Nevada Office of HIV/AIDS
Ryan White HIV/AIDS Program
15-61: CAREWare Subrecipient Setup Information

*INSTRUCTIONS: This form is to be **completed digitally** by the Agency's Executive Director and e-mailed to CAREWareHelp@health.nv.gov. For questions or help completing this form please contact CAREWareHelp@health.nv.gov. Handwritten forms will not be accepted.*

Date: _____

Subrecipient Name: _____

Subrecipient Street Address: _____

City, State, Zip: _____ _____ _____

Leave Blank – For OHA Use Only

Subrecipient ID: _____ **Grantee B ID:** _____

Does the Subrecipient Receive 330 Funding (FQHC)? ☐ Yes ☐ No

Please select the ownership status:

☐ Public/Local
☐ Public/State
☐ Public/Federal
☐ Private / Non-profit (not faith based)
☐ Private / For-profit
☐ Faith-based Organization
☐ Unincorporated
☐ Other

Does the Subrecipient Receive Minority AIDS Initiative Funding? ☐ Yes ☐ No

Please select the most appropriate Subrecipient Type:

☐ Hospital / Hospital-based Clinic
☐ Publically-funded Community Health Center
☐ Publically-funded Community Mental Health Center
☐ Other Community-based Service Organization
☐ Health Department
☐ VA Facility
☐ Substance Abuse Treatment Center
☐ Solo/Group Private Medical Practice
☐ Agency Reporting for Multiple Fee-for-Service Providers
☐ PLWHA Coalition
☐ Other Facility
☐ HL7 Import Provider

Total paid staff in FTEs serving individuals living with HIV: _____

Select any of the following if they describe your agency:

☐ An Agency in which racial/ethnic minority group members make up greater than 50% of the agency's board members.
☐ Racial/ethnic minority group members make up greater than 50% of the agency's professional staff members in HIV direct services
☐ Solo or group private health care practice in which greater than 50% of the clinicians are racial/ethnic minority group members.
☐ Other "traditional" provider that has historically served racial/ethnic minority patients/clients but does not meet the other criteria.
☐ Other type of agency or facility.