Contact Information

Agency/Business Name: ______________________________ Form Completed By: ___________________________

Region:

__ Mid & Lower Hudson Valley __ Queens/Staten Island __ Upper Manhattan __ Long Island __ Western New York

Which **Senior Leader** in your agency is ultimately responsible for **guiding and supporting the coordination** of the NYLinks initiative across HIV services at the agency?

Name: Title:

Email: Phone:

Who is the **QI Project Lead** and point of contact from your agency for the NYLinks initiative? *Ideally, this is someone with quality improvement and performance measurement experience who is well placed to engage and motivate others and enable actions that make a difference at the organizational and community levels, and act as a champion for strategies that emerge from the collaboration in the NYLinks Regional Group.*

Name: Title:

Email: Phone:

Who from your agency is the **Data Lead** responsible for **collecting and or presenting performance data** related to linkage, retention and/or HIV Viral Load Suppression?

Name: Title:

Email: Phone:

For clinical sites, list the person responsible for **directing and managing the HIV medical staff** at your agency. Is this person be willing to serve as the **Clinical Lead** function on the NYLinks Team? **Y / N** (If, no please list name and contact of individual who will serve as the **Clinical Lead** for NYLinks below.)

Name: Title:

Email: Phone:

NYLinks Clinical Lead Name:

Email: Phone:

For Supportive Service Agencies, who is the **Director or Manager of Programs**?

Name: Title:

Email: Phone:

Who is the **consumer/patient representative* actively participating in quality improvement activities** to improve linkage, retention &/or VLS? If you do not have one yet, who should be your consumer representative on the team?

Name: Title:

Email: Phone:

**Consumers/patients participate as equal members at Regional Group meetings, working to identify and improve aspects of HIV care related to linkage and retention. Please assure that consumers/patients who volunteer in this capacity are aware and agree to the level of involvement and disclosure necessary for this level of participation in the NYLinks Initiative.*

Return the completed document to: Stephen Crowe, stephen.crowe@health.ny.gov

Contact Information (Continued)

Additionally, who else at your organization should be on our email/mailing list for regional meetings, webinars, facility level cascades, training opportunities, and any regional updates? Feel free to add as many as you like.

Name:	Title:
Email:	Phone:

Name:	Title:
Email:	Phone:

Name:	Title:
Email:	Phone:

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