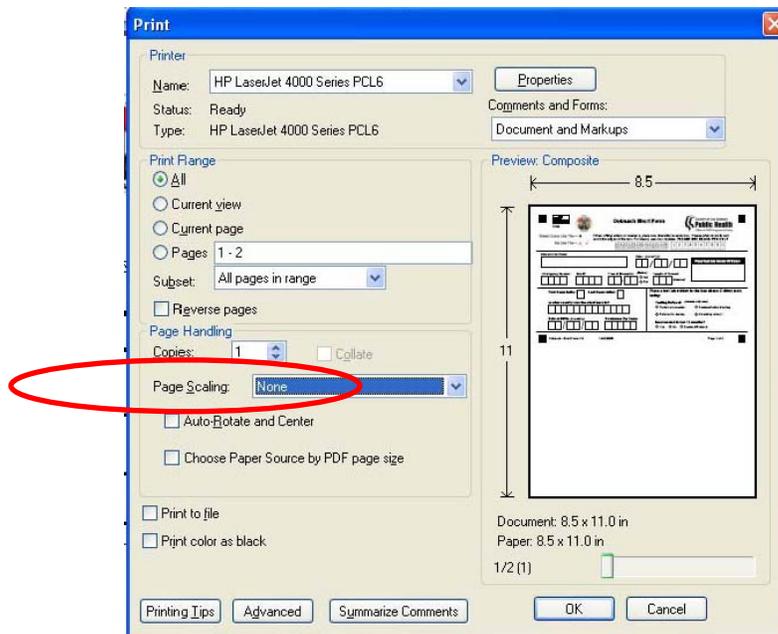
   - Copies should only be made from a master hard copy (provided by OAPP Program Managers) or directly from a printed PDF form.

   - Make copies of the original on a photocopier (these copies are called first generation copies). Do not make copies on a fax machine.

   - Make sure that all copies are aligned correctly and that each copy **contains the dark boxes** on each of the four corners of the form. These boxes provide the

positional guidelines so that the scanning software can locate areas that need to be scanned.

- Copies of forms **must be double-sided**.

- Only use original or first generation copies of the forms. It is critical that the four square boxes in each corner are completely black and filled.

> **IMPORTANT:** DO NOT make copies of first generation photocopies. The scanning software will not be able to read the data from second or third-generation photocopies. Photocopies that cannot be read by the software may be returned to the provider. Scanning equipment is very sensitive and will consider a form "poor quality" even if the quality of the form "looks" good.

To reduce the number of forms that are returned to the agency, please follow the procedures above and only use original or first generation forms. If the scanning equipment cannot read the forms, they will be returned to the providers. Providers may need to transcribe these forms onto first-generation photocopied forms.

Figure 1. Data Submission Flowchart
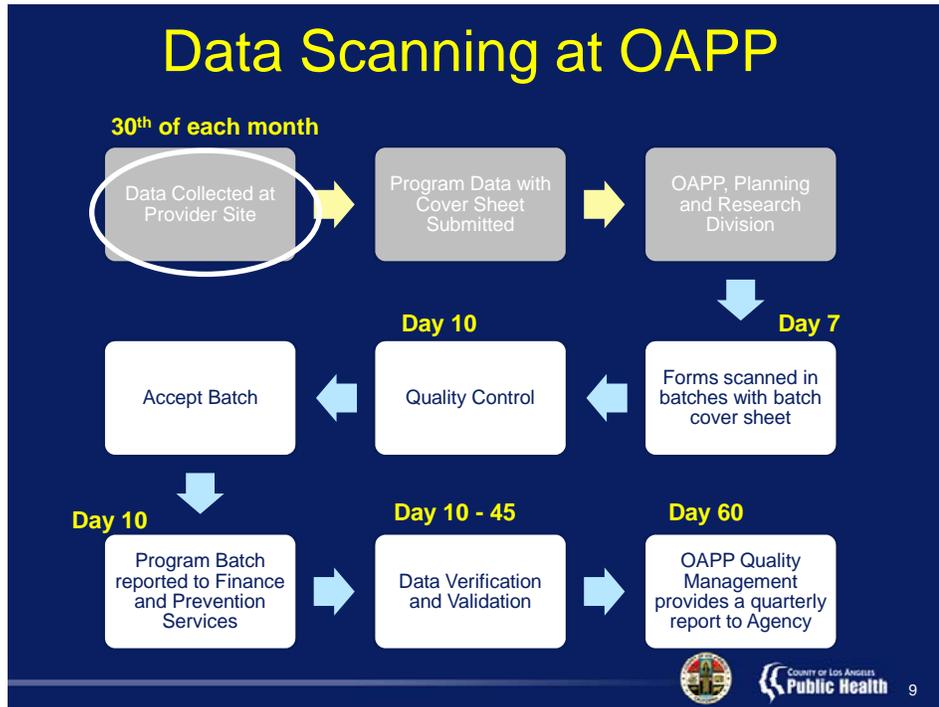
1. Data Collected at Provider Site

a. Use the correct form. Remember there are different forms for each intervention type and the form will change depending on which session of the intervention you are conducting. If you have questions about which form to use 1) refer to Table 1 (p. 20) in the procedure manual, 2) contact your OAPP Program Manager, or 3) call the Warm-line.

> **IMPORTANT:** All forms that are missing even one required variable/field will be returned to the agency. If the information to complete the form is not available then the agency will not receive credit for providing services to the client/participant.
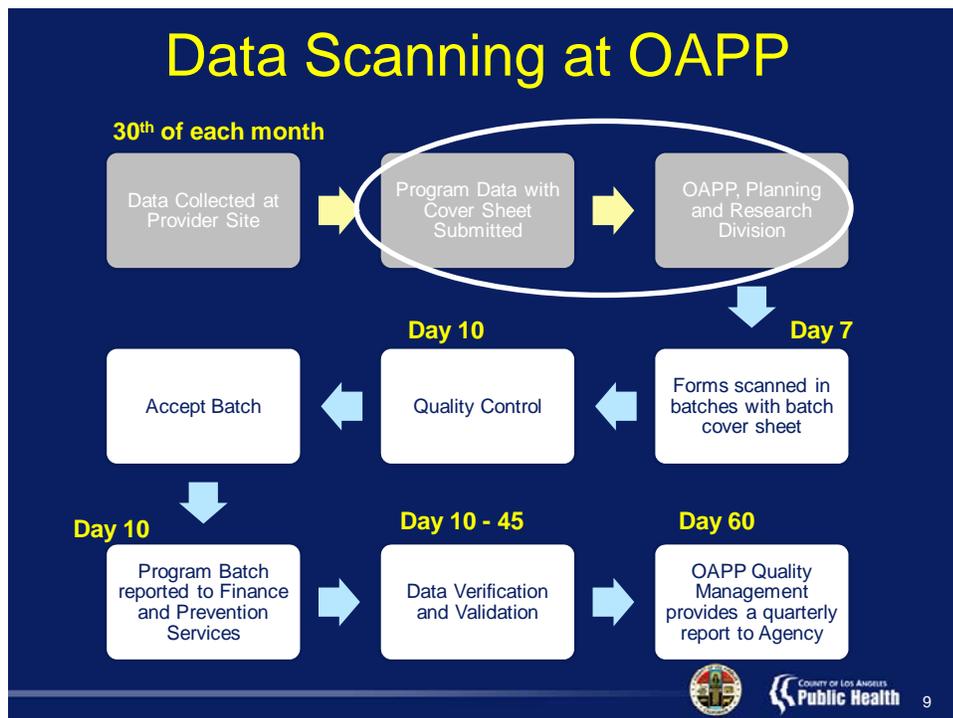
b. Complete the forms, especially all required variables/fields. All information are critical.

Data Scanning at OAPP
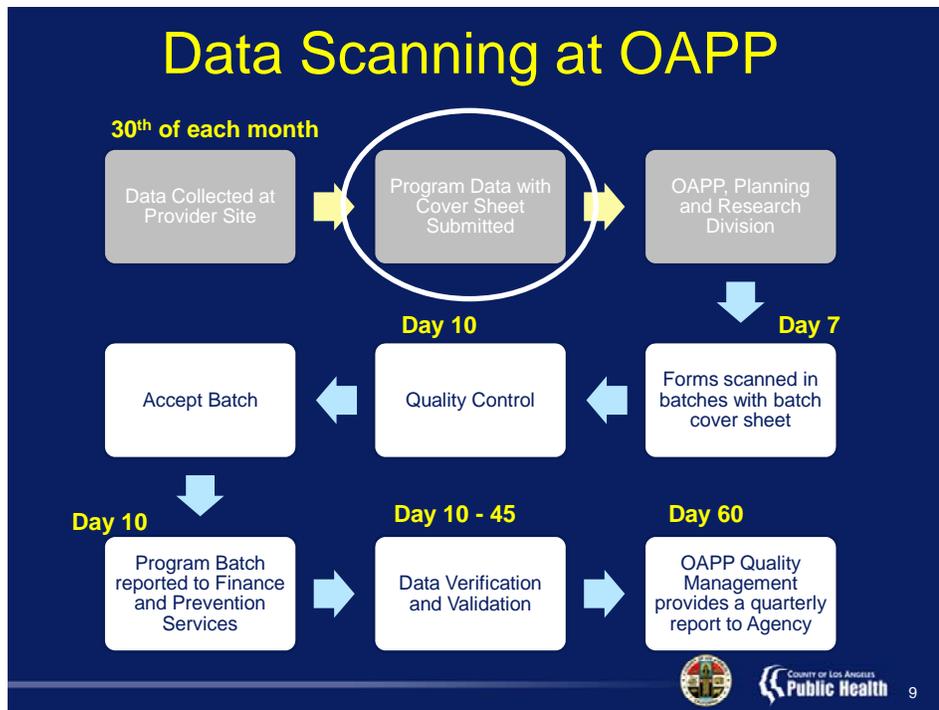
2. Prepare Forms for Submission

   a. Agency program managers/coordinators should conduct a quality assurance check by reviewing all forms for completeness and legibility prior to submitting the forms to OAPP.

- Make sure all pages are in sequential order.
- All forms should be accounted for and equal to the number of forms indicated on the cover sheet.
- Make sure circles are shaded in completely.
- Text should be printed as outlined in the protocol.
- All required variables should be completed.
- Make sure that questions requiring only one answer have one response selected.
- Check for internal consistencies with answers (e.g. for sexual health history, if a client indicates that they have never tested for HIV before, the field for date of last HIV test result should be blank).

   b. Individual data collection forms should be stapled and the pages should be in order.

   c. Include the approved data collection cover sheet (see Appendix A, page 71).

- Indicate how many of each form are being submitted for each intervention type.
- Cover sheet must be signed by the HE/RR program manager/coordinator.
- Record the unique four digit number for the agency.

- Contact your OAPP Program Manager if you do not know your Agency ID number.

Data Scanning at OAPP

30th of each month

Data Collected at Provider Site → Program Data with Cover Sheet Submitted → OAPP, Planning and Research Division

Day 10 **Day 7**

Accept Batch ← Quality Control ← Forms scanned in batches with batch cover sheet

Day 10

Program Batch reported to Finance and Prevention Services

Day 10 - 45

Data Verification and Validation

Day 60

OAPP Quality Management provides a quarterly report to Agency

County of Los Angeles Public Health

9

3. **Method of Delivery**
   a. **Hand deliver to the 10th Floor receptionist and address the package to Planning and Research Division**

   b. **Via Mail (standard or Express)**

   c. **Electronic Transmission (see below)**

4. **Due Date:** Forms are due to (received by) OAPP no later than the 30th of the following month. For example, data collected in December 2009 are due to OAPP no later than January 30, 2010.

> **IMPORTANT:** Not submitting forms by the deadline may delay payment and reimbursement for services. All forms are due (received) no later than the 30th of the following month.

Remote Scanning Option

A program may have the option of scanning forms on site and sending forms to OAPP through our Secure File Transmission Protocol (SFTP) providing that several criteria are met and your OAPP Program Manager has approved. A few of these criteria include having a compatible scanner, the ability to communicate with our SFTP through our

remote scanning software, and the capacity to maintain necessary equipment and connectivity. Contact your OAPP Program Manager for details.
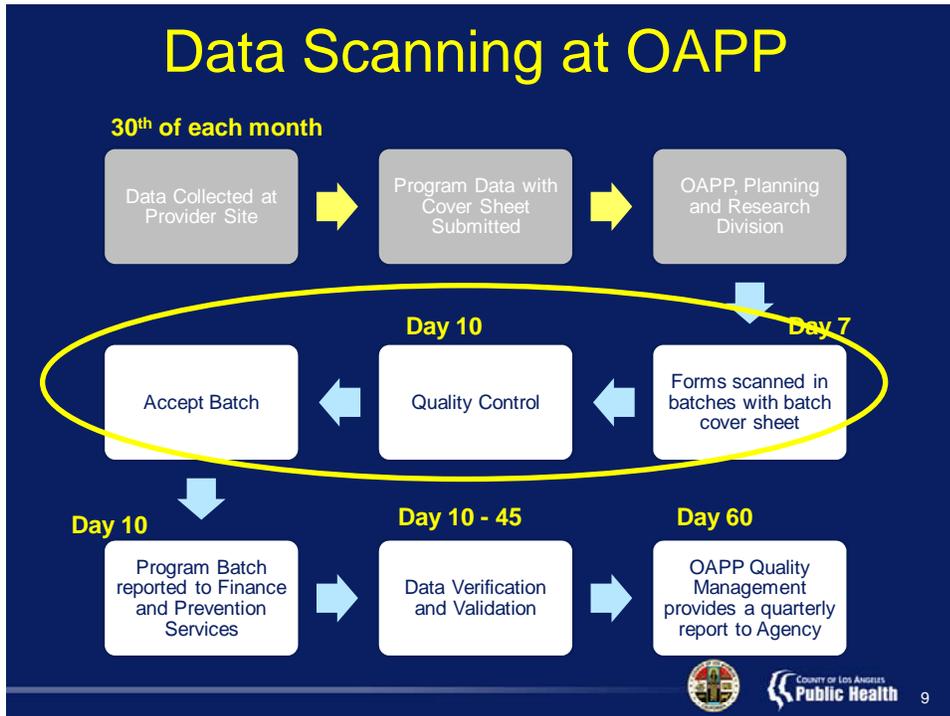
5. Once OAPP Planning and Research Staff receive the forms, OAPP staff will scan the HE/RR forms and the cover sheet in batches within seven (7) days from the time OAPP receives the forms.

6. On Day 7 (from the time OAPP receives the forms) until the 30th of the month, agency staff can pick up the forms from OAPP 10th floor reception between 9:00 a.m. and 4:30 p.m.

7. Between Day 7 and Day 10, Forms will be checked for quality. The Quality Control procedure ensures:

    a. All required variables are complete

    b. All pages of each form are readable (first generation forms, legible writing style)

    c. The number of forms received matches the number indicated on the cover sheet

If conditions a, b, and c listed above are not met, the forms will be rejected.
If conditions a, b, and c listed above are all met, the forms will be approved.

8. **Accepted/Rejected Forms:** By Day 10, OAPP Planning and Research staff will generate a program data collection form report. Listing of accepted and rejected forms will be sent to OAPP Financial Services Division and Prevention Services Division for payment processing, as well as to providers.
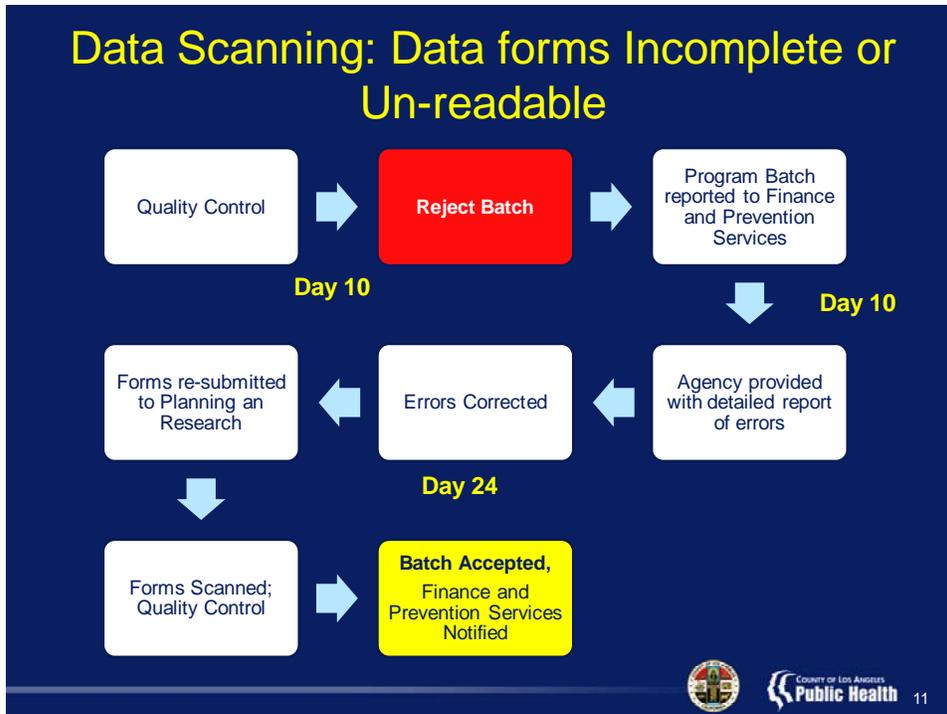
a. Programs will have two (2) weeks to fix errors and resubmit the revised data collection forms with a new cover sheet.

b. The process will start again from item 5 above until all errors are corrected.

> **IMPORTANT:** Rejected data collection forms **may** delay payment and reimbursement for services as well as contribute to missing data in quarterly reports provided to agencies and the community.

Steps to Ensure Data Quality

Poor quality data cannot and should not be used for prevention planning or program evaluation. There are various things that can lead to poor quality data. Some examples are too many missing values, answer choices are not legible, multiple answers were provided for a field that asks for only one answer choice, etc. Below is a list of dos and don'ts for collecting data on OAPP's standardized forms. This list was created to ensure that the data in Los Angeles County are high quality data.

DO……..

- When writing text or numbers, stay within the boundaries of the text box. Do not allow characters to cross over into an adjacent box –the software will not pick up any text outside of these boundaries.

- Only a single character (whether it is a letter or number) should be placed in each text box (if the text field consists of multiple boxes). If the text box consists of a single text field, please write the text within those boundaries.

- Please read the instructions carefully after each question in order to know when to fill out multiple answer choices **(*choose all that apply)*), or a single answer choice (***choose only one*)**.

- Please read the instructions carefully since there may be **skip instructions** or **instructions referring to different time-frames**.

- When writing down characters/letters in text fields, **please start with the text box on the left-hand side and move left to right**.

- Fill in leading zeros.

Length of Contact:
(0) 3 0 (minutes)

- If you make a mistake when writing numbers or text, cross out the mistake with one horizontal line, and write the correct response directly above the error. If you have made several mistakes, please start over with a blank form.

Date: *(mm/dd/yy)*
1 1 / 2 0 / 0 9 ~~1 0~~

- If you made a mistake and incorrectly marked an answer choice or marked multiple answer choices when the question only allows for a single answer choice (or anything else of that nature), please indicate which mark is the correct/intended choice. OAPP staff will verify that choice and correct it when verifying the scanned data. If many mistakes were made on the forms, please start over with a new form.

Session: (mark only one)

✗ **Session 1**

● **Final Session**

○ **30 Day Follow Up**

- ONLY use black or blue ink on the forms.

- Print alphabets using all **UPPER CASE LETTERS**.

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

- Print numbers in the following manner.

1	2	3	4	5	6	7	8	9	0

- ONLY print or copy the forms on standard **WHITE** paper.

- Print forms with multiple pages **DOUBLE-SIDED**.

- Staple forms with multiple pages at the **TOP MIDDLE** of the page.

DON'T……..

- Do not place staples through the cornerstones or form ID.

- Do not submit poor quality forms.

- Do not make Xerox copies of submitted forms prior to submitting them to OAPP.

- Do not mark N/A, not applicable, or print any other markings in text boxes that do not apply to your client/participant. For example, if the client did not select "Other" as an answer choice then the "Specify" text box does not apply. In this case, leave the box blank. Do not mark or write in the box.

- Do not use white out or correction tape on the forms.

- Do not make stray marks on the forms near the cornerstones (black boxes in each corner of every page) or over the form ID (located in the top left corner of each page).

- Do not use a pencil, highlighter, or any other color ink other than black or blue ink to complete the forms.

- Do not print or copy the forms on color paper, or paper that is heavier than 20 pounds.

- Do not use lower case letters. Lower case letters can be confused with other letters and some numbers.

HE/RR Data Verification and Validation

In addition to the review and checks agency program coordinators conduct prior to submitting the forms to OAPP and the quality check conducted at OAPP by Planning and Research staff, data not read by the scanning software will be verified by OAPP staff. The percentage of data which need verification can vary; however, current OAPP-funded programs using this technology demonstrate that about 50% of text fields need to be verified while <5% of choice (bubble) fields need verification. In addition, some of the data are randomly selected to go through a final data validation process in which final data are compared to hard-copy data collection forms. Approximately five percent (5%) of all forms will be verified for completeness and internal accuracy using this methodology. This process is done to ensure a high quality and data accuracy. Prevention planning, resource allocation, data sharing, and program improvement are conducted routinely based on the data received.

> **IMPORTANT:** These data are not only used locally for prevention planning and accountability, but also on a national level. OAPP is required to send HE/RR data to CDC.

HE/RR Quarterly Data Report

OAPP Program Managers will provide each agency a data report every three months (quarterly). This data report will contain progress toward goals and a summary of outcome measures.

HE/RR Data Collection and Submission Requirements

HE/RR Data Collection Forms

There are several different HE/RR data collection forms. The forms you will need to use for your HE/RR program will depend on 1) the intervention type that is used in your program, 2) the number of sessions for each intervention type, and 3) the language your client reads (for self-administered forms). The table below is a listing of all HE/RR forms, whether the form is administered by agency staff or self-administered by the client, and when each form should be completed.

Table 1. HE/RR Forms

Form Name	Administered by	Frequency of Completion					
		First Session/ Baseline	In-Between Sessions	Final Session	30 Day F/U	60 Day F/U	90 Day F/U
IDI/CRCS	**Agency staff**	X		X		X	
Administrative	**Agency staff**		X		X (for IDI/ CRCS)		X (for IDI/ CRCS)
Outreach	**Agency staff**	X					
Group Self Administered Questionnaire (English or Spanish)	**HE/RR client**	X		X	X		

Completing HE/RR Data Collection Forms

Required Fields

All variables/fields are critical in measuring the acceptability of the intervention, effectiveness of the intervention, to document the activities of the intervention, and to provide evidence that the intervention was conducted (administrative information). However, the following table includes a list of "REQUIRED" variables/fields. These fields are required either for financial reimbursement or because the data must be reported to CDC.

Table 2. Required Fields

Variable/Field	HE/RR FORM			
	Outreach	IDI/CRCS	GSAQ	Administrative
First Initial of Client Name	X	X	X	X
Last Initial of Client Name	X	X	X	X
Date of Session/Outreach/Follow-up	X	X	X	X
Program ID	X	X	X	X
Site ID	X	X	X	X
Date of Birth	X	X	X	X
Resident Zip Code	X	X	X	X
Gender Identity	X	X	X	X
Race/Ethnicity	X	X	X	NR
Intervention Type	NR	X	X	X
Session Number	NR	X	X	X
HIV Status	NR	X	X	NR
Sharing Injection Paraphernalia	NR	X	X	NR
Sexual Behavior	NR	X	X	NR
Sexual Orientation	NR	X	X	NR

NR=Not Required

> **IMPORTANT: If any of these fields are missing, the form will be returned to the agency.**

Outreach Encounters

A. Intervention, Client Identification, Testing Referral, and Client Demographic Variables/Fields in the Outreach Form
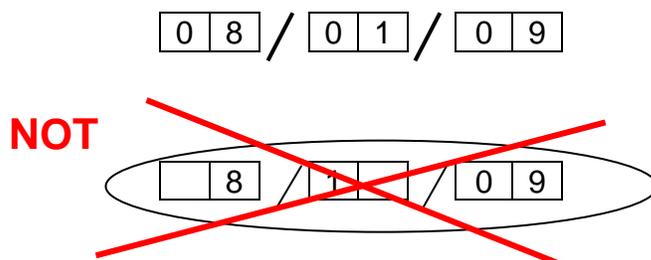
This form should be completed:
- on all clients/participants participating in an outreach encounter, -and-
- by agency staff in a one-on-one interview with the client/participant.

1. **Program ID is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the unique four digit number for the agency.
   - The Program ID is assigned to each agency by OAPP. Agencies cannot create their own four digit Program ID.
   - Contact your OAPP Program Manager if you do not know your Program ID number.

2. **Site ID is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the unique four digit number corresponding to the site where the program is conducted.
   - Site IDs are assigned to each agency by OAPP. Agencies cannot create their own four digit Site IDs.
   - Contact your OAPP Program Manager if you do not know which Site ID to record on this form.

3. **Date is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the date of this intervention session or follow-up session.
   - Print the two digit month in the first two boxes.

- Print the two digit day in the third and fourth box.
- Print the last two digits of a four digit year in the last two boxes.
- If the month, day, or year contains a zero, fill in the zero. **Do not leave any of the squares blank.**
- For example, if the date is August 1, 20<u>09</u> the date field should look like this.

$$\boxed{0}\boxed{8}\ /\ \boxed{0}\boxed{1}\ /\ \boxed{0}\boxed{9}$$

NOT

$$\boxed{\ }\boxed{8}\ /\ \boxed{\ }\boxed{\ }\ /\ \boxed{0}\boxed{9}$$

4. Time of Encounter
- Record the time that this session of the intervention or follow-up started.
- Record the time using a 12 hour format.

5. Length of Contact
- Record the length of contact in minutes.
- For example, if the session lasted 1.5 hours then put the number 090 in the boxes.
- If you don't know how long the session lasted, place 999 in the boxes.

6. Client Initials are a "required" field. This variable/field must be completed or the form will be rejected.
- Record the first initial of the client/participant's FIRST NAME in the first box.
- Record the first initial of the client/participant's last name in the second box.

> **IMPORTANT:** This variable/field is one of the fields used to create the unique client identification number. If this information is not legible, missing, or incorrect then the information collected at other sessions, follow-up and HIV testing cannot be linked. If information cannot be linked, it will not be possible to monitor or measure the outcomes of the intervention or program performance indicators.

7. Country of Origin
- Record the name of the country that the client/participant was born.

8. Date of Birth is a "required" field. This variable/field must be completed or the form will be rejected.
- Record the client/participant's date of birth.
- Print the two digit month in the first two boxes.
- Print the two digit day in the third and fourth box.

- Print the last two digits of a four digit year in the last two boxes.
- If the month, day, or year contains a zero, fill in the zero. **Do not leave any of the squares blank.**
- For example, if the date is August 1, 19<u>79</u> the date field should look like this.

$$\boxed{0\ \ 8}\ /\ \boxed{0\ \ 1}\ /\ \boxed{7\ \ 9}$$

NOT

$$\boxed{\ \ \ 8}\ /\ \boxed{1\ \ \ }\ /\ \boxed{7\ \ 9}$$

9. **Residence Zip Code is a "required" field.** This variable/field must be completed or the form will be rejected.
   - This question should be asked EVERY time this form is completed. It is possible for your client/participant to move during the intervention or follow-up sessions. This is especially true for homeless individuals.
   - If your client/participant is homeless, ask for the zip code of the place where the client/participant spent the night last night. If you are unable to determine after asking this, if the client does not know, or if client refuses, enter a "9" in each of the boxes as the answer on the form. Do not leave this variable/field blank.

10. **Incarcerated**
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

11. **Testing Referral**
   - This question should be asked of ALL clients/participants, not just those who state that they do not know their HIV status.
   - Select only one answer choice by completely filling in the corresponding bubble/circle.
   - If the client's/participant's answer choice is "Tested at encounter", then place the lab sticker in the box on the form. The lab sticker must be aligned with the box.

B. Client Demographics and Target Population Variables/Fields in the Outreach Form

1. **Gender Identity is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Select **only one** answer choice ("Male", "Female", "Transgendered M to F", or "Transgendered F to M") for this variable by completely filling in one bubble/circle.

   1a. Gender at Birth
   - Select **only one** answer choice ("Male", or "Female") for this variable by completely filling in one bubble/circle.

2. **Race/Ethnicity is a "required" field.**
   - Select as many answer responses that apply to the client/participant by completely filling in the bubble(s)/circle(s).
   - If one of the answers selected is "Other Race", please list the other race(s) in the text box, field 2a.

   2a. Specify Other Race
   - Only complete this variable/field if "Other Race" was selected.
   - Record the race(s) in the box.
   - Do not write outside the box. Any information that is printed outside the box will not be read by Teleform.

3. **Homeless Status**
   - Select only one answer choice by completely filling in the bubble/circle.
   - If the client declines to state his/her homeless status, select the answer choice "Unable or unwilling to give any information as to homeless status."
   - Select one answer choice, do not leave this field blank.

4. **Target Population**
   - Ask the client/participant questions to identify if he/she belongs to a target population.
   - Select as many answer responses that apply to the client/participant by completely filling in the bubble(s)/circle(s).

Intervention Designed for Individuals and Comprehensive Risk and Counseling Services (IDI and CRCS)

This form should be completed:
   - on all clients/participants participating in an **individual-level** intervention or comprehensive risk counseling and services program,
   - by agency staff in an one-on-one interview with the client/participant, in a private place,
   - on the first session of the intervention,
   - on the last session of the intervention, -and-
   - on the 60 day follow-up session.

When to complete the IDI/CRCS Forms

Form Name	Administered by	Frequency of Completion					
		First Session/ Baseline	In-Between Sessions	Final Session	30 Day F/U	60 Day F/U	90 Day F/U
IDI/CRCS	**Agency staff**	X		X		X	
Administrative	**Agency staff**		X		X		X

A. Session, Intervention, Agency, and Site Identification Variables/Fields in the IDI/CRCS Form
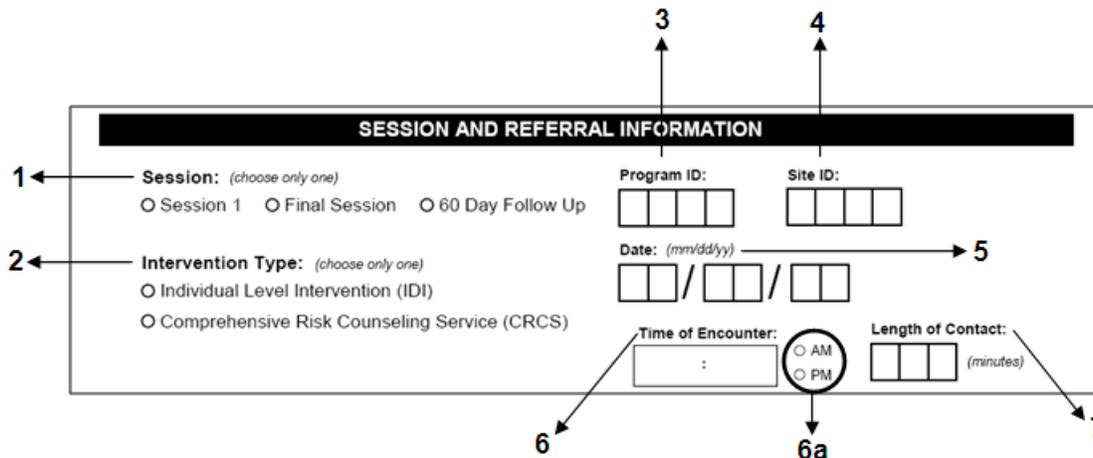
1. **Session number is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Select "Session 1" if this is the client/participants first session of the current IDI or CRCS intervention.
   - Select "Final Session" if this is the last session of the current IDI or CRCS intervention. Usually, the "Final Session" will be Session 3 of an IDI and Session 5 of a CRCS program.
   - Select "60 Day Follow Up" if this is the 60 day follow-up session since the Final Session.
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

2. **Intervention Type is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Select "Individual Level Intervention" if this is an intervention designed for individuals (IDI)
   - Select "Comprehensive Risk Counseling Service" if this is a more intensive program that is usually sessions long and includes a program plan.
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

3. **Program ID is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the unique four digit number for the agency.
   - The Program ID is assigned to each agency by OAPP. Agencies cannot create their own four digit Program ID.
   - Contact your OAPP Program Manager if you do not know your Program ID number.

4. **Site ID is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the unique four digit number corresponding to the site where the program is conducted.
   - Site IDs are assigned to each agency by OAPP. Agencies cannot create their own four digit Site IDs.
   - Contact your OAPP Program Manager if you do not know which Site ID to record on this form.

5. **Date is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the date of this intervention session or follow-up session.
   - Print the two digit month in the first two boxes.
   - Print the two digit day in the third and fourth box.
   - Print the last two digits of a four digit year in the last two boxes.
   - If the month, day, or year contains a zero, fill in the zero. **Do not leave any of the squares blank.**
   - For example, if the date is August 1, 20<u>09</u> the date field should look like this.

$$0\ 8\ /\ 0\ 1\ /\ 0\ 9$$

Not

$$\boxed{}\;8\;/\;\boxed{1}\;/\;\boxed{0}\;\boxed{9}$$

6. **Time of Encounter**
   - Record the time that this session of the intervention or follow-up started.
   - Record the time using a 12 hour format and include both hours and minutes.

   6a. AM/PM
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

7. **Length of Contact**
   - Record the length of contact in minutes.
   - For example, if the session lasted 1.5 hours then put the number 090 in the boxes.
   - If you don't know how long the session lasted, place 999 in the boxes.

B. Referral Source, Testing Referral, and Additional Referral Variables/Fields in the IDI/CRCS Form

1. Source of Referral. This variable/field should only be completed at the **FIRST SESSION** of either the IDI or CRCS.

> **IMPORTANT:** This variable/field should only be completed at the **FIRST SESSION** of either the IDI or CRCS.

    1a. Record where the client was referred from or how the client found out about the intervention/program.
- Select **only one** answer choice for this variable by completely filling in one bubble/circle.
- If the client/participant says he/she was referred from multiple sources, **ask the client to select one.**
- If the client/participant selects "Agency" (your agency or any other agency), you will need to ask 1B "If you were referred from an agency, which program were you referred from?"
- If the client/participant selects "Other", you will need to ask 1C "Please tell me where you were referred from."

    1b. Record the <u>type of program </u>the client was referred from.
- This question should only be asked if the client/participant stated that he/she was referred from an agency.

- Select **only one** answer choice for this variable by completely filling in one bubble/circle.
- If the client/participant says he/she was referred from multiple sources, **ask the client to select one.**
- If "Other" is selected, you should not specify what the other program is. Since there is no box to capture the information, it will not be read by Teleform.

1c. Record the "Other" referral source.
- This question should only be asked if the client/participant stated that he/she was referred from an "other" source.
- Print the name of the other type of referral source in the box. For example, if the client was referred from a dental clinic, you should put dental clinic in the box rather than the name of the dentist or clinic (e.g. Smiles Forever, Dr. Smith, etc.)

2. Testing Referral
- Record the Testing Referral activity

2a. Test Lab Sticker
- If client/participant is referred to testing at your provider site that day, include the HIV test lab sticker (this is only for programs who also have HIV testing on site).

3. Referrals Provided
- This section should be completed EVERY time this form is administered.
- This variable/field is asking about referrals that you will give/gave to the client during the session.

3a. No Referrals
- If no referrals were provided on the same day that this form is being completed, then completely fill in the bubble/circle "No referrals provided" and go to page 2 "Client Background Information" section.
- If a referral was given, leave the "No referrals provided" bubble blank and go to the variable/field titled "Risk/Harm Reduction".
- Agency staff may have to complete the rest of the form and/or conduct the intervention activity before completing this section.

3b. Types of Referrals Provided
- This variable/field is asking about referrals that you will give/gave to the client during the session.
- Starting with the answer choices in the "Risk/Harm Reduction" section through "Other Referrals" **select all** the types of referrals that you provided to the client/participant at this session.
- If your client/participant is not HIV positive, you should not select any of the answer choices under "Positive Referrals".
- If "other referral" is selected, go to 3c and specify what referrals were provided.
- Agency staff may have to complete the rest of the form and/or conduct the intervention activity before completing this section.

3c. Specify Referral Type
- Only complete this variable/field if "Other referral" was selected.
- Print the name(s) of the other type of referral(s) in the box.

C. Client Background Information Variables/Fields in the IDI/CRCS Form

1. **Client Initials are a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the first initial of the client/participant's FIRST NAME in the first box.
   - Record the first initial of the client/participant's last name in the second box.

> **IMPORTANT:** This variable/field is one of the fields used to create the unique client identification number. If this information is not legible, missing, or incorrect then the information collected at other sessions, follow-up and HIV testing cannot be linked. If information cannot be linked, it will not be possible to monitor or measure the outcomes of the intervention or program performance indicators.

2. **Residence Zip Code is a "required" field.** This variable/field must be completed or the form will be rejected.
   - This question should be asked EVERY time this form is completed. It is possible for your client/participant to move during the intervention or follow-up sessions. This is especially true for homeless individuals.
   - If your client/participant is homeless, ask for the zip code of the place where the client/participant spent the night last night. If you are unable to determine after asking

this, if the client does not know, or if client refuses, enter a "9" in each of the boxes as the answer on the form. Do not leave this variable/field blank.

3. **Date of Birth is a "required" field.** This variable/field must be completed or the form will be rejected.
    - Record the client/participant's date of birth.
    - Print the two digit month in the first two boxes.
    - Print the two digit day in the third and fourth box.
    - Print the last two digits of a four digit year in the last two boxes.
    - If the month, day, or year contains a zero, fill in the zero. **Do not leave any of the squares blank.**
    - For example, if the date is August 1, 19<u>79</u> the date field should look like this.

$$0\;8\;/\;0\;1\;/\;7\;9$$

NOT

$$\underline{\;\;}\;8\;/\;1\;\underline{\;\;}\;/\;7\;9$$

> **IMPORTANT:** This variable/field is one of the fields used to create the unique client identification number. If this information is not legible, missing, or incorrect then the information collected at other sessions, follow-up and HIV testing cannot be linked. If information cannot be linked, it will not be possible to monitor or measure the outcomes of the intervention or program performance indicators.

4. **Country of Origin**. Record the name of the COUNTRY that the client/participant was born. This question should be asked only at the first session (baseline).

5. **Incarcerated**
    - If this is the FIRST SESSION of the intervention then ask "Have you been incarcerated anytime in the **past 12 months**?"
    - If this is the LAST SESSION –or- 60 DAY FOLLOW-UP, then ask "Have you been incarcerated anytime since the last session (last time a risk assessment was conducted)"?
    - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

6. **Sex Worker**
    - Ask the client/participant if he/she **identifies** as a sex worker.
    - If the client/participant declines to state, leave the bubble empty or blank.

D. Demographic Variables/Fields in the IDI/CRCS Form

1. Gender Identity is a "required" field. This variable/field must be completed or the form will be rejected.
- This question should be asked EVERY time this form is completed.
- Select **only one** answer choice ("Male", "Female", "Transgendered M to F", "Transgendered F to M", or "Other") for this variable by completely filling in one bubble/circle.

  1a. Specify Other Gender
  - Only complete this variable/field if "Other" was selected.
  - Record what the "Other" gender is in the box.

2. Race/Ethnicity (this is a required field)
- Select as many answer responses that apply to the client/participant by completely filling in the bubble(s)/circle(s).

  2a. **Specify Other Race**
  - Only complete this variable/field if "Other Race" was selected.
  - Record the race(s) in the box.

3. Gender at Birth
- Select only one answer choice by completely filling in the bubble/circle.
- If pregnant answer 3a.

  3a. Pregnant
  - This question should be asked EVERY time this form is completed for ALL FEMALE clients/participants.

- Select **only one** answer choice for this variable by completely filling in one bubble/circle.
- If the answer choice is "Yes" then ask "Are you in perinatal care?" field 3b.
- If the answer choice is "No" then go to the "Sexual Orientation" section field 4.

3b. Perinatal Care
- This question should be asked EVERY time this form is completed for ALL PREGNANT FEMALE clients/participants.
- Select **only one** answer choice for this variable by completely filling in one bubble/circle.

4. Sexual Orientation
- This question should be asked EVERY time this form is completed.
- Select only one answer choice by completely filling in the bubble/circle.
- If "Other" is selected as the answer, specify how the client identifies in the text box, field 4a.

4a. Specify Other Sexual Orientation
- Only complete this variable/field if "Other" sexual orientation was selected.
- Record the response in the box.

5. Homeless Status
- Select only one answer choice by completely filling in the bubble/circle.

6. Current Health Insurance Coverage
- This question should be asked EVERY time this form is completed.
- Select all answer choices that apply by completely filling in the bubble(s)/circle(s).
- If "Other" is selected as an answer, specify what health insurance the client/participant has in the text box, field 6a.

6a. Specify Other Health Insurance
- Only complete this variable/field if "Other" health insurance coverage was selected as one of the answer choices.
- Record the response in the box.

E. Partner Services Variables/Fields in the IDI/CRCS Form

1. Partner Services
- Select only one answer choice by completely filling in the bubble/circle.
- If the answer "Yes, PS activities this session" is selected, record your initials or ID in the box, field 1a

1a. PS Initials/ID
- Only complete this variable/field if "Yes, PS activities this session" was selected.

2. PS Activity: Skill Building for Self Notification
- Only complete this variable/field if "Yes, PS activities this session" was selected in item 1.
- Completely fill in the bubble/circle if this activity was conducted during the intervention/follow-up session.
- If Skill Building for Self Notification activity was conducted during this intervention/follow-up session record the number of partners in the corresponding box. If you do not know the number of partners, do not leave the box blank. Record 999 in the box.
- If Skill Building for Self Notification activity was not conducted during this intervention/follow-up session then go to the next activity "Anonymous third party notification" item 3.

3. PS Activity: Anonymous Third Party Notification
- Only complete this variable/field if "Yes, PS activities this session" was selected in item 1.
- Completely fill in the bubble/circle if this activity was conducted during the intervention/follow-up session.
- If Third Party Notification activity was conducted during this intervention/follow-up session record the number of partners in the corresponding box. If you do not know the number of partners, do not leave the box blank. Record 999 in the box.
- If Third Part Notification activity was not conducted during this intervention/follow-up session then go to the next activity "Dual Client/Partner Session" item 4.

4. PS Activity: Dual Client/Partner Session
- Only complete this variable/field if "Yes, PS activities this session" was selected in item 1.

- Completely fill in the bubble/circle if this activity was conducted during the intervention/follow-up session.
- If Dual Client/Partner Session was conducted during this intervention/follow-up session record the number of partners in the corresponding box. If you do not know the number of partners, do not leave the box blank. Record 999 in the box.
- If Dual Client/Partner Session was not conducted during this intervention/follow-up session then go to the next activity "Dual Client/Partner Session" item 4.

F. Sexual Behavior History Variables/Fields in the IDI/CRCS Form

> **IMPORTANT:** This variable/field is a "required" field.

1. Sexual Behavior History: No Response
- If this is the FIRST SESSION of the IDI or CRCS intervention, ask the client/participant "Did you have vaginal or anal sex in the last 12 months?" If the client/participant answers no, go to the "Substances Used" Section on the top of the last page of the HE/RR IDI and CRCS Form.
- If this is the LAST SESSION or the 60 DAY FOLLOW-UP SESSION of the IDI or CRCS intervention, ask the client/participant "Did you have vaginal or anal sex since the last session when we completed a risk assessment?" If the client/participant answers no, go to the "Substances Used" Section on the top of the last page of the HE/RR IDI and CRCS Form.

2. Sexual Behavior History: Yes Response
- This question should be asked EVERY time this form is completed.
- If this is the FIRST SESSION of the IDI or CRCS intervention, ask the client/participant "Did you have vaginal or anal sex in the last 12 months?" If the client/participant answers yes complete all the items in the "LAST 12 MONTHS" column –AND- "Always Complete" column.
- If this is the LAST SESSION or the 60 DAY FOLLOW-UP SESSION of the IDI or CRCS intervention, ask the client/participant "Did you have vaginal or anal sex since the last session or since we last met?" If the client/participant answers yes complete all the items in the "SINCE THE LAST SESSION" column –AND- "Always Complete" column.

IMPORTANT: "Since Last Session" is defined as since the client/participant last took the risk assessment not since you last saw the client.

G. Sexual Activity Variables/Fields in the IDI/CRCS Form

If this is client's FIRST SESSION, complete the section labeled "In the Last 12 months".

If this is client's FINAL SESSION or 60 DAY FOLLOW UP, complete the section labeled "Since the Last Session".

The section labeled "Always used condoms during sex activity" should be completed for ALL Sessions.

	COMPLETE THIS COLUMN IF THIS IS YOUR FIRST SESSION			COMPLETE THIS COLUMN AT ALL OTHER SESSIONS			ALWAYS COMPLETE
SEX ACTIVITY	**LAST 12 MONTHS**			**SINCE THE LAST SESSION**			**Always used condoms during sex activity**
	All Partners in Last 12 Months			All Partners Since Last Session			
	Male	Female	Transgender	Male	Female	Transgender	
Oral Sex	○	○	○	○	○	○	
Vaginal Sex	○	○	○	○	○	○	○
Anal Sex	○	○	○	○	○	○	○
Exchanged sex for drugs/money/ something needed	○	○	○	○	○	○	○
Sex while intoxicated/ high on drugs	○	○	○	○	○	○	○
Sex with a partner who is an IDU	○	○	○	○	○	○	○
Sex with a partner who is HIV+	○	○	○	○	○	○	○
Sex with a partner whose HIV status is unknown	○	○	○	○	○	○	○
Sex with a partner who exchanges sex for drugs/money/etc.	○	○	○	○	○	○	○
Sex with anonymous partner	○	○	○	○	○	○	○
FOR FEMALE CLIENTS ONLY: Sex with a male or transgender partner who has sex with other men	○		○	○		○	○

Note: The last sexual activity "Sex with a male or transgender partner who has sex with other men" should only be answered by female CLIENTS/PARTICIPANTS.

- Ask the client/participant if he/she has had <u>sexual activity</u> in <u>timeframe</u> with…for each sexual activity with each gender

> **IMPORTANT:** Ask the client if he/she has had <u>sexual activity</u> with men. Then ask the question again to see if they had a female partner. Finally, ask the question to find out if they had a transgender partner.

H. Number of Sexual Partner Variables/Fields in the IDI/CRCS Form

1. Number of Sexual Partners
- The timeframe is in the **LAST 30 DAYS**.
- Client should only count those partners that they had **vaginal or anal sex** with in the past 30 days.
- Record the number of male, female, and/or transgender sexual partners in the box. If the client/participant does not remember, ask them to estimate the number. If the client cannot estimate the number or declines to state- enter 999 in the box.
- If the client/participant did not have any sexual partners, place "000" in the corresponding box.

I. Substances Used Variables/Fields in the IDI/CRCS Form

> **IMPORTANT:** Substances refer to recreational street drugs that the client may have used in the last 12 months or since the last session, but does *NOT* include any drugs taken under a doctor's order or hormones.

1. **Injected and Shared Works In the Last 12 Months or Since the Last Session (this is a required field)**
   - All clients should answer at every session.
   - Ask the client/participant if he/she **injected AND shared needles or works in the past 12 months or since the last session**. Ask the client/participant "Did you inject any substance **AND shared needles or works in the past 12 months or since the last session**?"
   - If the client/participant reported "Yes" they injected the substance completely fill in the corresponding circle/bubble.
   - If the client/participant reported "No" they injected the substance completely fill in the corresponding circle/bubble.
   - If the client/participant declines to state or refuses to answer leave the bubbles/circles blank.

2. **Ever Injected and Shared Works**
   - All clients should answer at every session.
   - Ask the client/participant if he/she **EVER injected AND shared needles or works**. Ask the client/participant "Did you ever inject any substance **AND shared needles or works**?"
   - If the client/participant reported "Yes" they injected the substance completely fill in the corresponding circle/bubble.
   - If the client/participant reported "No" they injected the substance completely fill in the corresponding circle/bubble.
   - If the client/participant declines to state or refuses to answer leave the bubbles/circles blank.

3. **Substances Used**
   - If this is the FIRST SESSION of the IDI or CRCS intervention, ask the client/participant "Did you use any substances in the last 12 months?" If the client/participant answers yes complete all the items in #4.
   - If this is the LAST SESSION or the 60 DAY FOLLOW-UP SESSION of the IDI or CRCS intervention, ask the client/participant ask the client/participant "Did you use any substances since the last session when we completed a risk assessment?" If the client/participant answers yes complete all the items in #4.
   - If the client/participant answers "No, alcohol or drug use" or "Declined/Refused" then skip to the "HIV Test Information" Section of the form.

4. **List of Substances Used**

- Ask the client/participant if he/she used <u>list substance</u> in the last 12 months or since the last session. If the client/participant reported that they used the substance completely fill in the corresponding circle/bubble.
- This variable/field is a **mark all that apply** field.
- If "Other Drug" is reported, print the names of the other drug in the box (item 4a).
- The next set of questions is in item 5.

4a. Specify Other Substances Used
- This question should be asked only if client/participant reported using "Other Drugs."
- Record the names of the other drugs in the box.

5. Injected
- Ask the client/participant if he/she **INJECTED** <u>list substance</u> in the last 12 months or since the last session. Ask the client/participant "Did you inject <u>list substance</u> in the <u>list timeframe</u>?"
- If the client/participant reported "Yes" they injected the substance completely fill in the corresponding circle/bubble.
- If the client/participant reported "No" they injected the substance completely fill in the corresponding circle/bubble.
- If the client/participant declines to state or refuses to answer leave the bubbles/circles under injected blank for each substance the client refused to answer.

6. Sex While High or Intoxicated
- Ask the client/participant if he/she **had sex while high or intoxicated with** <u>list substance</u> in the last 12 months or since the last session. Ask the client/participant "Did you have sex while high, intoxicated, or under the influence of <u>list substance</u> in the <u>list timeframe</u>?"
- If the client/participant reported "Yes" they had sex while high or intoxicated with <u>name of substance</u> completely fill in the corresponding circle/bubble.
- If the client/participant reported "No" they had sex while high or intoxicated with <u>name of substance</u> completely fill in the corresponding circle/bubble.
- If the client/participant declines to state or refuses to answer leave the bubbles/circles under sex while high or intoxicated blank for each substance the client refused to answer.

J. HIV Test Information and HIV Medical Care Variables/Fields in the IDI/CRCS Form

1. Number of prior HIV tests
- The timeframe for this question is **EVER not including today.**
- If the client/participant stated that he/she has never tested before, enter a "0" in the box.
- If the client "Declined/Refused to Answer", completely fill in the bubble/circle corresponding to the "Declined/Refused to Answer" answer choice. Do not fill in a "0" in the box. Leave the box blank if the client "Declined/Refused to Answer."
- There is only one response for this item. Either fill in a number in the box –OR- fill in the bubble/circle for "Declined/Refused to Answer."
- If the client/participant has never tested before go to the "STDs & Hepatitis" section.
- If the client/participant has had an HIV test go to item 2 "Date of last test result."

2. Date of Last Test Result
- This question should only be answered if the client/participant has tested for HIV.
- Ask the client what was the date of the last HIV test result they received.
- Only record the two digit month and last two digits of the four digit year in the boxes.
- If the client/participant cannot remember enter "9999" in the boxes.

3. Last Test Result (this field is required only if client/participant had a prior HIV test)
- This question should only be answered if the client/participant has tested for HIV.
- Ask the client what was the result of their most recent HIV test that they received?
- Choose only one answer choice
- If the client/participant declines to answer, select "Declined/Refused to Answer".
- If the client/participant selects "Positive" as their answer choice, the next item should be item 4.
- If the client/participant selects any other response other than "Positive", go to the "STDs & Hepatitis" section.

4. HIV Medical Care ⟹ Only for HIV Positive Clients/Participants
- If this is the FIRST SESSION, answer the questions for the past six months. Ask the client "How many times did you see a health care provider for your HIV in the past six months? Please do not include times when you had an emergency room visit or a hospital admission, or only had a lab test done."
- If this is the LAST or 60 day FOLLOW-UP SESSION, answer the questions since the previous session. Ask the client "How many times did you see a health care provider for your HIV since our last session? Please do not include times when you had an emergency room visit or a hospital admission, or only had a lab test done."
- Record the number of times the client/participant saw a health care provider for HIV in the boxes.
- If the client/participant did not go to a health care provider for their HIV in the specified time period, place a "0" (zero) in the box.
- If the client/participant declines to state or does not know, completely filling in the bubble/circle for the "Declined/Don't Know" answer choice.

5. Date of Last HIV Medical Care Visit ⟹ Only for HIV + Clients/Participants
- This question should only be answered if the client/participant has tested for HIV.
- Ask the client what was the date of the last HIV Medical Care Visit.
- Only record the two digit month and last two digits of the four digit year in the boxes.
- If the client/participant cannot remember enter "9999" in the boxes.

6. HIV Care Referral ⟹ Only for HIV Positive Clients/Participants
- Select only one answer choice by completely filling in one bubble/circle.
- Go to the "STDs & Hepatitis" section.

K. STDs & Hepatitis Variables/Fields in the IDI/CRCS Form

1. STDs & Hepatitis
- If this is the FIRST SESSION, ask the question for the past 12 months. Ask the client/participant "Have you had any STD or Hepatitis in the past 12 months?"

- If this is the LAST or 60 day FOLLOW-UP SESSION, ask the question since the last session. Ask the client "Have you had a STD or Hepatitis since our last session when we completed a risk assessment?"
- If the client/participant response is "No", then select "No STDs/Hepatitis" by completely filling in the bubble/circle and go to item 4.
- If the client/participant response is "Yes or Maybe", then go to item 2.

2. Types of STDs & Hepatitis
- If this is the FIRST SESSION, ask the question for the past 12 months. Ask the client/participant "Have you had name of disease in the past 12 months?"
- If this is the LAST or 60 day FOLLOW-UP SESSION, ask the question since the last session. Ask the client "Have you had name of disease since our last session when we completed a risk assessment?"
- If the client/participant response is "Yes", completely fill in the bubble/circle to the corresponding STD.
- If the client/participant response is "No", leave the corresponding bubble/circle blank.
- If the client/participant response is "Other STD", record the other STD(s) in the box (item 3)

3. Other STD
- Answer this question only if the client/participant reported an "Other STD" in item 2 as one of the answer choices.
- Print the name of the other STDs.

4. Hepatitis Vaccination
- The timeframe for this question is EVER in lifetime.
- Report the clients answer by completely filling in the bubble/circle.
- Both answer choices can be selected if the client received both Hep A and Hep B vaccine.
- If the client states that they only received the first dose of the vaccine, the response to the question would still be "Yes" and you should fill in the appropriate bubble/circle.

L. Client Information, Perceived Severity, Perceived Self-Efficacy, and Transmission Risk Variables/Fields in the IDI/CRCS Form, Self-Administered Questionnaire Section

Self Administered Questionnaire

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

41549

When writing letters or numbers, place one character in each box. Please print carefully and avoid the edges of the box. For letters, use only capitals. PLEASE USE BLACK PEN ONLY

Shade Circles Like This-> ●

Not Like This-> ✗ ○

A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

1 2 3 4 5 6 7 8 9 0

Please complete all of the following questions.
If you need assistance please ask the person who gave you this form.

1 ← Place the first initials of your first and last name in the boxes below:

First Name Initial: Last Name Initial:

3 ← What is your date of birth? *(mm/dd/yy)*

[ ] / [ ] / [ ]

4 ← What is the zip code for your home/regular hang out?

[   ]

2 → What gender do you consider yourself?
(choose only one gender)

O Male

O Female

O Transgendered: M to F

O Transgendered: F to M

O Other

For the next set of questions, please indicate to what extent you agree or disagree:

5 ← AIDS is now nearly cured.
(choose only one)

O Strongly Disagree

O Disagree

O Neither Agree nor Disagree

O Agree

O Strongly Agree

6 → Being HIV-positive isn't that big of a deal now that treatments are better. *(choose only one)*

O Strongly Disagree

O Disagree

O Neither Agree nor Disagree

O Agree

O Strongly Agree

7 ← If you are HIV-, what do you think your chances of getting HIV are? If you are HIV+, what do you think your chances of transmitting HIV are?
(choose only one)

O Very Likely

O Likely

O Neither Likely nor Unlikely

O Unlikely

O Very Unlikely

8 → I am able to use a condom under any situation so that I don't get or spread HIV. *(Such as when I am drunk or high or when my partner doesn't want to use condoms)*
(choose only one)

O Strongly Disagree

O Disagree

O Neither Agree nor Disagree

O Agree

O Strongly Agree

HE/RR IDI-CRCS ENGLISH v1.0 11-25-09

Page 5 of 6

1. **Client Initials are a "required" field.** This variable/field must be completed or the form will be rejected.
    - The client/participant should record the first initial of their FIRST NAME in the first box.
    - The client/participant should record the first initial of their LAST NAME in the last box.

> **IMPORTANT:** This variable/field is one of the fields used to create the unique client identification number. If this information is not legible, missing, or incorrect then the information collected at other sessions, follow-up and HIV testing cannot be linked. If information cannot be linked, it will not be possible to monitor or measure the outcomes of the intervention or program performance indicators.

2. **Gender Identity is a "required" field.** This variable/field must be completed or the form will be rejected.
    - The client/participant should select **only one** answer choice ("Male", "Female", "Transgendered M to F", "Transgendered F to M", or "Other") for this variable by completely filling in one bubble/circle.

3. **Date of Birth is a "required" field.** This variable/field must be completed or the form will be rejected.
    - The client/participant should record their date of birth.
    - The client/participant must print the two digit month in the first two boxes.
    - The client/participant must print the two digit day in the third and fourth box.
    - The client/participant must print the last two digits of a four digit year in the last two boxes.
    - If the month, day, or year contains a zero, fill in the zero. **Do not leave any of the squares blank.**
    - For example, if the date is August 1, 19<u>79</u> the date field should look like this.

<div align="center">

| 0 | 8 | / | 0 | 1 | / | 7 | 9 |

NOT

| | 8 | / | 1 | | / | 7 | 9 |

</div>

4. **Residence Zip Code is a "required" field.** This variable/field must be completed or the form will be rejected.
    - This question should be asked EVERY time this form is completed. It is possible for your client/participant to move during the intervention or follow-up sessions. This is especially true for homeless individuals.
    - If your client/participant is homeless, ask for the zip code of the place where the client/participant spent the night last night. If you are unable to determine after asking

this, if the client does not know, or if client refuses, enter a "9" in each of the boxes as the answer on the form. Do not leave this variable/field blank.

5. **AIDS is now nearly cured.**
   - The client/participant should select **one** of the five answer choices by completely filling in the bubble/circle.
   - If the client/participant does not know the answer, the client should make a guess.

6. **Being HIV-positive isn't that big a deal now that treatments are better.**
   - The client/participant should select **one** of the five answer choices by completely filling in the bubble/circle.
   - If the client/participant does not know the answer, the client should make a guess.

7. **Transmission Risk**
   - If the client/participant is **HIV positive,** then he/she should answer the question "What do you think your chances of transmitting HIV are?"
   - If the client/participant is **HIV negative,** then he/she should answer the question "what do you think your chances of getting HIV are?"
   - The client/participant should select **one** of the five answer choices by completely filling in the bubble/circle.
   - If the client/participant does not know the answer, the client should make a guess.

8. **Self Efficacy**
   - The client/participant should select **one** of the five answer choices by completely filling in the bubble/circle.
   - If the client/participant does not know the answer, the client should make a guess.

Self Administered Questionnaire

41549

For the next set of questions, please indicate if you believe the statement is true or false:

	True	False	Don't Know
Pulling out the penis before a man climaxes/cums keeps a man/woman from getting HIV during sex.	○	○	○
A man/woman can get HIV if he/she has anal sex with a man.	○	○	○
People who have been infected with HIV quickly show serious signs of being infected.	○	○	○
There is a vaccine that can stop adults from getting HIV.	○	○	○
People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV.	○	○	○
Having sex with more than one partner can increase a person's chance of being infected with HIV.	○	○	○

1

Thank you! All of your responses will remain confidential.
Your answers will help our agency to better serve you.
If you have any questions or concerns as a result of these questions or your answers,
you may talk with your group facilitator.

Admin Use Only: To be completed by agency staff.

Date: (mm/dd/yy)

2 ←

Intervention Type:

○ Individual Level Intervention (IDI)
○ Comprehensive Risk Counseling Service (CRCS)
○ Group

☐☐ / ☐☐ / ☐☐ → 5

Session:

○ Session 1
○ Final Session
○ 30 Fay Follow Up
○ 60 Day Follow Up

6

Program ID: **Site ID:**

3 ← ☐☐☐☐   ☐☐☐☐

4

1. **HIV Knowledge**
   - The client/participant should answer each of the six HIV knowledge questions and select **one** of the five answer choices by completely filling in the bubble/circle.
   - **Each row** in the table should have **one** bubble/circle filled.

> **This is the end of the client/participant portion of the Self Administered Questionnaire**
> **The additional fields should be completed by agency staff.**

2. **Intervention Type is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Select "Intervention Designed for Individuals" if this is conducted privately with one client/participant at a time.
   - Select "Comprehensive Risk Counseling Service" if this is a more intensive program that is usually sessions long and includes a program plan.
   - Select "Group" if the intervention has multiple clients/participants enrolled in the same intervention program.
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

3. **Program ID is a "required" field.** This variable/field must be completed or the form will be rejected.
- Record the unique four digit number for the agency.
- The Program ID is assigned to each agency by OAPP. Agencies cannot create their own four digit Program ID.
- Contact your OAPP Program Manager if you do not know your Program ID number.

4. **Site ID is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the unique four digit number corresponding to the site where the program is conducted.
   - Site IDs are assigned to each agency by OAPP. Agencies cannot create their own four digit Site IDs.
   - Contact your OAPP Program Manager if you do not know which Site ID to record on this form.

5. **Date is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the date of this intervention session or follow-up session.
   - Print the two digit month in the first two boxes.
   - Print the two digit day in the third and fourth box.
   - Print the last two digits of a four digit year in the last two boxes.

- If the month, day, or year contains a zero, fill in the zero. **Do not leave any of the squares blank.**
- For example, if the date is August 1, 20<u>09</u> the date field should look like this.

| 0 | 8 | / | 0 | 1 | / | 0 | 9 |

Not

| | 8 | / | 1 | | / | 0 | 9 |

6. **Session number is a "required" field.** This variable/field must be completed or the form will be rejected.
    - Select "Session 1" if this is the client/participants first session of the current IDI, CRCS, or IDG intervention.
    - Select "Last Session" if this is the client/participant's last session of an IDI, CRCS, or IDG intervention.
    - Select "30 Day Follow-up" only if this is a group-level intervention. DO NOT administer this questionnaire at the 30 Day Follow-up for IDI or CRCS interventions.
    - Select "60 Day Follow-up" if the client/participant is enrolled in an IDI or CRCS intervention. This questionnaire will rarely be used for a 60 Day Follow-up for Group Interventions. If you have questions when to use this form, contact your OAPP program manager.
    - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

This is the end of the HE/RR IDI & CRCS Form.

Administrative Form for IDI, CRCS, and IDG Interventions

This form should be completed:
- by the agency staff in-between sessions, -and-
- for sessions that are not the first or last session.

1. **Program ID is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the unique four digit number for the agency.
   - The Program ID is assigned to each agency by OAPP. Agencies cannot create their own four digit Program ID.
   - Contact your OAPP Program Manager if you do not know your Program ID number.

2. **Site ID is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the unique four digit number corresponding to the site where the program is conducted.
   - Site IDs are assigned to each agency by OAPP. Agencies cannot create their own four digit Site IDs.
   - Contact your OAPP Program Manager if you do not know which Site ID to record on this form.

3. **Date is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the date of this intervention session or follow-up session.
   - Print the two digit month in the first two boxes.
   - Print the two digit day in the third and fourth box.
   - Print the last two digits of a four digit year in the last two boxes.
   - If the month, day, or year contains a zero, fill in the zero. **Do not leave any of the squares blank.**
   - For example, if the date is August 1, 20<u>09</u> the date field should look like this.

4. **Time of Encounter**
   - Record the time that this session of the intervention or follow-up started.
   - Record the time using a 12 hour format and include a colon (:) to separate hours and minutes.

   4a. AM/PM
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

   4b. Length of Contact
   - Record the length of contact in minutes.
   - For example, if the session lasted 1.5 hours then put the number 090 in the boxes.

5. **Session number is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Select "Session 2" if this is the client/participants second session of the current IDI, CRCS, or IDG intervention.
   - Select "Session 3" if this is the client/participant's third session of an IDI, CRCS, or IDG intervention that has more than three (3) sessions. If the intervention only has three (3) sessions, DO NOT use this form. Use the IDI or GSAQ form because this would be considered the LAST SESSION of the intervention.
   - Select "Session 4" if this is the client/participant's fourth session of an IDI, CRCS, or IDG intervention that has more than four (4) sessions. If the intervention only has four (4) sessions, DO NOT use this form. Use the IDI or GSAQ form because this would be considered the LAST SESSION of the intervention.
   - Select "Session 5" if this is the client/participant's fifth session of an IDI, CRCS, or IDG intervention that has at least six (6) sessions. If the intervention only has five (5) sessions, DO NOT use this form. Use the IDI or GSAQ form because this would be considered the LAST SESSION of the intervention.
   - DO NOT use this form for the 60 day Follow-up. Only use this form for 30 and 90 day Follow-up sessions.
   - If this is an "Other" session fill in the session number in field 5a.
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

6. **Intervention Type is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Select "Intervention Designed for Individuals" if this is conducted privately with one client/participant at a time.
   - Select "Comprehensive Risk Counseling Service" if this is a more intensive program that is usually sessions long and includes a program plan.
   - Select "Intervention Designed for Groups" if the intervention has multiple clients/participants enrolled in the same intervention program.
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

7. **Record the Testing Referral Activity**
   - If client/participant is referred to testing at your provider site that day, include the HIV test lab sticker (this is only for programs who also have HIV testing on site).

8. **Client Initials are a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the first initial of the client/participant's FIRST NAME in the first box.
   - Record the first initial of the client/participant's last name in the second box.

> **IMPORTANT:** This variable/field is one of the fields used to create the unique client identification number. If this information is not legible, missing, or incorrect then the information collected at other sessions, follow-up and HIV testing cannot be linked. If information cannot be linked, it will not be possible to monitor or measure the outcomes of the intervention or program performance indicators.

9. **Date of Birth is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the client/participant's date of birth.
   - Print the two digit month in the first two boxes.
   - Print the two digit day in the third and fourth box.
   - Print the last two digits of a four digit year in the last two boxes.
   - If the month, day, or year contains a zero, fill in the zero. **Do not leave any of the squares blank.**
   - For example, if the date is August 1, 19<u>79</u> the date field should look like this.

| 0 | 8 | | 0 | 1 | | 7 | 9 |

Not

| | 8 | / | 1 | | / | 7 | 9 |

10. **Residence Zip Code is a "required" field.** This variable/field must be completed or the form will be rejected.
    - This question should be asked EVERY time this form is completed. It is possible for your client/participant to move during the intervention or follow-up sessions. This is especially true for homeless individuals.
    - If your client/participant is homeless, ask for the zip code of the place where the client/participant spent the night last night. If you are unable to determine after asking this, if the client does not know, or if client refuses, enter a "9" in each of the boxes as the answer on the form. Do not leave this variable/field blank.

11. **Gender Identity is a "required" field.** This variable/field must be completed or the form will be rejected.
    - Select **only one** answer choice ("Male", "Female", "Transgendered M to F", "Transgendered F to M", or "Other") for this variable by completely filling in one bubble/circle.

Intervention Designed for Groups (IDG)

This form should be completed:
- on all clients/participants participating in a **group-level** intervention,
- by clients/participants as a self-administered form,
- on the first session of the intervention,
- on the last session of the intervention, -and-
- on the 30 day follow-up session.

When to complete the IDI/CRCS Forms

Form Name	Administered by	Frequency of Completion					
		First Session/ Baseline	In-Between Sessions	Final Session	30 Day F/U	60 Day F/U	90 Day F/U
IDG	**Client/Participant**	X		X	X		
Administrative	**Agency staff**		X				

A. Client Information and Demographic Variables/Fields in the IDG/GSAQ Form

1. **Client Initials are a "required" field.** This variable/field must be completed or the form will be rejected.
   - The client/participant should record the first initial of their FIRST NAME in the first box.
   - The client/participant should record the first initial of their LAST NAME in the last box.

> **IMPORTANT:** This variable/field is one of the fields used to create the unique client identification number. If this information is not legible, missing, or incorrect then the information collected at other sessions, follow-up and HIV testing cannot be linked. If information cannot be linked, it will not be possible to monitor or measure the outcomes of the intervention or program performance indicators.

2. **Date of Birth is a "required" field.** This variable/field must be completed or the form will be rejected.
   - The client/participant should record their date of birth.
   - The client/participant must print the two digit month in the first two boxes.

3. **Residence Zip Code is a "required" field.** This variable/field must be completed or the form will be rejected.
   - This question should be asked EVERY time this form is completed. It is possible for your client/participant to move during the intervention or follow-up sessions. This is especially true for homeless individuals.
   - If your client/participant is homeless, ask for the zip code of the place where the client/participant spent the night last night. If you are unable to determine after asking this, if the client does not know, or if client refuses, enter a "9" in each of the boxes as the answer on the form. Do not leave this variable/field blank.

4. **Country of Origin**
   - Client/Participant should record the name of the COUNTRY that the he/she was born. This question should be asked only at the first session (baseline).

5. **Incarcerated**
   - If this is the FIRST SESSION of the intervention then the client should report if he/she has been incarcerated in the past 12 months.
   - If this is the LAST SESSION –or- 30 DAY FOLLOW-UP, then the client/participant should report if he/she was incarcerated anytime since the last session (last time a risk assessment was conducted)"?
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

6. **Sex Worker**
   - The client/participant should state if he/she **identifies** as a sex worker.

7. **Gender Identity is a "required" field.** This variable/field must be completed or the form will be rejected.
   - The client/participant should select **only one** answer choice ("Male", "Female", "Transgendered M to F", "Transgendered F to M", or "Other") for this variable by completely filling in one bubble/circle.
   - If the client/participant is Female then she should answer the question (7a) "Are you pregnant?"

- If the client/participant is an "Other" gender, the client/participant should specify what the other gender is in field 7c.

7a. Pregnant
- This question should be answered by ALL FEMALE clients/participants.
- The client should select **only one** answer choice for this variable by completely filling in one bubble/circle.
- If the answer choice is "Yes" then the client/participant should go to field 7b "Are you in prenatal care?"
- If the answer choice is "No" then go to the "Gender at Birth" section field 8.

7b. Prenatal Care
- This question should be answered by ALL PREGNANT FEMALE clients/participants.
- The client/participant should select **only one** answer choice for this variable by completely filling in one bubble/circle.

7c. Specify Other Gender
- The client/participant should only complete this variable/field if he/she selected "Other" as an answer choice.
- The client/participant should record what the "Other" gender is in the box.

8. Gender at Birth
- Select only one answer choice by completely filling in the bubble/circle.

9. Sexual Orientation
- This question should be asked EVERY time this form is completed.
- Select only one answer choice by completely filling in the bubble/circle.
- If "Other" is selected as the answer, specify how the client identifies in the text box, field 9a.

9a. Specify Other Sexual Orientation
- Only complete this variable/field if "Other" sexual orientation was selected.
- Record the response in the box.

10. Current Health Insurance Coverage
- This question should be asked EVERY time this form is completed.
- Select all answer choices that apply by completely filling in the bubble(s)/circle(s).
- If "Other" is selected as an answer, specify what health insurance the client/participant has in the text box, field 10a.

10a. Specify Other Health Insurance
- Only complete this variable/field if "Other" health insurance coverage was selected as one of the answer choices.
- Record the response in the box.

11. Homeless Status
- Select only one answer choice by completely filling in the bubble/circle.

12. Race/Ethnicity (this is a required field)
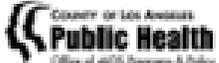- The client/participant may select as many answer responses that apply by completely filling in the bubble(s)/circle(s).
- If one of the answers selected is "Other Race", please list the other race(s) in the text box, field 12a.

12a. Specify Other Race
- Only complete this variable/field if "Other Race" was selected.
- Record the race(s) in the box.

B. Sexual Behavior History Variables/Fields in the IDG/GSAQ Form

> **Note:** The last sexual activity "Sex with a male partner who has sex with other men" should only be answered by female CLIENTS/PARTICIPANTS.

- The client should answer this section row by row while paying careful attention to the different timeframes in the first two columns.

1. **Number of Sexual Partners**
   - The timeframe is in the **LAST 30 DAYS**.
   - Client should only count those partners that they had **vaginal or anal sex** with in the past 30 days.
   - The client should record the number of male, female, and/or transgender sexual partners in the box. If the client/participant does not remember, he/she should estimate the number. If the client cannot estimate the number or declines to state- enter 999 in the box.
   - If the client/participant did not have any sexual partners, place a "0" in the corresponding box.

C. Sexual Health History Variables/Fields in the IDG/GSAQ Form

1. **STDs & Hepatitis**
   - If this is the FIRST SESSION, the client should respond thinking about the past 12 months.
   - If this is the LAST or 30 day FOLLOW-UP SESSION, the client should answer since his/her last session that a risk assessment was conducted.

1a. No STDs/Hepatitis

- If the client/participant response is "No", then select "No STDs/Hepatitis" by completely filling in the bubble/circle and go to item 2.
- If the client/participant response is "Yes or Maybe", then the client should answer all that apply by completely filling in the bubble/circle in item 1.
- If the client/participant response is "Other STD", the client/participant should specify the other STD(s) in the box (item 1b).

1b. Other STD

- Answer this question only if an "Other STD" in item 2 is one of the answer choices.
- Print the name of the other STDs.

2. Hepatitis Vaccination

- The timeframe for this question is EVER in lifetime.
- Both answer choices can be selected if the client received both Hep A and Hep B vaccine.
- If the client states that they only received the first dose of the vaccine, the response to the question would still be "Yes".

3. HIV Testing

- The timeframe for this question is EVER in lifetime.
- Enter the number of HIV tests. If the client/participant never took a HIV test, the client/participant should mark a 0 (zero) in the box.

4. Date of Last Test Result

- Client/participant should only answer if they have taken a HIV test.
- Only record the two digit month and last two digits of the four digit year in the boxes.
- If the client/participant cannot remember enter "9999" in the boxes.

5. Last Test Result is a "required" variable/field if the client has taken at least one HIV test

- Select only one answer choice

6. HIV Medical Care ⟹ Only for HIV Positive Clients/Participants

- If this is the FIRST SESSION, answer the questions for the past six months.
- If this is the LAST or 30 day FOLLOW-UP SESSION, answer the questions since the previous session when a risk assessment was conducted.
- If the client/participant did not go to a health care provider for their HIV in the specified time period, a "0" (zero) should be placed in the box.

7. Date of Last HIV Medical Care Visit ⟹ Only for HIV + Clients/Participants

- This question should only be answered if the client/participant has tested for HIV.
- Only record the two digit month and last two digits of the four digit year in the boxes.
- If the client/participant cannot remember enter "9999" in the boxes.

8. HIV Care Referral ⟹ Only for HIV Positive Clients/Participants

- Select only one answer choice by completely filling in one bubble/circle.

D. Substance Use History Variables/Fields in the IDG/GSAQ Form

SUBSTANCE USE HISTORY

The following questions are about recreational street drugs that you may have used in the last 12 months or since the last session but does NOT include any drugs taken under a doctor's order or hormones.

1 In the last 12 months or since the last session, have you injected any substance (drugs, hormones, insulin, vitamins, etc.) AND shared needles or works?
○ Yes   ○ No

2 Have you EVER injected any substance (drugs, hormones, insulin, vitamins, etc) AND shared needles or works?
○ Yes   ○ No

3 In the last 12 months or since the last session, have you used any of the following substances?

○ No alcohol or drug use   ○ Declined/Refused

If no alcohol or drug use, please skip this section. If yes, please mark all that apply.

4 Did you use any of the following substances(s)?	**4b** If yes, did you have sex while using the drug?	**4c** Did you inject the drug?
○ Alcohol	○ Yes ○ No	
○ Methamphetamine (speed, crank, crystal, tina)	○ Yes ○ No	○ Yes ○ No
○ Cocaine (powder)	○ Yes ○ No	○ Yes ○ No
○ Crack (rock)	○ Yes ○ No	○ Yes ○ No
○ Heroin (horse, junk, skag, smack, H)	○ Yes ○ No	○ Yes ○ No
○ Other Drug, Specify: ____**4a**	○ Yes ○ No	○ Yes ○ No

1. **Injected and Shared Works In the Last 12 Months or Since the Last Session (this is a required field)**
   - This question is asking the client/participant if he/she **injected AND shared needles or works in the past 12 months or since the last session a risk assessment was conducted**.

2. **Ever Injected and Shared Works**
   - This question is asking the client/participant if he/she **EVER injected AND shared needles or works**.

3. **Substances Used**
   - If this is the FIRST SESSION of the IDG intervention, the client/participant should answer the question for the past 12 months. If the client/participant answers yes complete all the items in #4.

- If this is the LAST SESSION or the 30 DAY FOLLOW-UP SESSION of the IDG intervention, the client/participant should answer the question from the time of his/her last session that the risk assessment was completed. If the client/participant answers yes complete all the items in #4.
- If the client/participant answers "No, alcohol or drug use" or "Declined/Refused" then he/she should skip to the "Self-Administered Questionnaire" Section of the form.

4. List of Substances Used
- The client/participant should complete this section answering the questions row by row.
- If "Other Drug" is reported, print the names of the other drug in the box (item 4a).

4a. Substances Used
- This question should be asked only if client/participant reported using "Other Drugs."
- Record the names of the other drugs in the box.

4b. Sex While Using Drugs
- The client/participant should answer if he/she **HAD SEX** while **USING** list substance in the last 12 months or since the last session.
- If the client/participant declines to state or refuses to answer, the bubbles/circles under injected should be left blank for each substance the client refused to answer.

4c. Injected
- The client/participant should answer if he/she **INJECTED** list substance in the last 12 months or since the last session.
- If the client/participant declines to state or refuses to answer, the bubbles/circles under injected should be left blank for each substance the client refused to answer.

E. Perceived Severity, Perceived Self-Efficacy, and Transmission Risk Variables/Fields in the IDG/GSAQ Form, Self-Administered Questionnaire Section

GROUP SELF ADMINISTERED QUESTIONNAIRE (GSAQ)

County of Los Angeles — Public Health
Office of AIDS Programs & Policy

SELF-PERCEIVED RISK AND KNOWLEDGE

Please indicate to what extent you agree or disagree with the statements below:

1 — AIDS is now nearly cured.
(choose only one)
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

2 — Being HIV-positive isn't that big of a deal now that treatments are better. (choose only one)
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

3 — If you are HIV-, what do you think your chances of getting HIV are? If you are HIV+, what do you think your chances of transmitting HIV are?
(choose only one)
- o Very Likely
- o Likely
- o Neither Likely nor Unlikely
- o Unlikely
- o Very Unlikely

4 — I am able to use a condom under any situation so that I don't get or spread HIV. (Such as when I am drunk or high or when my partner doesn't want to use condoms)
(choose only one)
- o Strongly Disagree
- o Disagree
- o Neither Agree nor Disagree
- o Agree
- o Strongly Agree

For the next set of questions, please indicate if you believe the statement is true or false:

	True	False	Don't Know
Pulling out the penis before a man climaxes/cums keeps a man/woman from getting HIV during sex.	o	o	o
A man/woman can get HIV if he/she has anal sex with a man.	o	o	o
People who have been infected with HIV quickly show serious signs of being infected.	o	o	o
There is a vaccine that can stop adults from getting HIV.	o	o	o
People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV.	o	o	o
Having sex with more than one partner can increase a person's chance of being infected with HIV.	o	o	o

5

Thank you! All of your responses will remain confidential.
Your answers will help our agency to better serve you.
If you have any questions or concerns as a result of these questions or your answers, you may talk with your group facilitator.

GSAQ v1.0 ENGLISH 11-25-09   Page 5 of 6

1. **AIDS is now nearly cured**
    *   The client/participant should select **one** of the five answer choices by completely filling in the bubble/circle.
    *   If the client/participant does not know the answer, the client should make a guess.

2. **Being HIV-positive isn't that big a deal now that treatments are better**
    *   The client/participant should select **one** of the five answer choices by completely filling in the bubble/circle.
    *   If the client/participant does not know the answer, the client should make a guess.

3. **Transmission Risk**
    *   If the client/participant is **HIV positive,** then he/she should answer the question "What do you think your chances of transmitting HIV are?"
    *   If the client/participant is **HIV negative,** then he/she should answer the question "what do you think your chances of getting HIV are?"
    *   The client/participant should select **one** of the five answer choices by completely filling in the bubble/circle.
    *   If the client/participant does not know the answer, the client should make a guess.

4. **Self Efficacy**
    *   The client/participant should select **one** of the five answer choices by completely filling in the bubble/circle.
    *   If the client/participant does not know the answer, the client should make a guess.

5. **HIV Knowledge**
    *   The client/participant should answer each of the six HIV knowledge questions and select **one** of the five answer choices by completely filling in the bubble/circle.
    *   **Each row** in the table should have **one** bubble/circle filled.

> **This is the end of the client/participant portion of the Self Administered Questionnaire**
> **The additional fields should be completed by agency staff.**

F. Administrative Variables/Fields in the IDG/GSAQ Form

1. **Program ID is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the unique four digit number for the agency.
   - The Program ID is assigned to each agency by OAPP. Agencies cannot create their own four digit Program ID.
   - Contact your OAPP Program Manager if you do not know your Program ID number.

2. **Site ID is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the unique four digit number corresponding to the site where the program is conducted.
   - Site IDs are assigned to each agency by OAPP. Agencies cannot create their own four digit Site IDs.
   - Contact your OAPP Program Manager if you do not know which Site ID to record on this form.

3. **Session number is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Select **only one** answer choice for this variable by completely filling in one bubble/circle.

4. **Date is a "required" field.** This variable/field must be completed or the form will be rejected.
   - Record the date of this intervention session or follow-up session.
   - Print the two digit month in the first two boxes.
   - Print the two digit day in the third and fourth box.
   - Print the last two digits of a four digit year in the last two boxes.
   - If the month, day, or year contains a zero, fill in the zero. **Do not leave any of the squares blank.**
   - For example, if the date is August 1, 20<u>09</u> the date field should look like this.
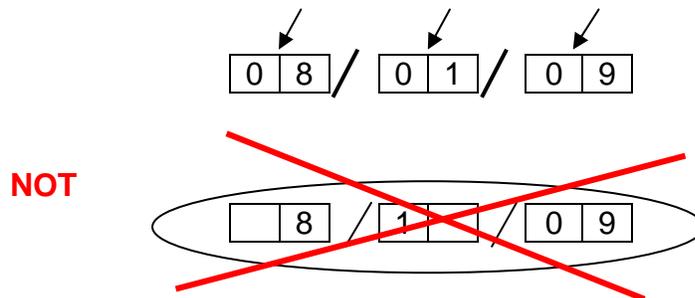
5. **Record the Testing Referral Activity**
   - If client/participant is referred to testing at your provider site that day, include the HIV test lab sticker (this is only for programs who also have HIV testing on site)

6. **Time of Encounter**
   8. Record the time that this session of the intervention or follow-up started.
   9. Record the time using a 12 hour format including hours and minutes.
   - Select **only one** answer choice for **AM/PM** by completely filling in one bubble/circle.

7. **Source of Referral.** This variable/field should only be completed at the **FIRST SESSION** of the IDG.
   - Record where the client was referred from or how the client found out about the intervention/program.

- Select **only one** answer choice for this variable by completely filling in one bubble/circle.
- If the client/participant says he/she was referred from multiple sources, **ask the client to select one.**
- If the client/participant selects "Agency" (your agency or any other agency), you will need to ask 7b "If you were referred from an agency, which program were you referred from?"
- If the client/participant selects "Other", you will need to ask 7a "Please tell me where you were referred from."

7a. Record the "Other" referral source
- This question should only be asked if the client/participant stated that he/she was referred from an "other" source.
- Print the name of the other type of referral source in the box. For example, if the client was referred from a dental clinic, you should put dental clinic in the box rather than the name of the dentist or clinic (e.g. Smiles Forever, Dr. Smith, etc.)

7b. Record the type of program the client was referred from
- This question should only be asked if the client/participant stated that he/she was referred from an agency.
- Select **only one** answer choice for this variable by completely filling in one bubble/circle.
- If the client/participant says he/she was referred from multiple sources, **ask the client to select one.**
- If "Other" is selected, you should not specify what the other program is. Since there is no box to capture the information, it will not be read by Teleform.

8. Referrals Provided
- This section should be completed EVERY time this form is administered.
- This variable/field is asking about referrals that you will give/gave to the client during the session.

8a. No Referrals
- If no referrals were provided on the same day that this form is being completed, then completely fill in the bubble/circle "No referrals provided."
- If a referral was given, leave the "No referrals provided" bubble blank and go to the variable/field titled "Risk/Harm Reduction".
- Agency staff may have to complete the rest of the form and/or conduct the intervention activity before completing this section.

8b. Types of Referrals Provided
- This variable/field is asking about referrals that you will give/gave to the client during the session.
- Starting with the answer choices in the "Risk/Harm Reduction" section through "Other Referrals" **select all** the types of referrals that you provided to the client/participant at this session.

- If your client/participant is not HIV positive, you should not select any of the answer choices under "Positive Referrals".
- If "other referral" is selected, go to 8c and specify what referrals were provided.
- Agency staff may have to complete the rest of the form and/or conduct the intervention activity before completing this section.

8c. Specify Referral Type
- Only complete this variable/field if "Other referral" was selected.
- Print the name(s) of the other type of referral(s) in the box.

This is the end of the IDG/GSAQ Form.

> **IMPORTANT:** The group-level forms are available in English and Spanish language.

APPENDICES

Appendix A – Cover Sheet

Appendix B - Outreach Data Collection Form

Appendix C - IDI/CRCS Data Collection Form (English)

Appendix D - IDI/CRCS Data Collection Form (Spanish)

Appendix E – IDG/GSAQ Data Collection Form (English)

Appendix F – IDG/GSAQ Data Collection Form (Spanish)

Appendix G – Administrative Form

Appendix A: Cover Sheet

54641

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

HE/RR DATA COLLECTION FORMS COVER SHEET

INSTRUCTIONS: This cover sheet must be included with all data collection forms submitted each month. HE/RR program coordinators must review all forms for completeness and accuracy prior to submission.

Number IDI/CRCS forms submitted

When writing letters or numbers, place one character in each box. For letters, use only capitals.

| A | B | C | D | E | F | G | H | I | J | K | L | M |
| N | O | P | Q | R | S | T | U | V | W | X | Y | Z |

Number of IDG/GSAQ forms submitted

Number of HE/RR Administrative forms submitted

Number of Outreach forms submitted

○ **Mark this box if you are re-submitting these forms**

Staff Initials   **Staff Signature**

_____

Agency ID

Scanned forms must be completed legibly. Photo copies of data collection forms must be first-generation only. Forms submitted with non-legible data or on non-first generation copies will be rejected and providers will be responsilbe for resubmission.

Data collection forms are due no later than the 30th of the following month. For example, December data collection forms are due no later than January 30th.

HE/RR Monthly BATCH COVER SHEET V1.0 11-25-09

Appendix B: Outreach Data Collection Form

Outreach Short Form

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

26461

Gender Identity: *(choose only one gender)*

○ Male

○ Female

○ Transgendered: M to F

○ Transgendered: F to M

Gender at Birth: *(choose only one)*

○ Male   ○ Female

Race/Ethnicity: *(choose all that apply)*

○ Black / African-American   ○ Asian

○ American Indian/ Alaska Native   ○ White

○ Hispanic/ Latino(a)   ○ Don't Know

○ Native Hawaiian/ Pacific Islander ○ Decline/Refused to Answer

○ Other race, specify: [   ]

Homeless Status: *(choose only one)*

○ Not Homeless/Has a permanent living situation indoors

○ Homeless, living outdoors

○ Homeless, staying in a shelter or transitional housing where other services are provided

○ Homeless, sleeping in a car or temporary indoor situation without additional services

○ Homeless, but cannot or will not give more detail

○ Unable or unwilling to give any information as to homeless status

Target Population: *(choose all that apply)*

○ Client is a sex worker   ○ Client shared injection paraphernalia

○ Client is HIV-positive   ○ Client is a Non-gay identified male

○ Client is a gay male   ○ Client is a transgender

○ Client is a woman   ○ Client is a youth between ages 12-24

Outreach v1.0 11-25-09   Page 2 of 2

Outreach Short Form

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

26461

Shade Circles Like This--> ●

Not Like This--> ⊗ ✓

When writing letters or numbers, place one character in each box. Please print carefully and avoid the edges of the box. For letters, use only capitals. **PLEASE USE BLACK PEN ONLY**

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

1	2	3	4	5	6	7	8	9	0

Program ID:

Site ID:

Length of Contact: *(minutes)*

Time of Encounter: ○ AM ○ PM

Date: *(mm/dd/yy)*

First Name Initial:

Last Name Initial:

What country was the client born in?

Date of Birth: *(mm/dd/yy)*

Residence Zip Code:

Testing Referral: *(choose only one)*

○ Tested at encounter   ○ Declined/refused testing

○ Referred for testing   ○ No testing referral

Place a test lab sticker in the box below if client tests today:

↓

Place Test Lab Sticker #1 Below

Incarcerated in last 12 months?

○ Yes   ○ No   ○ Declined/Refused

Outreach v1.0 11-25-09

Page 1 of 2

Appendix C: IDI/CRCS Data Collection Form (English)

Risk Assessment
Health Education/Risk Reduction
IDI & CRCS

9650

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

Shade Circles Like This--> ●

Not Like This--> ⊗ ✓

When writing letters or numbers, place one character in each box. Please print carefully and avoid the edges of the box. For letters, use only capitals. **PLEASE USE BLACK PEN ONLY**

| A | B | C | D | E | F | G | H | I | J | K | L | M |
| N | O | P | Q | R | S | T | U | V | W | X | Y | Z |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |

SESSION AND REFERRAL INFORMATION

Session: *(choose only one)*

O Session 1   O Final Session   O 60 Day Follow Up

Program ID: ☐☐☐☐

Site ID: ☐☐☐☐

Intervention Type: *(choose only one)*

O Individual Level Intervention (IDI)

O Comprehensive Risk Counseling Service (CRCS)

Date: *(mm/dd/yy)* ☐☐ / ☐☐ / ☐☐

Time of Encounter: ☐ : ☐
O AM
O PM

Length of Contact: ☐☐☐ *(minutes)*

Complete this section for IDI and CRCS encounters at the FIRST SESSION ONLY:

How was client referred? *(choose only one)*

O Agency***   O Friend/Family

O HC/PI   O Self

O Partner   O Don't Know

O Other, specify: _____

***If client was referred from an agency, which program? *(choose only one)*

O HCT   O HC/PI   O Partner Services

O CRCS   O HE/RR   O Outreach Encounter

O Intake   O Don't Know   O Other

Complete this section if client is unaware of their status or wishes to be tested. Place a test lab sticker in the box if client tests today:

Testing Referral: *(choose only one)*

O Tested at encounter

O Referred for testing

O Declined/refused testing

O No testing referral

Place Test Lab Sticker #1 Below

Referrals: *(choose all that apply)*

O No referrals provided

Risk/Harm Reduction

O Comprehensive risk counseling (CRCS)

O HIV education & prevention services

O Follow-up HIV counseling

O Prevention skill development

O Prevention support group

O Individual psychotherapy/counseling

Substance Use Services

O Alcohol/Drug Treatment

O Harm reduction services

O Syringe exchange program (SEP)

Positive Referrals

O HIV medical care

O HIV case management

Other Referrals

O HCV medical services

O Post exposure prophylaxis (PEP)

O Hepatitis testing/vaccination

O General medical services

O Other referral, specify:

O Social services

O Reproductive services

O STD testing & treatment

O TB testing & treatment

HE/RR IDI/CRCS ENGLISH v1.0 11-25-09

Page 1 of 6

9650

**Risk Assessment
Health Education/Risk Reduction
IDI & CRCS**

**COUNTY OF LOS ANGELES
Public Health**
Office of AIDS Programs & Policy

CLIENT BACKGROUND INFORMATION

First Name Initial: ☐   **Last Name Initial:** ☐

Date of Birth: *(mm/dd/yy)*
☐☐ / ☐☐ / ☐☐

Incarcerated? ○ Yes ○ No ○ Declined/Refused
(In last 12 months or since last session)

Residence Zip Code:
☐☐☐☐☐

What country was the client born in?
☐☐☐☐☐☐☐☐☐☐

Is client a sex worker? ○ Yes ○ No

Gender Identity: *(choose only one gender)*

○ Male

○ Female

○ Transgendered: M to F

○ Transgendered: F to M

○ Other, specify: ☐

Gender at Birth: *(choose only one)*

○ Male   ○ Female

Pregnant? ○ Yes   ○ No   ○ Client doesn't know

If Yes, in Perinatal Care? ○ Yes   ○ No

Homeless Status: *(choose only one)*

○ Not Homeless/Has a permanent living situation indoors

○ Homeless, living outdoors

○ Homeless, staying in a shelter or transitional housing where other services are provided

○ Homeless, sleeping in a car or temporary indoor situation without additional services

○ Homeless, but cannot or will not give more detail

○ Unable or unwilling to give any information as to homeless status

Race/Ethnicity: *(choose all that apply)*

○ Black / African-American   ○ Asian

○ American Indian/ Alaska Native   ○ White

○ Hispanic/ Latino(a)   ○ Don't Know

○ Native Hawaiian/ Pacific Islander   ○ Decline/Refused to Answer

○ Other race, specify: ☐

Sexual Orientation: *(choose only one)*

○ Heterosexual/straight

○ Bisexual

○ Gay or lesbian

○ Declined/Refused

○ Other, specify: ☐

Current Health Insurance Coverage: *(choose all that apply)*

○ No coverage   ○ Medi-Cal (Medicaid)

○ Private   ○ Indian Health Service

○ Military   ○ Other, specify:

○ Medicare   ☐

Partner Services (PS) discussed/offered to client?
(choose only one)

○ No, PS not discussed

○ Yes, client declined services

○ Yes, PS referred out

○ Yes, PS activities this session

(If yes to activities this session, initial below and indicate activities in PS Activities section) to the right)

PS Initials/ID ☐☐☐☐ *(if activities)*

If PS activities took place this session, indicate activities below and fill in PS initials/ID in section on left.

PS Activities: *(choose all that apply)*   # of Partners (1-999)

○ Skill building w/ client for self notification (indicate # of partners)   ☐☐☐

○ Anonymous third party notification (indicate # of partners)   ☐☐☐

○ Dual client/partner session (indicate # of partners)   ☐☐☐

Risk Assessment
Health Education/Risk Reduction
IDI & CRCS

9650

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

SEXUAL BEHAVIOR HISTORY

Did client have vaginal or anal sex in the last 12 months or since the last session? ○ Yes   ○ No
If yes, please complete questions below. If NO, SKIP to page 4.

If this is client's FIRST SESSION, complete the section labeled "In the Last 12 months".

If this is client's FINAL SESSION or 60 DAY FOLLOW UP, complete the section labeled "Since the Last Session".

The section labeled "Always used condoms during sex activity" should be completed for ALL Sessions.

	COMPLETE THIS COLUMN IF THIS IS YOUR FIRST SESSION			COMPLETE THIS COLUMN AT ALL OTHER SESSIONS			ALWAYS COMPLETE
	LAST 12 MONTHS			**SINCE THE LAST SESSION**			**Always used condoms during sex activity**
SEX ACTIVITY	All Partners in Last 12 Months			All Partners Since Last Session			
	Male	Female	Transgender	Male	Female	Transgender	
Oral Sex	○	○	○	○	○	○	
Vaginal Sex	○	○	○	○	○	○	○
Anal Sex	○	○	○	○	○	○	○
Exchanged sex for drugs/money/ something needed	○	○	○	○	○	○	○
Sex while intoxicated/ high on drugs	○	○	○	○	○	○	○
Sex with a partner who is an IDU	○	○	○	○	○	○	○
Sex with a partner who is HIV+	○	○	○	○	○	○	○
Sex with a partner whose HIV status is unknown	○	○	○	○	○	○	○
Sex with a partner who exchanges sex for drugs/money/etc.	○	○	○	○	○	○	○
Sex with anonymous partner	○	○	○	○	○	○	○
FOR FEMALE CLIENTS ONLY: Sex with a male or transgender partner who has sex with other men	○		○	○		○	○

How many partners has the client had vaginal or anal sex with in past 30 days? (0-999)

Male
☐☐☐

Female
☐☐☐

Transgender
☐☐☐

Risk Assessment
Health Education/Risk Reduction
IDI & CRCS

9650

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

SUBSTANCE USE HISTORY

In the last 12 months OR since the last session, has client injected any substance (drugs, hormones, insulin, vitamins, etc.) AND shared needles or works?
O Yes O No

Has client EVER injected any substance (drugs, hormones, insulin, vitamins, etc.) AND shared needles or works?
O Yes O No

SUBSTANCES USED
(Last 12 months or Since the Last Session)
O No alcohol or drug use   O Declined/Refused

If no drug use in last 12 mo. or since last session, skip the section to the right

Mark all substances used:	Injected:		Had sex while high or intoxicated:	
O Alcohol			O Yes	O No
O Methamphetamine	O Yes	O No	O Yes	O No
O Cocaine (Powder)	O Yes	O No	O Yes	O No
O Crack (Rock)	O Yes	O No	O Yes	O No
O Heroin (dope, junk, skag, smack, H)	O Yes	O No	O Yes	O No
O Other Drug, Specify:	O Yes	O No	O Yes	O No

HIV Test Information

Number of prior HIV tests:
(enter "0" if never tested before today)

[ ][ ]   O Declined/Refused to Answer

(mm/yy)
Date of last HIV test result received? [ ][ ] / [ ][ ]

If you have tested before, what was the last test result you received? *(Choose only one)*

O Negative

O Positive

O Preliminary positive (no confirmatory result received by client)

O Inconclusive, discordant, invalid

O Never received a result

O Declined/Refused to Answer

HIV Medical Care

If client states he/she is HIV+, complete the following questions.
If this is the FIRST session, answer the questions for the past 6 months. For all other intervention sessions or follow up, answer the following questions in terms of 'since last session:

How many times did you see a health care provider for your HIV? Please don't include times when you had an emergency room visit or a hospital admission, or only had a lab test done.
If first session, # in past 6 months.
All other sessions, # since last session.

Enter # from 0-199
[ ][ ][ ] O Declined/Don't Know

(mm/yy)
Date of last HIV medical care visit? [ ][ ] / [ ][ ]

If client tested positive today and was not referred this visit, why? (Choose only one)
O Client already in care
O Client declined care

STDs & HEPATITIS: Last 12 Months or Since the Last Session *(choose all that apply)*:

O No STDs/Hepatitis	O Chlamydia	O Genital Herpes (HSV)
O Syphilis (syph, the pox, lues)	O Human Papilloma Virus (HPV)	O Hepatitis C (HCV)
O Gonorrhea (GC, clap, drip)	O Trichomoniasis (trich)	O Other STD, specify:
O Hepatitis A (HAV)	O Hepatitis B (HBV)	

Have you EVER been vaccinated for either of the following? *(choose all that apply)*:
O Hepatitis A   O Hepatitis B

Self Administered Questionnaire

41549

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

When writing letters or numbers, place one character in each box. Please print carefully and avoid the edges of the box. For letters, use only capitals. **PLEASE USE BLACK PEN ONLY**

Shade Circles Like This--> ●

Not Like This--> ⊗ ✓

| A | B | C | D | E | F | G | H | I | J | K | L | M |
| N | O | P | Q | R | S | T | U | V | W | X | Y | Z |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |

Please complete all of the following questions.
If you need assistance please ask the person who gave you this form.

Place the first initials of your first and last name in the boxes below:

First Name Initial: Last Name Initial:

What is your date of birth? (mm/dd/yy)

[ ] [ ] / [ ] [ ] / [ ] [ ]

What is the zip code for your home/regular hang out?

[ ] [ ] [ ] [ ] [ ]

What gender do you consider yourself?
(choose only one gender)

O Male

O Female

O Transgendered: M to F

O Transgendered: F to M

O Other

For the next set of questions, please indicate to what extent you agree or disagree:

AIDS is now nearly cured.
(choose only one)
O Strongly Disagree

O Disagree

O Neither Agree nor Disagree

O Agree

O Strongly Agree

Being HIV-positive isn't that big of a deal now that treatments are better. (choose only one)
O Strongly Disagree

O Disagree

O Neither Agree nor Disagree

O Agree

O Strongly Agree

If you are HIV-, what do you think your chances of getting HIV are? If you are HIV+, what do you think your chances of transmitting HIV are?
(choose only one)

O Very Likely

O Likely

O Neither Likely nor Unlikely

O Unlikely

O Very Unlikely

I am able to use a condom under any situation so that I don't get or spread HIV. (Such as when I am drunk or high or when my partner doesn't want to use condoms)
(choose only one)

O Strongly Disagree

O Disagree

O Neither Agree nor Disagree

O Agree

O Strongly Agree

Self Administered Questionnaire

For the next set of questions, please indicate if you believe the statement is true or false:

	True	False	Don't Know
Pulling out the penis before a man climaxes/cums keeps a man/woman from getting HIV during sex.	O	O	O
A man/woman can get HIV if he/she has anal sex with a man.	O	O	O
People who have been infected with HIV quickly show serious signs of being infected.	O	O	O
There is a vaccine that can stop adults from getting HIV.	O	O	O
People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV.	O	O	O
Having sex with more than one partner can increase a person's chance of being infected with HIV.	O	O	O

Thank you! All of your responses will remain confidential.
Your answers will help our agency to better serve you.
If you have any questions or concerns as a result of these questions or your answers,
you may talk with your group facilitator.

Admin Use Only: To be completed by agency staff.

Intervention Type:

O Individual Level Intervention (IDI)

O Comprehensive Risk Counseling Service (CRCS)

O Group

Date: *(mm/dd/yy)*

☐☐ / ☐☐ / ☐☐

Session:

O Session 1

O Final Session

O 30 Fay Follow Up

O 60 Day Follow Up

Program ID: **Site ID:**

☐☐☐☐   ☐☐☐☐

Appendix D: IDI/CRCS Data Collection Form (Spanish)

Risk Assessment
Health Education/Risk Reduction
IDI & CRCS

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

9650

Shade Circles Like This--> ●

Not Like This--> ⊗ ✓

When writing letters or numbers, place one character in each box. Please print carefully and avoid the edges of the box. For letters, use only capitals. **PLEASE USE BLACK PEN ONLY**

A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

1 2 3 4 5 6 7 8 9 0

SESSION AND REFERRAL INFORMATION

Session: *(choose only one)*

O Session 1   O Final Session   O 60 Day Follow Up

Program ID:

Site ID:

Intervention Type: *(choose only one)*

O Individual Level Intervention (IDI)

O Comprehensive Risk Counseling Service (CRCS)

Date: *(mm/dd/yy)*

☐ ☐ / ☐ ☐ / ☐ ☐

Time of Encounter:

:

O AM
O PM

Length of Contact:

☐ ☐ ☐ *(minutes)*

Complete this section for IDI and CRCS encounters at the FIRST SESSION ONLY:

How was client referred? *(choose only one)*

O Agency***   O Friend/Family

O HC/PI   O Self

O Partner   O Don't Know

O Other, specify: [_____]

If client was referred from an agency, which program? *(choose only one)*

O HCT   O HC/PI   O Partner Services

O CRCS   O HE/RR   O Outreach Encounter

O Intake   O Don't Know   O Other

Complete this section if client is unaware of their status or wishes to be tested. Place a test lab sticker in the box if client tests today:

Testing Referral: *(choose only one)*

O Tested at encounter

O Referred for testing

O Declined/refused testing

O No testing referral

Place Test Lab Sticker #1 Below

[   ]

Referrals: *(choose all that apply)*

O No referrals provided

Risk/Harm Reduction

O Comprehensive risk counseling (CRCS)

O HIV education & prevention services

O Follow-up HIV counseling

O Prevention skill development

O Prevention support group

O Individual psychotherapy/counseling

Substance Use Services

O Alcohol/Drug Treatment

O Harm reduction services

O Syringe exchange program (SEP)

Positive Referrals

O HIV medical care

O HIV case management

Other Referrals

O HCV medical services

O Post exposure prophylaxis (PEP)

O Hepatitis testing/vaccination

O General medical services

O Other referral, specify:

[   ]

O Social services

O Reproductive services

O STD testing & treatment

O TB testing & treatment

HE/RR IDI/CRCS SPANISH v1.0 11-25-09

Page 1 of 6

Risk Assessment
Health Education/Risk Reduction
IDI & CRCS

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

9650

CLIENT BACKGROUND INFORMATION

First Name Initial: ☐   **Last Name Initial:** ☐

Date of Birth: *(mm/dd/yy)*
☐☐ / ☐☐ / ☐☐

Incarcerated? ⭕ Yes ⭕ No ⭕ Declined/Refused
(In last 12 months or since last session)

Residence Zip Code:
☐☐☐☐☐

What country was the client born in?
☐☐☐☐☐☐☐☐☐☐☐

Is client a sex worker? ⭕ Yes ⭕ No

Gender Identity: *(choose only one gender)*

⭕ Male

⭕ Female

⭕ Transgendered: M to F

⭕ Transgendered: F to M

⭕ Other, specify: ☐

Gender at Birth: *(choose only one)*

⭕ Male   ⭕ Female

  Pregnant? ⭕ Yes   ⭕ No   ⭕ Client doesn't know
  If Yes, in Perinatal Care? ⭕ Yes   ⭕ No

Homeless Status: *(choose only one)*

⭕ Not Homeless/Has a permanent living situation indoors

⭕ Homeless, living outdoors

⭕ Homeless, staying in a shelter or transitional housing where other services are provided

⭕ Homeless, sleeping in a car or temporary indoor situation without additional services

⭕ Homeless, but cannot or will not give more detail

⭕ Unable or unwilling to give any information as to homeless status

Race/Ethnicity: *(choose all that apply)*

⭕ Black / African-American   ⭕ Asian

⭕ American Indian/ Alaska Native   ⭕ White

⭕ Hispanic/ Latino(a)   ⭕ Don't Know

⭕ Native Hawaiian/ Pacific Islander ⭕ Decline/Refused to Answer

⭕ Other race, specify: ☐

Sexual Orientation: *(choose only one)*

⭕ Heterosexual/straight

⭕ Bisexual

⭕ Gay or lesbian

⭕ Declined/Refused

⭕ Other, specify: ☐

Current Health Insurance Coverage: *(choose all that apply)*

⭕ No coverage   ⭕ Medi-Cal (Medicaid)

⭕ Private   ⭕ Indian Health Service

⭕ Military   ⭕ Other, specify: ☐

⭕ Medicare

Partner Services (PS) discussed/offered to client?
(choose only one)

⭕ No, PS not discussed

⭕ Yes, client declined services

⭕ Yes, PS referred out

⭕ Yes, PS activities this session

(If yes to activities this session, initial below and indicate activities in PS Activities section) to the right)

PS Initials/ID ☐☐☐☐ *(if activities)*

If PS activities took place this session, indicate activities below and fill in PS initials/ID in section on left.

PS Activities: *(choose all that apply)*   # of Partners (1-999)

⭕ Skill building w/ client for self notification (indicate # of partners)   ☐☐☐

⭕ Anonymous third party notification (indicate # of partners)   ☐☐☐

⭕ Dual client/partner session (indicate # of partners)   ☐☐☐

Risk Assessment
Health Education/Risk Reduction
IDI & CRCS

9650

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

SEXUAL BEHAVIOR HISTORY

Did client have vaginal or anal sex in the last 12 months or since the last session? ○ Yes   ○ No
If yes, please complete questions below. If NO, SKIP to page 4.

If this is client's FIRST SESSION, complete the section labeled "In the Last 12 months".

If this is client's FINAL SESSION or 60 DAY FOLLOW UP, complete the section labeled "Since the Last Session".

The section labeled "Always used condoms during sex activity" should be completed for ALL Sessions.

	COMPLETE THIS COLUMN IF THIS IS YOUR FIRST SESSION			COMPLETE THIS COLUMN AT ALL OTHER SESSIONS			ALWAYS COMPLETE
	LAST 12 MONTHS			**SINCE THE LAST SESSION**			**Always used condoms during sex activity**
SEX ACTIVITY	All Partners in Last 12 Months			All Partners Since Last Session			
	Male	Female	Transgender	Male	Female	Transgender	
Oral Sex	○	○	○	○	○	○	
Vaginal Sex	○	○	○	○	○	○	○
Anal Sex	○	○	○	○	○	○	○
Exchanged sex for drugs/money/ something needed	○	○	○	○	○	○	○
Sex while intoxicated/ high on drugs	○	○	○	○	○	○	○
Sex with a partner who is an IDU	○	○	○	○	○	○	○
Sex with a partner who is HIV+	○	○	○	○	○	○	○
Sex with a partner whose HIV status is unknown	○	○	○	○	○	○	○
Sex with a partner who exchanges sex for drugs/money/etc.	○	○	○	○	○	○	○
Sex with anonymous partner	○	○	○	○	○	○	○
FOR FEMALE CLIENTS ONLY: Sex with a male or transgender partner who has sex with other men	○		○	○		○	○

How many partners has the client had vaginal or anal sex with in past 30 days? (0-999)

Male   Female   Transgender

[ ][ ][ ]   [ ][ ][ ]   [ ][ ][ ]

Risk Assessment
Health Education/Risk Reduction
IDI & CRCS

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

SUBSTANCE USE HISTORY

In the last 12 months OR since the last session, has client injected any substance (drugs, hormones, insulin, vitamins, etc.) AND shared needles or works?
O Yes O No

Has client EVER injected any substance (drugs, hormones, insulin, vitamins, etc.) AND shared needles or works?
O Yes   O No

SUBSTANCES USED
(Last 12 months or Since the Last Session)
O No alcohol or drug use   O Declined/Refused

If no drug use in last 12 mo. or since last session, skip the section to the right

Mark all substances used:	Injected:		Had sex while high or intoxicated:	
O Alcohol			O Yes	O No
O Methamphetamine	O Yes	O No	O Yes	O No
O Cocaine (Powder)	O Yes	O No	O Yes	O No
O Crack (Rock)	O Yes	O No	O Yes	O No
O Heroin (dope, junk, skag, smack, H)	O Yes	O No	O Yes	O No
O Other Drug, Specify:	O Yes	O No	O Yes	O No

HIV Test Information

Number of prior HIV tests:
(enter "0" if never tested before today)

[ ][ ]   O Declined/Refused to Answer

(mm/yy)
Date of last HIV test result received? [ ][ ] / [ ][ ]

If you have tested before, what was the last test result you received?   *(Choose only one)*

O Negative

O Positive

O Preliminary positive (no confirmatory result received by client)

O Inconclusive, discordant, invalid

O Never received a result

O Declined/Refused to Answer

HIV Medical Care

If client states he/she is HIV+, complete the following questions.
If this is the FIRST session, answer the questions for the past 6 months. For all other intervention sessions or follow up, answer the following questions in terms of 'since last session:

How many times did you see a health care provider for your HIV? Please don't include times when you had an emergency room visit or a hospital admission, or only had a lab test done.
If first session, # in past 6 months.
All other sessions, # since last session.

Enter # from 0-199

[ ][ ][ ] O Declined/Don't Know

(mm/yy)
Date of last HIV medical care visit? [ ][ ] / [ ][ ]

If client tested positive today and was not referred this visit, why? (Choose only one)
  O Client already in care
  O Client declined care

STDs & HEPATITIS: Last 12 Months or Since the Last Session *(choose all that apply)*:

O No STDs/Hepatitis	O Chlamydia	O Genital Herpes (HSV)
O Syphilis (syph, the pox, lues)	O Human Papilloma Virus (HPV)	O Hepatitis C (HCV)
O Gonorrhea (GC, clap, drip)	O Trichomoniasis (trich)	O Other STD, specify:
O Hepatitis A (HAV)	O Hepatitis B (HBV)	

Have you EVER been vaccinated for either of the following? *(choose all that apply)*:
  O Hepatitis A   O Hepatitis B

HE/RR IDI/CRCS SPANISH v1.0 11-25-09

Page 4 of 6

Cuestionario Auto-Administrado

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

Cuando escriba letras ó números, coloque un caractér en cada casilla. Escriba en letras mayúsculas solamente.

UTILIZE UNA PLUMA DE TINTA NEGRA

Rellene el círculo así → ●

No así → ✗ ✓

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

1	2	3	4	5	6	7	8	9	0

Por favor conteste las siguientes preguntas.
Si Ud. necesita ayuda, comuníquese con la persona que le dio este formulario.

Inicial de su primer nombre:

Inicial de su apellido:

¿Qué género se considera Ud?
- O Hombre
- O Mujer
- O Transgénero: Hombre a Mujer
- O Transgénero: Mujer a Hombre
- O Otro

¿Cuál es su fecha de nacimiento? *(mm/dd/aa)*

¿Cuál es el código postal de su hogar/lugar habitual donde socializa?

Para el próximo grupo de preguntas, por favor indique hasta dónde está de acuerdo o desacuerdo:

El SIDA ha sido casi curado.
- O Totalmente en Desacuerdo
- O En Desacuerdo
- O Ni de Acuerdo ni en Desacuerdo
- O De Acuerdo
- O Totalmente de Acuerdo

Ser VIH positivo no es gran cosa ahora que los tratamientos son mejores.
- O Totalmente en Desacuerdo
- O En Desacuerdo
- O Ni de Acuerdo ni en Desacuerdo
- O De Acuerdo
- O Totalmente de Acuerdo

Si Ud. es VIH-, ¿cuál cree que es su probabilidad de infectarse con VIH?
Si Ud. es VIH+, ¿cuál cree que es su probabilidad de transmitir el VIH?

- O Muy probable
- O Probable
- O Ni Probable ni Improbable
- O Improbable
- O Muy Improbable

Soy capaz de usar condones bajo cualquier circunstancia para no infectarme o pasar el VIH.
(como cuando estoy borracho/a ó drogado/a ó cuando mi pareja no quiere usar condones)

- O Totalmente en Desacuerdo
- O En Desacuerdo
- O Ni de Acuerdo ni en Desacuerdo
- O De Acuerdo
- O Totalmente de Acuerdo

Cuestionario Auto-Administrado

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

Para el próximo grupo de preguntas, por favor indique si cree que la frase es verdadera o falsa:

	Verdadero	Falso	No Sé
Sacar el pene antes que el hombre alcance el clímax/eyacule, no deja que la mujer se infecte con VIH durante el sexo.	O	O	O
Hobres o mujeres se pueden infectar del VIH si tienen sexo anal con un hombre.	O	O	O
La gente que se infecta con el VIH muestra pronto señales serias de haberse Infectado.	O	O	O
Hay una vacuna que no deja que los adultos se infecten con el VIH.	O	O	O
Es probable que la gente se infecte con el VIH al besar profundamente ó poner la lengua en la boca de su pareja, si su pareja tiene el VIH.	O	O	O
Tener relaciones con más de una pareja puede aumentar la probabilidad que una persona se infecte con el VIH.	O	O	O

¡Gracias!

Sus respuestas serán confidenciales.
Sus respuestas ayudarán a nuestra agencia a servirle mejor.
Si Ud tiene alguna pregunta o inquietud por estas preguntas o sus
respuestas, puede hablar con su facilitador de grupo.

Sección Administrativo: Esta sección debe ser completada por un/a trabajador/a de la agencia.

Intervention Type:

O Individual Level Intervention (IDI)

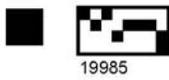O Comprehensive Risk Counseling Service (CRCS)

O Group

Date: *(mm/dd/yy)*

☐☐ / ☐☐ / ☐☐

Session:

O Session 1

O Final Session

O 30 Fay Follow Up

O 60 Day Follow Up

Program ID: ☐☐☐☐   **Site ID:** ☐☐☐☐

HE/RR ICI-CRCS SPANISH v1.0 11-25-09

Page 6 of 6

Appendix E: IDG/GSAQ Data Collection Form (English)

GROUP SELF ADMINISTERED QUESTIONNAIRE (GSAQ)

19985

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

Shade Circles Like This--> ●

Not Like This-->

When writing letters or numbers, place one character in each box. Please print carefully and avoid the edges of the box. For letters, use only capitals. **PLEASE USE BLACK PEN ONLY**

| A | B | C | D | E | F | G | H | I | J | K | L | M |
| N | O | P | Q | R | S | T | U | V | W | X | Y | Z |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |

SOME BACKGROUND INFORMATION ABOUT YOU

First Name Initial:

Last Name Initial:

What is your date of birth? *(mm/dd/yy)*

What is the zip code for your home?

In what country were you born?

Have you been incarcerated in the last 12 months or since the last session? O Yes O No

Are you a sex worker? O Yes O No

What gender do you consider yourself?
(choose only one gender)

O Male

O Female

O Transgender: M to F

O Transgender: F to M

O Other, specify:

What was your gender at birth?
(choose only one)

O Male O Female

If female, are you pregnant?
O Yes O No O Don't Know

If pregnant, are you in prenatal care?
O Yes O No

Which of the following comes closest to your sexual orientation? *(choose only one)*

O Heterosexual/straight O Gay or lesbian

O Bisexual O Declined/Refused

O Other, specify:

What type of health insurance do you currently have?
(choose all that apply)

O No coverage O Medi-Cal (Medicaid)

O Private O Indian Health Service

O Military O Other, specify:

O Medicare

What is your homeless status? *(choose only one)*

O Not Homeless/Has a permanent living situation indoors

O Homeless, living outdoors

O Homeless, staying in a shelter or transitional housing where other services are being provided

O Homeless, sleeping in a car or temporary indoor situation without additional services

O Homeless, but cannot or will not give more detail

O Unable or unwilling to give any information as to homeless status

What is your race/ethnicity? *(mark all that apply)*

O Black/African-American O Asian

O American Indian/Alaska Native O White

O Hispanic/Latino(a) O Don't Know

O Native Hawaiian/Pacific Islander O Declined

O Other race, specify:

GSAQ v1.0 ENGLISH 11-25-09

Page 1 of 6

GROUP SELF ADMINISTERED QUESTIONNAIRE (GSAQ)

COUNTY OF LOS ANGELES Public Health Office of AIDS Programs & Policy
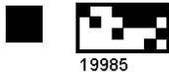
SEXUAL BEHAVIOR HISTORY

Did you have vaginal or anal sex in the last 12 months or since the last session? ○ Yes   ○ No
If yes, please complete questions below. If NO, SKIP to page 3.

If this is your FIRST SESSION, complete the section labeled "In the Last 12 months".

If this is your FINAL SESSION or 30 DAY FOLLOW UP, complete the section labeled "Since the Last Session".

The section labeled "Always used condoms during sex activity" should be completed for ALL Sessions.

	COMPLETE THIS COLUMN IF THIS IS YOUR FIRST SESSION			COMPLETE THIS COLUMN AT ALL OTHER SESSIONS			ALWAYS COMPLETE
SEX ACTIVITY	**LAST 12 MONTHS**			**SINCE THE LAST SESSION**			**Always used condoms during sex activity**
	All Partners in Last 12 Months			All Partners Since Last Session			
	Male	Female	Transgender	Male	Female	Transgender	
Oral Sex	○	○	○	○	○	○	
Vaginal Sex	○	○	○	○	○	○	○
Anal Sex	○	○	○	○	○	○	○
Exchanged sex for drugs/money/ something needed	○	○	○	○	○	○	○
Sex while intoxicated/ high on drugs	○	○	○	○	○	○	○
Sex with a partner who is an IDU	○	○	○	○	○	○	○
Sex with a partner who is HIV+	○	○	○	○	○	○	○
Sex with a partner whose HIV status is unknown	○	○	○	○	○	○	○
Sex with a partner who exchanges sex for drugs/money/etc.	○	○	○	○	○	○	○
Sex with anonymous partner	○	○	○	○	○	○	○
FOR FEMALE CLIENTS ONLY: Sex with a male or transgender partner who has sex with other men	○		○	○		○	○

How many partners have you had vaginal or anal sex with in the past 30 days? (0-999)

Male [   ][   ][   ]   Female [   ][   ][   ]   Transgender [   ][   ][   ]

GSAQ v1.0 ENGLISH 11-25-09

Page 2 of 6

SEXUAL HEALTH HISTORY

Were you diagnosed with an STD or Hepatitis in the last 12 months or since the last session? *(mark all that apply)*

O No STDs/Hepatitis   O Chlamydia   O Genital Herpes (HSV)

O Syphilis (syph, the pox, lues)   O Human Papilloma Virus (HPV)   O Hepatitis C (HCV)

O Gonorrhea (GC, clap, drip)   O Trichomoniasis (trich)   O Other STD, specify:

O Hepatitis A (HAV)   O Hepatitis B (HBV)

Have you EVER been vaccinated for either of the following? *(choose all that apply):*

O Hepatitis A   O Hepatitis B

How many times have you tested for HIV?

(enter "0" if you have never tested before today)

O Mark here if you Decline/Refused to Answer

What was the date of your last HIV test result received? *(mm/yy)*

If you have tested before, what was the last HIV test result you received? *(choose only one)*

O Negative   O Inconclusive, discordant, invalid

O Preliminary Positive (no confirmatory result received by client)   O Never received a result

O Positive   O Declined/Refused to answer

HIV Medical Care

If you are HIV+, complete the following questions. If this is the FIRST session, answer the question for the past 6 months. For all other intervention sessions or follow up, answer the following questions in terms of 'since last session':

How many times did you see a health care provider for your HIV? Please don't include times when you had an emergency room visit or a hospital admission, or only had a lab test done.

If first session, # in past 6 months.
All other sessions, # since last session.

Enter # from 0-199

O Declined/Don't Know

Date of last HIV medical care visit? *(mm/yy)*

HIV Medical Care:
(If you tested positive today and were not referred this visit, why?)

O Already in care

O Declined care

GROUP SELF ADMINISTERED QUESTIONNAIRE (GSAQ)

COUNTY OF LOS ANGELES Public Health
Office of AIDS Programs & Policy

SUBSTANCE USE HISTORY

The following questions are about recreational street drugs that you may have used in the last 12 months or since the last session but does NOT include any drugs taken under a doctor's order or hormones.

In the last 12 months or since the last session, have you injected any substance (drugs, hormones, insulin, vitamins, etc.) AND shared needles or works?

O Yes   O No

Have you EVER injected any substance (drugs, hormones, insulin, vitamins, etc) AND shared needles or works?

O Yes   O No

In the last 12 months or since the last session, have you used any of the following substances?

O No alcohol or drug use   O Declined/Refused

If no alcohol or drug use, please skip this section. If yes, please mark all that apply.

Did you use any of the following substances(s)?	If yes, did you have sex while using the drug?	Did you inject the drug?
O Alcohol	O Yes O No	
O Methamphetamine (speed, crank, crystal, tina)	O Yes O No	O Yes O No
O Cocaine (powder)	O Yes O No	O Yes O No
O Crack (rock)	O Yes O No	O Yes O No
O Heroin (horse, junk, skag, smack, H)	O Yes O No	O Yes O No
O Other Drug, Specify:	O Yes O No	O Yes O No

Please continue on next page ➡

GROUP SELF ADMINISTERED QUESTIONNAIRE (GSAQ)

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

SELF-PERCEIVED RISK AND KNOWLEDGE

Please indicate to what extent you agree or disagree with the statements below:

AIDS is now nearly cured.
(choose only one)
O Strongly Disagree
O Disagree
O Neither Agree nor Disagree
O Agree
O Strongly Agree

Being HIV-positive isn't that big of a deal now that treatments are better. *(choose only one)*
O Strongly Disagree
O Disagree
O Neither Agree nor Disagree
O Agree
O Strongly Agree

If you are HIV-, what do you think your chances of getting HIV are? If you are HIV+, what do you think your chances of transmitting HIV are?
(choose only one)
O Very Likely
O Likely
O Neither Likely nor Unlikely
O Unlikely
O Very Unlikely

I am able to use a condom under any situation so that I don't get or spread HIV. *(Such as when I am drunk or high or when my partner doesn't want to use condoms)*
(choose only one)
O Strongly Disagree
O Disagree
O Neither Agree nor Disagree
O Agree
O Strongly Agree

For the next set of questions, please indicate if you believe the statement is true or false:

	True	False	Don't Know
Pulling out the penis before a man climaxes/cums keeps a man/woman from getting HIV during sex.	O	O	O
A man/woman can get HIV if he/she has anal sex with a man.	O	O	O
People who have been infected with HIV quickly show serious signs of being infected.	O	O	O
There is a vaccine that can stop adults from getting HIV.	O	O	O
People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV.	O	O	O
Having sex with more than one partner can increase a person's chance of being infected with HIV.	O	O	O

Thank you! All of your responses will remain confidential.
Your answers will help our agency to better serve you.
If you have any questions or concerns as a result of these questions or your answers,
you may talk with your group facilitator.

GROUP SELF ADMINISTERED QUESTIONNAIRE
(GSAQ)

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

ADMINISTRATIVE USE ONLY

Program ID: ☐☐☐☐ **Site ID:** ☐☐☐☐

Time of Encounter:
☐☐ : ☐☐
○ AM
○ PM

Session: *(choose only one)*
○ Session 1
○ Final Session
○ 30 Day Follow Up

Complete this section at the first session only:
How was client referred? *(choose only one)*
○ Agency***   ○ Friend/Family
○ HC/PI   ○ Self
○ Partner   ○ Don't Know
○ Other, specify: ☐☐☐☐☐☐

Session Date:
(mm/dd/yy)
☐☐ / ☐☐ / ☐☐

Complete this section if client is unaware of their status or wishes to be tested. Place a test lab sticker in the box if client tests today:

Testing Referral: *(choose only one)*
○ Tested at encounter
○ Referred for testing
○ Declined/refused testing
○ No testing referral

Place Test Lab Sticker #1 Below

***If client was referred from an agency, which program?
○ HCT   ○ HC/PI   ○ HE/RR
○ Partner Services   ○ CRCS
○ Intake   ○ Outreach Encounter
○ Other   ○ Don't Know

Referrals: *(choose all that apply)*
○ No referrals provided

Risk/Harm Reduction
○ Comprehensive risk counseling (CRCS)
○ HIV education & prevention services
○ Follow-up HIV counseling

○ Prevention support group
○ Prevention skill development
○ Individual psychotherapy/counseling

Positive Referrals
○ HIV medical care
○ HIV case management

Other Referrals
○ HCV medical services
○ Post exposure prophylaxis (PEP)
○ Hepatitis testing/vaccination
○ General medical services
○ Social services

○ Reproductive services
○ STD testing & treatment
○ TB testing & treatment
○ Other referral, specify: ☐☐☐☐☐☐

Substance Use Services
○ Alcohol/Drug Treatment
○ Harm reduction services
○ Syringe exchange program (SEP)

GSAQ v1.0 ENGLISH 11-25-09

Page 6 of 6

Appendix F: IDG/GSAQ Data Collection Form (Spanish)

12043

CUESTIONARIO AUTO-ADMINISTRADO DE GRUPO (GSAQ)

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

Cuando escriba letras ó números, coloque un caractér en cada casilla. Escriba en letras mayúsculas solamente.

| A | B | C | D | E | F | G | H | I | J | K | L | M |
| N | O | P | Q | R | S | T | U | V | W | X | Y | Z |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |

UTILIZE UNA PLUMA DE TINTA NEGRA

Rellene el círculo así   --> ●

No así   --> ✗ ✓

INFORMACION SOBRE USTED

Inicial de su primer nombre:

Inicial de su apellido:

¿Cuál es su fecha de nacimiento? *(mm/dd/aa)*

¿Cuál es el código postal de su hogar/lugar habitual donde socializa?

¿En que país nació usted?

¿Qué clase de seguro medico tiene usted?
(Llene todas las opciones que correspondan)

○ No Tengo Seguranza   ○ Medi-Cal (Medicaid)

○ Seguro Privado   ○ Servicios para Indios Americanos

○ Militar   ○ Medicare

○ Otro, especifique:

¿Qué género se considera Ud? (escoja una opción)

○ Hombre   ○ Transgénero: Hombre a Mujer

○ Mujer   ○ Transgénero: Mujer a Hombre

○ Otro, especifique:

¿Cuál fue su género al nacer? (escoja una opción)

○ Hombre   ○ Mujer

¿Si es mujer, está embarazada?

○ Sí   ○ No   ○ No sé

¿Si está embarazada, está en cuidado prenatal?

○ Sí   ○ No

¿Cuál de las siguientes opciones describe su raza/orígen étnico? *(llene todas que correspondan)*

○ Negro/Afro-Americano   ○ Asiático

○ Nativo Americano/Nativo de Alaska   ○ Blanco

○ Hawaiiano/Isleño de las Islas del Pacífico   ○ Hispano/Latino(a)

○ Declino Responder   ○ No sé

○ Otro, especifique:

¿Alguna vez ha sido encarcelado en los últimos 12 meses o desde la última sesión? ○ Sí   ○ No

¿Es Ud. un(a) trabajador(a) sexual? ○ Sí   ○ No

¿Cuál es su situación de desamparado/a?
(escoja una opción)

○ No estoy desamparado(a)/Tengo un lugar bajo techo permanente

○ Desamparado/a, vivo en la calle

○ Desamparado/a, me quedo en un refugio u hogar temporal donde dan otros servicios

○ Desamparado/a, duermo en un vehículo ó situación bajo techo temporal sin servicios adicionales

○ Desamparado/a, pero no puedo ó no quiero dar más detalles

○ Incapaz o no dispuesto/a a dar ninguna información sobre mi situación de desamparado/a

¿Cuál de las siguientes opciones describe su orientación sexual? (escoja una opción)

○ Heterosexual   ○ Homosexual o Lesbiana

○ Bisexual   ○ Declino/Rehuso responder

○ Otro, especifique:

GSAQ Spanish v1.0 11-25-09

Page 1 of 6

CUESTIONARIO AUTO-ADMINISTRADO DE GRUPO (GSAQ)

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

HISTORIA SE CONDUCTAS SEXUALES

¿Tuvo sexo vaginal o anal en los últimos 12 meses o desde la última sesión? O Sí   O No
Si respondió que sí, completa las preguntas que siguen.
Si respondió que no, adelántese a la siguiente página.

Si esta sesión es su PRIMERA SESION, completa la sección que dice "En Los Ultimos 12 Meses"

Si esta sesión es su ULTIMA SESION o SEGUIMIENTO DE 30 DIAS, completa la sección que dice "Desde la Ultima Sesión"

Para TODAS LAS SESIONES, por favor completa la sección que dice "Siempre use condones durante actividades de sexo"

	Completa esta sección si esta es su PRIMERA SESION			Completa esta sección para SIGUIENTE SESIONES			Siempre Completa
	En Los Ultimos 12 Meses			**Desde la Ultima Sesión**			
Actividad Sexual	Todas parejas en las Ultimos 12 Meses			Todas parejas desde la Ultima Sesión			Siempre usé condones durante actividades de sexo
	Hombre	**Mujer**	**Transgénero**	**Hombre**	**Mujer**	**Transgénero**	
Sexo Oral	O	O	O	O	O	O	
Sexo Vaginal	O	O	O	O	O	O	O
Sexo Anal	O	O	O	O	O	O	O
Intercambió sexo para drogas, dinero, o algo que necesitaba	O	O	O	O	O	O	O
Sexo mientras estaba intoxicado/drogado	O	O	O	O	O	O	O
Sexo con pareja que se inyecta drogas	O	O	O	O	O	O	O
Sexo con pareja que es VIH positiva	O	O	O	O	O	O	O
Sexo con pareja cuya situación del VIH es desconocida	O	O	O	O	O	O	O
Sexo con pareja que intercambia sexo por drogas/dinero/etc.	O	O	O	O	O	O	O
Sexo con pareja anónima	O	O	O	O	O	O	O
Solamente para mujeres: Sexo con un hombre o Transgénero que tiene sexo con otros hombres	O		O	O		O	O

¿Con cuantas parejas tuvo sexo vaginal o anal en los últimos 30 días? # (0-999)

Hombres   Mujeres   Transgéneros

[ ][ ][ ]   [ ][ ][ ]   [ ][ ][ ]

GSAQ Spanish v1.0 11-25-09

Page 2 of 6

**CUESTIONARIO AUTO-ADMINISTRADO
DE GRUPO (GSAQ)**

**COUNTY OF LOS ANGELES
Public Health**
Office of AIDS Programs & Policy

12043

HISTORIA DE SALUD SEXUAL

¿Durante los últimos 12 meses, fue diagnosticado(a) con una enfermedad transmitida sexualmente (STD)? *(Llene todas las opciones que correspondan)*

O No STDs/Hepatitis   O Clamidia   O Herpes Genital (HSV)

O Sífilis (syph, the pox, lues)   O Verrugas Genitales/Anales (HPV)   O Hepatitis C (HCV)

O Gonorrea (GC, clap, drip)   O Trichomoniasis (trich)   O Otra, especifique:

O Hepatitis A (HAV)   O Hepatitis B (HBV)

¿Se ha vacunado por alguna de las siguientes? *(Llene todas las opciones que correspondan)*

O Hepatitis A   O Hepatitis B

Si se ha hecho la prueba de VIH, cuántas veces?
(Escribe "0" si no se había hecho la prueba antes de hoy)
O Rellene aquí si Ud. Declina/Rehusa Responder

Fecha de la última prueba que se hizo y recibió su resultado. *(mm/aa)*

¿Si se ha hecho la prueba de VIH, cuál fue su resultado más reciente? *(escoja una opción)*

O Negativo   O Inconcluso, discordante, inválido

O Positivo Preliminario (sin confirmación)   O Nunca recibí mis resultados

O Positivo   O Declino/Rehuso Responder

Si Ud. es VIH+, por favor conteste las siguientes preguntas:
Si esta es su PRIMERA sesión, conteste las preguntas pensando en los últimos 6 meses. Por otras sesiones, contesta las preguntas considerando el tiempo DESDE LA ULTIMA SESION.

¿Cuántas veces visitó a un proveedor de salud por su infección del VIH?
Por favor no incluya ninguna vez cuando tuvo una visita a una sala de emergencia, fue internado/a en el hospital, o solamente visitó el laboratorio para exámenes:

Por la primera sesión, # en los últimos 6 meses.
Por otras sesiones, # desde la última sesión.
Escribe # de 0-199

O Declino Responder/No sé

¿Fecha de su última visita de cuidado médico? *(mm/aa)*

Cuidado Médico por VIH:
Si su prueba de VIH resulto positiva hoy, ¿por que no recibió una referencia para cuidado médico?

O Ya estoy recibiendo cuidado médico por mi VIH

O Rehusé la referencia para cuidado médico

GSAQ Spanish v1.0 11-25-09   Page 3 of 6

November 30, 2009   94

12043

**CUESTIONARIO AUTO-ADMINISTRADO
DE GRUPO (GSAQ)**

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

HISTORIA DE SALUD SEXUAL

*Las siguientes preguntas son acerca de fármacos recreativos que Ud. haya usado en los últimos 12 meses,
ó desde la última sesión, pero NO incluye ninguna droga que haya tomado bajo prescripción médica u hormonas.*

**¿Alguna vez, se ha inyectado alguna sustancia (drogas, hormonas, insulina,
vitaminas, etc.) Y compartió sus agujas o equipo?**

O Sí   O No

**¿En los últimos 12 meses, se ha inyectado alguna sustancia (drogas, hormonas,
insulina, vitaminas, etc.) Y compartió sus agujas o equipo?**

O Sí   O No

**¿Durante los últimos 12 meses o desde la última sesión, he usado
alguna de las siguientes sustancias?**

O No use alcohol o drogas   O Declino Responder

*Si respondió NO, no hay que completar la última sección de este formulario.
Si respondió que SÍ, por favor llene todas las opciones que correspondan.*

¿Usó alguna de las siguientes sustancias?	Si respondió que sí, ¿tuvo sexo mientras usaba esta sustancia?	¿Se inyectó esta droga?
O **Alcohol**	O Sí O No	
O **Metanfetaminas (speed, crank, crystal, tina)**	O Sí O No	O Sí O No
O **Cocaína (polvo)**	O Sí O No	O Sí O No
O **Piedra (crack)**	O Sí O No	O Sí O No
O **Heroína (horse, junk, skag, smack, H)**	O Sí O No	O Sí O No
O **Otra, especifique:**	O Sí O No	O Sí O No

Por favor completa las preguntas en la siguiente página ➡

12043

CUESTIONARIO AUTO-ADMINISTRADO
DE GRUPO (GSAQ)

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

PREGUNTAS ADICIONALES

Por favor indique hasta dónde está de acuerdo o desacuerdo con cada frase:

El SIDA ha sido casi curado.
- ⭘ Totalmente en Desacuerdo
- ⭘ En Desacuerdo
- ⭘ Ni de Acuerdo ni en Desacuerdo
- ⭘ De Acuerdo
- ⭘ Totalmente de Acuerdo

Ser VIH positivo no es gran cosa ahora que los tratamientos son mejores.
- ⭘ Totalmente en Desacuerdo
- ⭘ En Desacuerdo
- ⭘ Ni de Acuerdo ni en Desacuerdo
- ⭘ De Acuerdo
- ⭘ Totalmente de Acuerdo

Si Ud. es VIH-, ¿cuál cree que es su probabilidad de infectarse con VIH? Si Ud. es VIH+, ¿cuál cree que es su probabilidad de transmitir el VIH?
- ⭘ Muy probable
- ⭘ Probable
- ⭘ Ni Probable ni Improbable
- ⭘ Improbable
- ⭘ Muy Improbable

Soy capaz de usar condones bajo cualquier circunstancia para no infectarme o pasar el VIH.
(como cuando estoy borracho/a ó drogado/a ó cuando mi pareja no quiere usar condones)
- ⭘ Totalmente en Desacuerdo
- ⭘ En Desacuerdo
- ⭘ Ni de Acuerdo ni en Desacuerdo
- ⭘ De Acuerdo
- ⭘ Totalmente de Acuerdo

Para el próximo grupo de preguntas, por favor indique si cree que la frase es verdadera o falsa:

	Verdadero	Falso	No Sé
Sacar el pene antes que el hombre alcance el clímax/eyacule, no deja que la mujer se infecte con VIH durante el sexo.	⭘	⭘	⭘
Hobres o mujeres se pueden infectar del VIH si tienen sexo anal con un hombre.	⭘	⭘	⭘
La gente que se infecta con el VIH muestra pronto señales serias de haberse Infectado.	⭘	⭘	⭘
Hay una vacuna que no deja que los adultos se infecten con el VIH.	⭘	⭘	⭘
Es probable que la gente se infecte con el VIH al besar profundamente ó poner la lengua en la boca de su pareja, si su pareja tiene el VIH.	⭘	⭘	⭘
Tener relaciones con más de una pareja puede aumentar la probabilidad que una persona se infecte con el VIH.	⭘	⭘	⭘

¡Gracias!
Sus respuestas serán confidenciales. Sus respuestas ayudarán a nuestra agencia a servirle mejor. Si Ud tiene alguna pregunta o inquietud por estas preguntas o sus respuestas, puede hablar con su facilitador de grupo.

CUESTIONARIO AUTO-ADMINISTRADO DE GRUPO (GSAQ)

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

ADMINISTRATIVE USE ONLY

Program ID: ☐☐☐☐ Site ID: ☐☐☐☐

Time of Encounter:
☐☐ : ☐☐   ○ AM
             ○ PM

Session: *(choose only one)*
○ Session 1
○ Final Session
○ 30 Day Follow Up

What is today's date?
(mm/dd/yy)
☐☐ / ☐☐ / ☐☐

Complete this section at the first session only:
How was client referred? *(choose only one)*
○ Agency***   ○ Friend/Family
○ HC/PI   ○ Self
○ Partner   ○ Don't Know
○ Other, specify: ☐☐☐☐☐☐

***If client was referred from an agency, which program?**
○ HCT   ○ HC/PI   ○ HE/RR
○ Partner Services   ○ CRCS
○ Intake   ○ Outreach Encounter
○ Other   ○ Don't Know

Complete this section if client is unaware of their status or wishes to be tested. Place a test lab sticker in the box if client tests today:

Testing Referral: *(choose only one)*
○ Tested at encounter
○ Referred for testing
○ Declined/refused testing
○ No testing referral

Place Test Lab Sticker #1 Below
☐

Referrals: *(choose all that apply)*
○ No referrals provided

Risk/Harm Reduction
○ Comprehensive risk counseling (CRCS)   ○ Prevention support group
○ HIV education & prevention services   ○ Prevention skill development
○ Follow-up HIV counseling   ○ Individual psychotherapy/counseling

Other Referrals
○ HCV medical services   ○ Reproductive services
○ Post exposure prophylaxis (PEP)   ○ STD testing & treatment
○ Hepatitis testing/vaccination   ○ TB testing & treatment
○ General medical services   ○ Other referral, specify:
○ Social services   ☐

Positive Referrals
○ HIV medical care
○ HIV case management

Substance Use Services
○ Alcohol/Drug Treatment
○ Harm reduction services
○ Syringe exchange program (SEP)

GSAQ Spanish v1.0 11-25-09

Page 6 of 6

Appendix G: Administrative Form

HE/RR Administrative Form

COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

31053

Shade Circles Like This--> ●

Not Like This--> ⊗ ⊘

When writing letters or numbers, place one character in each box. Please print carefully and avoid the edges of the box. For letters, use only capitals. **PLEASE USE BLACK PEN ONLY**

| A | B | C | D | E | F | G | H | I | J | K | L | M |
| N | O | P | Q | R | S | T | U | V | W | X | Y | Z |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |

Program ID: ☐☐☐☐

Site ID: ☐☐☐☐

Date: *(mm/dd/yy)* ☐☐ / ☐☐ / ☐☐

Time of Encounter: ☐ : ☐   ○ AM   ○ PM

Length of Contact: ☐☐☐ *(minutes)*

Session:
○ Session 2   ○ Session 5
○ Session 3   ○ 30 Day IDI or CRCS Follow Up
○ Session 4   ○ 90 Day IDI or CRCS Follow Up
○ Other, specify number: ☐☐

Intervention Type:
○ Intervention Designed for Individuals (IDI)
○ Comprehensive Risk Counseling Session (CRCS)
○ Intervention Designed for Groups (IDG)

Complete this section if client is unaware of their status or wishes to be tested. Place a test lab sticker in the box if client tests today:

Testing Referral: *(choose only one)*
○ Tested at encounter
○ Referred for testing
○ Declined/refused testing
○ No testing referral

Place Test Lab Sticker #1 Below

First Name Initial: ☐   **Last Name Initial:** ☐

Date of Birth: *(mm/dd/yy)* ☐☐ / ☐☐ / ☐☐

Residence Zip Code: ☐☐☐☐☐

Gender Identity: *(choose only one gender)*
○ Male
○ Female
○ Transgendered: M to F
○ Transgendered: F to M
○ Other

HE/RR Administrative v1.0 11-25-09