

**Texas Department of State Health Services**  
HIV/STD Prevention and Care Branch Reporting Coversheet

|                                 |  |   |                              |                                    |
|---------------------------------|--|---|------------------------------|------------------------------------|
| Name of Agency                  |  |   |                              |                                    |
| Region                          |  |   |                              |                                    |
| Scope of Work                   |  | <input type="checkbox"/> HIV Prevention |                              |                                    |
| Contract No.                    |  |   |                              |                                    |
| Report                          |  | <input type="checkbox"/> 1st            | <input type="checkbox"/> 2nd | <input type="checkbox"/> 3rd       |
|                                 |  | Year                                    |                              |                                    |
| Prepared By:                    |  | Name:                                   |                              |                                    |
|                                 |  | Title:                                  |                              |                                    |
|                                 |  | Email:                                  |                              |                                    |
|                                 |  | Phone:                                  |                              |                                    |
| If Initial Report<br>Check box→ |  | If Revised Report<br>Check box→         |                              | Revision Date:<br>Revision Number: |

**Reports must be emailed in MS Word or PDF format to: [hivstdreport.tech@dshs.state.tx.us](mailto:hivstdreport.tech@dshs.state.tx.us)**

**CC your:**

Prevention Program Consultant  
Public Health Regional HIV/STD Program Manager or Coordinator

All DSHS e-mail addresses follow the format: [firstname.lastname@dshs.state.tx.us](mailto:firstname.lastname@dshs.state.tx.us)

**\*If electronic submission is not an option, please contact your Prevention Program Consultant**

**Reporting due dates:**

| <i>Contract Term</i>      | <i>1<sup>st</sup> Report due</i> | <i>2<sup>nd</sup> Report due</i> | <i>3<sup>rd</sup> Report due</i> |
|---------------------------|----------------------------------|----------------------------------|----------------------------------|
| <i>January-December</i>   | <i>July 29,2016</i>              | <i>January 31,2017</i>           | <i>Not applicable</i>            |
| <i>September-December</i> | <i>March 31,2016</i>             | <i>September 30,2016</i>         | <i>January 31, 2017</i>          |

**I. PROGRAMMATIC HIGHLIGHTS:** Provide a **summary** of significant events/trends in the program since your last report. (e.g., success and achievement, changes in program activities, outreach efforts, and staff changes).

**II. COMMUNITY HIGHLIGHTS:** Provide a **summary** of significant events/trends in the community since your last report. Include anything you believe to be important to understand your program in the larger context of your community. (e.g. religious leader supports HIV testing, loss of funding for low income housing, local politician supports LGBTQ in the news, etc.)

**III. COLLABORATIVE EFFORTS:** Describe highlights of collaborative efforts not already described in another section of this report **that occurred since your last report** with other programs. Please include non-traditional partners as well as more traditional ones such as HIV prevention counseling, substance abuse, STD, TB, Ryan White programs, EBI providers, Texas Black Women’s Initiative, Texas HIV Syndicate, Spectrum of Care(Cascade) activities, Coalitions, and Regional activities including those with whom you have MOUs. Describe activities that took place as a result of collaborative efforts, personnel involvement, and participating agencies.

**IV. SPECIFIC FUNDED HIV PREVENTION ACTIVITIES:**

A. **Performance Measure Charts and Questions;** Insert and complete only the chart(s) and questions associated with the activities for which your program is funded. For example, if your program is NOT funded for Community Mobilization then you are NOT required to fill out the “Community Mobilization” chart.

**PLEASE INSERT FIRST CHART HERE. Answer all questions listed after the chart. Insert each additional chart and questions if funded for multiple HIV Prevention Activities.**

**V. QUALITY ASSURANCE:** Provide a **summary** of quality assurance activities conducted and what program changes will result from these activities. (Examples include data quality assurance, community assessment, reflective practices, Program Materials Review Panel (PMRP), file audits, staff meetings, client satisfaction surveys, staff observations, staff trainings, and EBI tailoring requests.)

**VI. PRE-EXPOSURE PROPHYLAXIS (PrEP), POST-EXPOSURE PROPHYLAXIS (PEP) ACTIVITIES:** Provide a summary of activities to include but not limited to increasing awareness and access to PrEP and PEP.