

**Nevada Office of HIV/AIDS
Ryan White Part B Program
16-01: Provider-Level Eligible Scope Survey**

Identifying Services to be reported under Eligible Scope

Please complete the table below. This will assist in identifying services you provide to Ryan White clients that may need to be reported under the new eligible scope requirements. Only complete the section of this table for service categories that receive funding from Ryan White Part B – Nevada Office of HIV/AIDS.

Service Category	Do you use other funding sources and/or bill insurance, Medicaid, Medicare etc. to provide this service to Ryan White clients at your agency?	Please describe these services, including - funding source or billing insurance - similarities/differences with services you provide under Ryan White - if you enter these services in another database
Early Intervention Services	<input type="checkbox"/> No – STOP. You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	
Health Education / Risk Reduction	<input type="checkbox"/> No – STOP. You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	

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Housing Services	<input type="checkbox"/> No – STOP . You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	
Medical Case Management	<input type="checkbox"/> No – STOP . You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	
Medial Transportation Services	<input type="checkbox"/> No – STOP . You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	

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Mental Health Services	<input type="checkbox"/> No – STOP. You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	
Non-Medical Case Management	<input type="checkbox"/> No – STOP. You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	
Oral Health Care	<input type="checkbox"/> No – STOP. You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	

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Outpatient/Ambulatory Medical Care	<input type="checkbox"/> No – STOP . You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	
Outreach Services	<input type="checkbox"/> No – STOP . You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	
Psychosocial Support Services	<input type="checkbox"/> No – STOP . You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	

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Treatment Adherence Counseling	<input type="checkbox"/> No – STOP . You do not need to complete the rest of this row. <input type="checkbox"/> Yes – please complete this row.	