|  |  |
| --- | --- |
| DATE: |  |
| REPORT PERIOD: |  |
| DATE OF SITE VISIT: |  |

Contact Information of Provider Staff/Attendees:

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | TITLE | CONTACT NUMBER | EMAIL ADDRESS |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

ACC-RBHA Contact information:

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | TITLE | CONTACT NUMBER | EMAIL ADDRESS |
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| --- | --- |
| TOTAL NUMBER OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) TEST ADMINISTERED |  |
| TOTAL NUMBER OF GROUP EDUCATION CLASSES: |  |
| TOTAL NUMBER OF INDIVIDUALS OUTREACHED FOR SUBSTANCE ABUSE BLOCK GRANT (SABG) SERVICES LINKED TO MEDICAL CARE |  |

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| **DESCRIBE THE PROCESS FOR REFERRING MEMBERS TO OTHER FACILITIES/PROVIDERS WHEN NECESSARY** |
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| **IDENTIFY WHICH PROVIDERS HAVE YOU WORKED COLLABORATIVELY WITH** |
|  |
| **DESCRIBE WHAT HAS WORKED WELL AND WHAT NEEDS IMPROVEMENT IN THE COLLABORATION AND COORDINATION OF SERVICES** |
|  |
| **DESCRIBE WHAT TECHNICAL ASSISTANCE WAS PROVIDED BY THE ACC-RBHA TO THE PROVIDER** |
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| **WHAT TRAINING(S) WOULD BE USEFUL TO STAFF?** |
|  |
| **WHAT TRAINING/TECHNICAL ASSISTANCE (TA) WAS PROVIDED AND TO WHOM?** |
|  |
| **WHAT TRAINING WOULD BE USEFUL TO STAFF?** |
|  |

|  |  |
| --- | --- |
| **LIST THE TYPE OF TRAINING STAFF RECEIVED REGARDING SABG** | |
| **TRAINING** | **FREQUENCY** |
|  |  |
| **DESCRIBE SUCCESS STORIES THAT HAVE OCCURRED** | |
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| **BARRIERS/CHALLENGES - IDENTIFY ANY BARRIERS/CHALLENGES AND DESCRIBE HOW YOU HAVE TRIED TO RESOLVE THEM, IF NOT RESOLVED PROVIDE STEPS THAT NEED TO BE TAKEN TO RESOLVE** |
|  |
| **FOLLOW UP ITEMS FROM SITE VISIT** |
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| --- | --- | --- | --- |
| **COMPLETED BY:** |  | **TITLE:** |  |
| **SIGNATURE:** |  | **DATE:** |  |