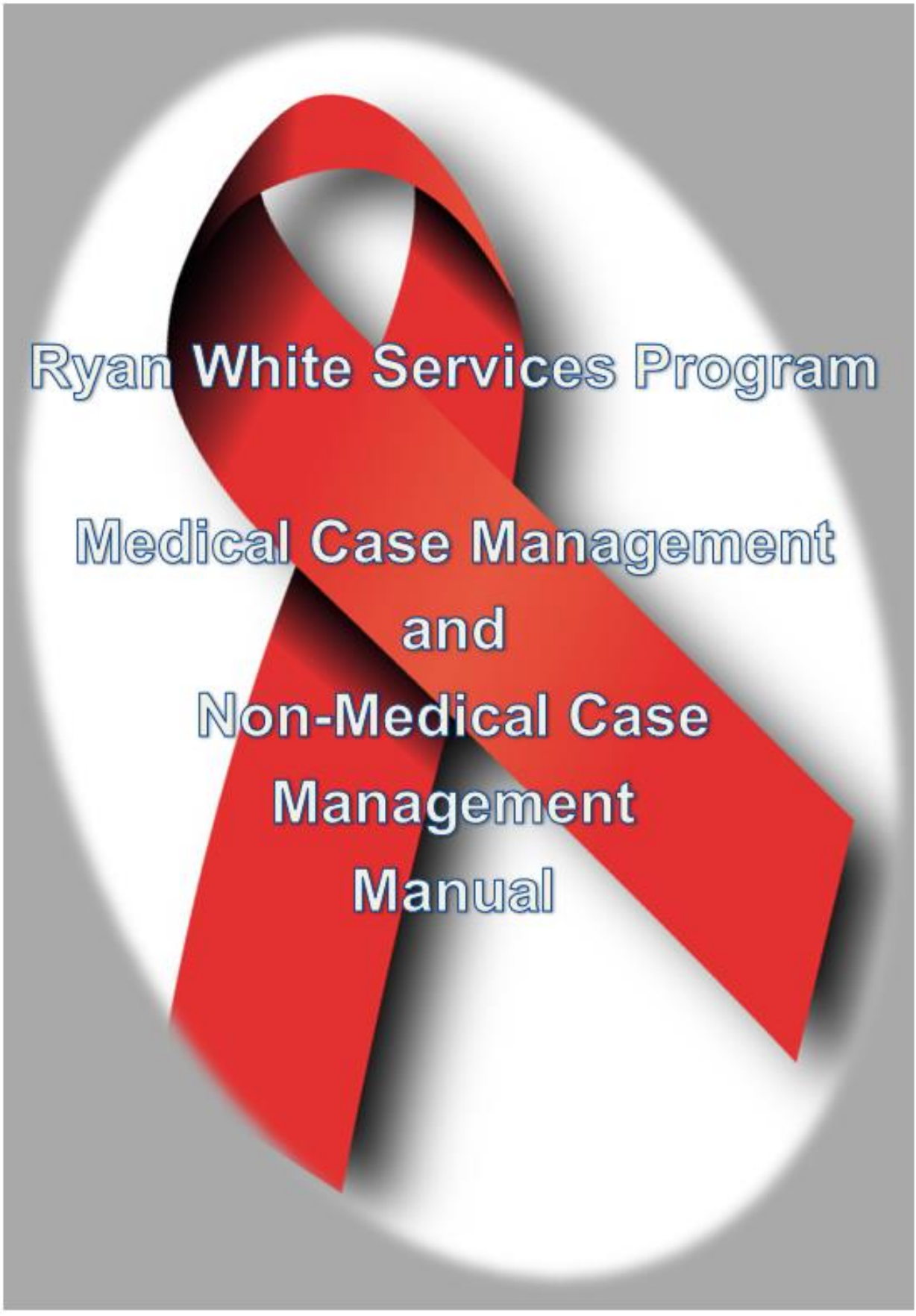
Ryan White Services Program
Medical Case Management
and
Non-Medical Case
Management
Manual

Ryan White Services Program

Medical Case Management and Non-Medical Case Management Manual

Version 2: September 2019
Marion County Public Health Department

MARION COUNTY
PUBLIC
HEALTH
DEPARTMENT
Prevent. Promote. Protect.

Ryan White/HIV Services
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July 1, 2019

Dear Case Managers and Care Coordinators:

I would like to welcome you to the Ryan White/HIV Services Program (RWSP) Medical and Non-Medical Case Management Services system. We recognize that case management services are the cornerstone of effective engagement and retention in care for so many persons living with HIV in our community. The RWSP goal is to offer a program that is comprehensive and consistent, free of barriers, and easily accessible for those seeking core medical and supportive services.

This manual, which was created two years ago and thoughtfully updated this year by members of the Quality Management Committee of the Indianapolis Transitional Grant Area's (TGA) Planning Council, provides common policies and procedures for delivering those essential case management services. The Committee, Planning Council, Community Partners, and RWSP staff who worked to update this Manual participated in a very inclusive and collegial process to deliver a tool which will be very helpful to the RWSP and you, the front-line workers charged with providing Medical and Non-Medical Case Management Services.

The purpose of this manual is to provide agencies funded by the Indianapolis TGA's RWSP with information on the policies, procedures, and compliance requirements for the successful and consistent delivery of Medical and Non-Medical Case Management Services. Agencies and their staff should use this manual as a tool for orientation and as an ongoing training instrument by which to ensure consistent service delivery across the TGA.

The RWSP fully supports this manual and will continually work with our community partners to ensure these practices are implemented and followed. Over the past two years the RWSP has referenced this manual frequently to respond to questions and provide guidance to our own work and to agency-based case managers.

Our sincere appreciation is extended to each of the Committee members for the outstanding work that they have done on this manual. We look forward to continued work with the Committee to fully implement this document, evaluate its effectiveness, and review and update again as needed.

Members of the Committee

Kyle Bonham *Manager—Ambulatory* *LifeCare* *IU Health Methodist Hospital*	**Francesca Urias Hall** *Ryan White Planning Council Coordinator* *Ryan White HIV Services Program* *Marion County Public Health Department*
Harold Brown *Ryan White Planning Council* *Community Partner*	**Catherine Kibiger** *Program Manager* *Ryan White Services* *Community Physician Network*
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Portia Duff *Ryan White Part C Program Coordinator/RWSP QM & Compliance Coordinator* *Ryan White HIV Services Program* *Marion County Public Health Department*	**Veronica Onofrey** *Director of Grant Management and Quality Improvement The Damien Center*
Nick Fennig *Associate Director of Ryan White Initiatives* *Meals on Wheels of Central Indiana*	**Cheryl Reed** *Member Liaison* *Anthem, Inc.*
Darrin Foltz *HIV Prevention Budget and Contract Manager* *Service Integration Team* *Advisory Council Liaison* *Division of HIV / STD / Viral Hepatitis* *Indiana State Department of Health*	**Bree Weaver, MD** *Assistant Professor of Clinical Medicine and Clinical Pediatrics* *Indiana University School of Medicine*

Sincerely,

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INTRODUCTION

The Ryan White HIV/AIDS Program (RWHAP) is the largest federally-funded program focused exclusively on providing Human Immunodeficiency Virus (HIV) care and treatment services to people living with HIV in the United States. Working with cities, states and local community-based organizations, the Program provides a comprehensive system of care for people living with HIV who are uninsured or underinsured. The legislation was first enacted in 1990 as the Ryan White Comprehensive AIDS (Acquired Immunodeficiency Syndrome) Resources Emergency (CARE) Act. It has been amended and reauthorized four times: in 1996, 2000, 2006, and 2009. The RWHAP legislation has been amended with each reauthorization to accommodate new and emerging needs, such as an increased emphasis on funding core medical services and changes in funding formulas.

The purpose of this manual is to provide agencies funded by the Indianapolis, Indiana Ryan White/HIV Services Program (RWSP) with information on the policies, procedures, and compliance requirements that are necessary in order to provide Ryan White funded Case Management Services. Agencies should utilize this manual as an orientation and ongoing training tool for staff assigned to these service categories to ensure initial and continued compliance. The utilization of this manual will provide agencies and case managers the tools necessary to meet the needs of individuals living with HIV through a supportive, caring, compliant and educational process. This manual will empower case managers to confidently select the application type for their client. Application types include intake/re-entry, recertification, and attestations. The end result will be a process that will afford clients the opportunity to enter care at an earlier state of illness, become medically and pharmaceutically compliant to be retained in care, reduce barriers to accessing services, and to reduce individual and community HIV viral loads.

Case Management/Care Coordination is the gateway for services for People Living with HIV/AIDS (PLWH) and is considered by clients to be one of the most significant services to which they have access. Therefore, it is important that individuals providing these services do so in a consistent, efficient and effective manner. The quality of the Case Management service a PLWH receives should not be determined by the agency or case manager assigned to that individual. All clients should expect to receive the same level of professionalism and knowledge independent of the agency that employs the case manager. The focus of our services should be on the client, active listening, respecting boundaries and implementing consistent policies/procedures and protocols established by and between the funding agents and the agencies providing the services, and the client receiving the service. This manual provides guidance on how to deliver these services and should be used in conjunction with the RWSP Standards of Care (SOC) that were established by the Indianapolis Ryan White Transitional Grant Area (TGA) Planning Council. These standards can be found in Attachment C.

This manual and the delivery of Medical and Non-medical Case Management are also governed by the Ryan White National Monitoring Standards. Each agency has been provided the National Monitoring Standards (NMS) and they should be available to all staff.

Additionally, central to the role of the case manager is to provide services that are ethical and designed to meet the needs of the individual. The following ethical standards will be used for case managers:

Delivery of case management services must:

1. Enhance the overall quality of life of clients enrolled in the program
2. Strive to benefit clients while preventing or limiting harm or burdens
3. Provide case management clients reasonable access and opportunity for services and render services equally
4. Secure and maintain all required documentation in accordance with these policies and procedures
5. Respect clients and their autonomy by honoring competent choices and wishes
6. Follow HIPAA Compliance

Although this manual may not meet the specific needs of all situations, it should be used to define current expectations of program descriptions and requirements. Situations that will arise outside of covered procedures as outlined in this manual should be discussed with Ryan White Program Staff on an individual basis. Once a decision has been determined by Ryan White Staff on a situation not covered in this manual, a policy clarification should be sent out to all care sites and, if appropriate, should be included in the revised manual at the next review.

All communication and service delivery should be handled in compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations, agency specific HIPAA regulations, agency compliance policies, and documented training. Falsification of any documents will result in the client or funded agency reimbursing all costs for services rendered and may lead to contract cancellation or not being funded in future grant cycles.

The RWSP has established a relationship and contractual agreement with sub-recipients of RWHAP funding. Part of our responsibility to our sub-recipients is to support their efforts of service to our clients, and to provide oversight and guidance to our sub-recipients to help them ensure that the services they provide are consistent with HRSA guidelines and regulations, contractual requirements, and that all expenses billed to RWSP would pass the tests of allowable, allocable, and reasonable.

There are places in this manual where the process states to submit a letter of explanation to the Ryan White HIV Services Program (RWSP) as to why specifically required supporting

documentation is missing. It is the responsibility of the sub-recipient or provider to verify client eligibility prior to delivering services. The RWSP expects that the sub-recipient will/has establish a relationship with the client and conducts a comprehensive assessment of need and eligibility for services. The RWSP relies on the sub-recipient to confirm client eligibility for services in compliance with HRSA regulations: proof of HIV status, proof of residency within the TGA, and proof that income meets TGA defined eligibility (currently 300% FPL). If the sub recipient has done their due diligence to make these determinations but the client is lacking the documentation required by the RWSP as proof, the RWSP will accept a letter from the sub-recipient attesting that the client meets the eligibility requirement and that the sub-recipient will work with the client to help them attain the required documentation. The sub-recipient may accept whatever "proof" their agency policies allow them to accept prior to writing the letter. However, since the RWSP relationship is with the sub-recipient and not the client, RWSP will only accept the required document listed in this manual or a letter from the sub-recipient. Our goal is to help protect our sub-recipients from any future repayment scenarios because services were provided to individuals who were not eligible for those services and payment was made to the sub-recipient for those services.

Throughout the implementation of this manual, suggestions, comments, and/or questions can be submitted to the RWSP Planning Council (PC) liaison who will submit the information de-identified to the chair of the Quality Management Subcommittee of the PC. All input received about the manual will be reviewed and updated annually to correspond to the sub-grantee fiscal year. The annual review of the manual will occur at the first providers meeting of the calendar year. The service definition for use in this manual and as provided to clients will be as described below. These service definitions are in compliance with HRSA Clarification Notices 15-02 and 16-02.

CAREWare:

At this time CAREWare is used by those receiving funding for case management. This manual is not intended to be a manual for using CAREWare. Please refer to supervisors within your agency for specific training on CAREWare. While this is not a training manual for CAREWare there are several times this manual may indicate a way some agencies may indicate something within that system.

HRSA SERVICE DEFINITIONS

Medical Case Management, including Treatment Adherence Services

Description:
Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. MCM includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include, but are not limited to:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Case conferencing related to identified medical needs
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, MCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
MCM services have as their objective improving healthcare outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for and adherence to complex HIV treatments shall be considered MCM or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a MCM visit should be reported in the MCM service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Non-Medical Case Management Services

Description:
Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by RWHAP Part recipient.

Key activities include but not limited to:

- Initial assessment of service needs
- Completion of other medical services applications
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Referral to legal services for assistance with HIV/AIDS related issues
- Providing access or referrals for assistance in searching for a job
- Referral to legal services for assistance with HIV/AIDS related issues
- Case conferencing with other case managers/staff to meet client needs
- Completion of insurance applications specific to agencies receiving both ISDH care coordination and Part A funding
- Providing access or referrals for assistance with emergency housing, food, utilities and transportation
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
NMCM services have as their objective providing guidance and assistance in improving access to needed services whereas MCM services have as their objective improving healthcare outcomes.

Agencies must include in their grant application copies of screening instruments/tools for mental health and substance use/abuse that will be used with agency clients. These forms may vary by site, but must be approved as part of the agency professional services grant. These screenings must be completed at the time of the initial intake and on a yearly basis.

SPECIAL CONSIDERATIONS AND BILLING CLARIFICATIONS FOR TGA USE BY SERVICE TYPE

Clients will obtain MCM or NMCM from one agency. A client can go to one agency for NMCM and a different agency for MCM. However, clients should not receive MCM from two different agencies at the same time.

A Medical Case Manager can bill for the initial intake or re-entry as a Medical Case Management services into the RWSP. If it is recertification, attestation, or any referral needs the time spent assisting with those activities is to be billed as Non-Medical Case Management. For example, if a client is being seen for a routine MCM visit and it is discovered that they need to recertify or needs any referrals, the MCM staff may complete the application and/or referral process but the billing must be to non-medical case management and not medical case management.

CHAPTER 1:

INTAKE PROCESS AND ENROLLMENT INTO SERVICES WITH NEWLY HIV DIAGNOSED, NEW TO THE RYAN WHITE PROGRAM, RE-ENTRY CLIENTS, OR MINORS

During the initial intake an agency case manager will first attempt to understand the client's current situation and then explain the various programs for which the client may be eligible. This process will include an explanation of eligibility data that will determine if a client is eligible for the Ryan White Services Program. These eligibility requirements include: HIV status, TGA residence, and client income.

To ensure correct application type for client enrollment into the Ryan White Services Program, please see Attachment E for Scenarios and Attachment F for Flow Chart.

Re-entry is defined as "a client's enrollment in the program has lapsed for 2 years or more." An enrollment/re-entry form is used. During re-entry, the case manager will first attempt to understand the client's current situation and then explain the various programs for which the client may be eligible. This process will include an explanation of eligibility data that will determine if a client is eligible for Ryan White Services. These eligibility requirements include a case manager assessment of: HIV status, TGA residence, and client income. Once a case manager determines a client is eligible for Ryan White Services, a case manager will assess client needs.

Once a case manager determines a client is eligible for the Ryan White Services Program, a case manager will assess client needs and complete the following:

- Explain and obtain a signed consent/rights and responsibilities and confidentiality release
- Conduct a mental health evaluation
- Conduct a substance abuse evaluation
- Signature page on Ryan White Application
- Complete application requirements
- Review page of how a client can become involved with the TGA Planning Council

Application Requirements

To complete the Ryan White Services Application, staff will have to obtain all of the documents required to determine eligibility. During the initial appointment scheduling, staff will inform clients what is needed to enroll in the RWSP. Clients will be instructed to bring the required documents to the initial intake. This process should ensure that applications can be completed in a timely manner in an effort to reduce barriers to care. All new, recertification, re-entry, and return-pending applications must be sent to the RWSP office within one business day of client signature. At the time of application submission to the RWSP office, the primary agency should also send the application to the secondary medical agency if there is one listed on the application. At the top of the Enrollment application, a case manager should select if it's a new enrollment or

a re-entry. If there are missing documents, please reference the **seven-day coverage period** section at the end of this chapter.

Ryan White Program Applications Will Include the Following:

-Photo Identification/Other Identification

A. State or federally-issued identification with TGA address is the preferred proof of identification.
B. Other acceptable documentation could include consulate cards or letters from a refugee agency.
C. If no identification document is available, a letter must be written by the case manager explaining why the preferred identification is unavailable and how it will be obtained.
D. Case Managers should work with clients to ensure they have preferred/acceptable identification by their 6-month recertification/attestation. Because people move and often do not update identification, separate documentation demonstrating TGA residency is required.

The RWSP will accept an enrollment application with a client's expired identification. Appropriate proof of residency must be submitted with the application. The expectation is that at the six-month attestation the client will have a valid ID with an in-TGA address. At the yearly recertification the client must have a valid ID with an in-TGA address or recertification will not be processed, unless there are extreme circumstances that are documented that have prevented the client from obtaining an ID for an entire year. If the barrier to obtaining a valid ID is that severe, it should be noted at the six-month recertification and the RWSP should be notified.

-Proof of Residence (POR)

To be eligible for services, the client must live in one of the following counties: Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam, or Shelby. The client must have at a minimum 1 proof of residence within the TGA.

POR may include the following:

A. Current (within one year) lease.
B. Current Social Security Award Letter.
C. Bill or official letter dated within the last 60 days.
    - Official letters are signed, on professional letterhead, or from a local, state, or federal governmental entity.
    - It must be the official letter; envelopes will not be accepted.

D. If no residence document is available, a letter must be written by the Case Manager explaining why and what is being done to obtain that document (e.g. client is literally homeless, etc.).
E. For immigrants, undocumented or otherwise, the RWSP will accept whatever documentation is available explained by a letter from the Case Manager. The Case Manager letter should include information about steps to be taken to help the client obtain appropriate documentation. The goal is to link individuals to care as rapidly as possible and for the Case Manager to work with the client to help them obtain appropriate documentation so they can access other services, programs or essentials for which they may be eligible.

A client who is in the Indiana Department of Corrections (IDOC) community work release program is eligible for services under the RWSP and must meet all eligibility requirements. The IDOC has determined that the client is responsible for medical issues/concerns.

Check stubs being used for proof of income will no longer be accepted for proof of residence.

-Proof of Income (POI)
To be eligible for services, a client must be under 300% Federal Poverty Level (FPL). Please ensure that you are using the most up to date FPL Guidelines sent out by Ryan White Program Staff.

Self-employed clients will provide the following:

A. Most recent tax return; Annual Gross Income divided by 12.
B. If a client did not file in the current year, an I-NET ('Workforce One Statement'- also referred to as 'employment verification statement') covering the most recent 12 months must be provided.
C. Any additional income must be documented. This could include pension, long term disability or other retirement statements.
D. If no income document is available, a letter must be written by the case manager to explain why and what is being done to obtain that document.

Proof of submission of the I-NET is acceptable as long as the agency submits proof of documentation once it is received. Both proof of the submission and the actual I-NET should be kept on file at the agency submitting the application.

Currently employed clients will provide the following:

A. Most recent check stubs. All income will be counted with the exception of one time payments, overtime and bonuses. All other income including tips, commission, shift differential and holiday pay shall be counted. If a client has

overtime, the difference in pay for the overtime is not counted. However, the number of hours at the base rate should be counted as income. This is considered the most recent 28 days of income.

B. The number of pay stubs required: one for clients paid monthly, two for clients paid bi-weekly, four for clients paid weekly. This must include all pay stubs during the most recent 28 days.
C. A 'year-to-date gross income divided by 12 months' or 'calculating a missing stub' cannot be used if any documented proof is missing.
D. If a client receives any other income, they must also provide documentation of this income. This could include pension, long term disability or other retirement statements.
E. If no income document is available, a letter must be written explaining why and what is being done to obtain that document.

Non-working clients will provide the following*:*

A. Most recent Social Security Income/Social Security Disability Income (SSI/SSDI) statement.
B. If a client does not receive SSI/SSDI and is not employed, an I-NET must be submitted.
C. If no income document is available a letter must be written explaining why and what is being done to obtain that document.
D. If a client receives any other income, they must also provide documentation of this income. This could include pension, long term disability or other retirement statements

Proof of submission of the I-NET is acceptable as long as the agency keeps proof of documentation once received.

A client becomes eligible for services at the point when they no longer have the income that would make them ineligible. The case manager can obtain an I-NET on the first day a client is no longer receiving income. A letter must be submitted explaining that the client just lost their employment/income.

-Insurance Verification

Proof of the client's current insurance cards should be photocopied, including any public or private insurance. In addition, Medicaid Eligibility Documentation (often referred to as a "verification") is needed to determine if the client is eligible on the date of the application. If eligible, a second "verification" is needed to determine the Medicaid eligibility date, and a third "verification" is needed to show the last date a client did not have Medicaid Coverage (this would be to show a start date).

The employer insurance verification forms should be completed if possible. A proof of employer verification will be requested; however, if one cannot be obtained, a letter from the case manager can be submitted indicating the refusal of the employer to complete. A client will not be denied enrollment based solely on not having a completed employer verification form. The form needs to be completed only once per employer. After it has been received by the RWSP for the first time, it will not need to be requested at each recertification, unless the client has changed employers.

The Insurance section on the application/recertification cannot be left blank (even if no insurance). RWSP should be listed even though it is not insurance. This section should specify the type of insurance (not just Medicaid or HIP [Healthy Indiana Plan]).The type of insurance should be the exact type indicated on the Medicaid verification.

If no insurance document is available, a letter must be written by the case manager explaining why and what is being done to obtain that document.

If a client just lost their job, correct information should be included in the Ryan White Application. If/when the insurance changes, a change form should be submitted with documentation to prove the change.

-Proof of Status

All new and re-entry applications must contain proof of HIV status (Medical Services ISDH [Indiana State Department of Health] verification, Confirmatory test documentation, IDOC ISDH Form, Completed HIV Case Report, Certification by HIV provider statement, Hospital discharge summary, HIV status lab report with detectable viral load, Progress note with physician signature).

Seven Day Coverage Period During New/Re-entry

If there are any missing documents, the client is then considered to be in a seven day (business day) coverage period, referred to as "pending coverage." During that time, staff should work with the client to obtain missing documentation. Agency staff should document all attempts/points of contact with the client in CAREWare. This should be documented within CAREWare regardless of the funding stream for MCM/NMCM. If the client does not provide the requested documentation before the seven day expiration, a request can be written on agency letterhead and faxed (with confirmation) or emailed to the agency business coordinator. Documentation should be kept with either method of response verifying the extension from Ryan White staff. It is not necessary to list the specific reason for an extension request. The documentation needs to be submitted prior to the expiration date of the seven day period. To clarify, a client can have up to two additional 7-business-day coverage allotments. A total of 21

business days will be provided. After 21 days, a client will need to supply all needed documentation to complete a new/re-entry application for 6-month coverage. You will need to use the new/re-entry application when submitting all of the needed documents. Additionally, there are no limitations to the 21-day coverage allotments; if a client is qualified to complete a new or re-entry application, they are able to receive the 21-day coverage allotment.

RW Applications of minor clients (under 18 yrs old)

-Photo Identification/Other Identification for both Minor and Guardian

A. State or federally-issued identification is the preferred proof of identification (ID, Birth Certificate).
B. Other acceptable documentation could include consulate cards or letters from a refugee agency.
C. If no identification document is available, a letter must be written by the case manager explaining why the preferred identification is unavailable and how it will be obtained.

The RWSP will accept an enrollment application with an expired identification of a minor's guardian. Appropriate proof of residency must be submitted with the application. The anticipation is that at the six-month attestation the Guardian will have a valid ID with an in-TGA address. At the yearly recertification the Guardian must have a valid ID with an in-TGA address or recertification will not be processed, unless there are extreme circumstances that are documented that have prevented the client from obtaining an ID for an entire year. If the barrier to obtaining a valid ID is that severe, it should be noted at the six-month recertification and the RWSP should be notified.

-Proof of Residence (POR)

To be eligible for services, the client must live in one of the following counties: Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam, or Shelby. The client must have at a minimum 1 proof of residence within the TGA.

POR may include the following:

A. Current lease.
B. Current Social Security Award Letter.
C. Bill or official letter dated within the last 60 days.
    - Official letters are signed, on professional letterhead, or from a local, state, or federal governmental entity.
    - It must be the official letter; envelopes will not be accepted.

D. If no residence document is available, a letter must be written by the Case Manager explaining why and what is being done to obtain that document (e.g. client is literally homeless).

E. For immigrants, undocumented or otherwise, the RWSP will accept whatever documentation is available explained by a letter from the Case Manager. The Case Manager letter should include information about steps to be taken to help the client obtain appropriate documentation. The goal is to link individuals to care as rapidly as possible and for the Case Manager to work with the client to help them obtain appropriate documentation so they can access other services, programs or essentials for which they may be eligible.

A client who is in the Indiana Department of Corrections (IDOC) community work release program is eligible for services under the RWSP and must meet all eligibility requirements. The IDOC has determined that the client is responsible for medical issues/concerns.

Check stubs being used for proof of income will no longer be accepted for proof of residence. Medicaid verification will not be accepted as proof of residence.

-Proof of Income (POI)

There is no income limit for youth under 18. If the minor client is not receiving any income then no documents need to be provided.

Currently employed minors will provide the following:

A. Most recent check stubs. All income will be counted with the exception of one time payments, overtime and bonuses. All other income including tips, commission, shift differential and holiday pay shall be counted. If a client has overtime, the difference in pay for the overtime is not counted. However, the number of hours at the base rate should be counted as income. This is considered the last 28 days of income.
B. The number of pay stubs required: one for clients paid monthly, two for clients paid bi-weekly, four for clients paid weekly. This must include all pay stubs during the most recent 28 days.
C. A ‘year-to-date gross income divided by 12 months’ or ‘calculating a missing stub’ cannot be used if any documented proof is missing.

-Proof of Status

All new and re-entry applications must contain proof of HIV status (Medical Services ISDH [Indiana State Department of Health] verification, Confirmatory test documentation, IDOC ISDH Form, Completed HIV Case Report, Certification by HIV provider statement, Hospital

discharge summary, HIV status lab report with detectable viral load, Progress note with physician signature).

-Unaccompanied Minors (no connection to a parent or legal guardian):
They will be handled as an emancipated youth and be able to sign the application for themselves. A letter explaining lack of adult guardianship must be included. All other requirements will look the same as any other minor application.

-Provision of treatment or services must follow your agency policies re: consent, etc.
-You must follow whatever reporting (to DCS, etc) rules apply-that's your agency call
Once the minor reaches the age of majority (18 years):
-They are subject to the standard adult eligibility guidelines and requirements
-Submit a Notice of Change that they are now 18 and at the next recertification submit an Adult Application

There are other documents that an agency may have a client complete:

- An agency signed release of information as needed
- Signed client conduct statement
- Signed informed participation agreement
- Signed client conduct
- Signed confidentiality form
- Complete ISDH Care Coordination Intake on paper form to enter into a computer after appointment

A case manager will also review the following with the client:

- Eligibility requirements for Ryan White Services Program and the need for updates from client as they occur.
- Ways to contact case manager and set appointments in the future
- Recertification periods for each program
- Return phone call policies
- Ways to obtain referrals in the future
- How to request assistance and referrals for other funded programs (utilities, transportation assistance, food pantry access, food vouchers, boost, legal services, dental, vision, and housing)
- How to become involved with the Ryan White Planning Council if residing in the TGA
- How assistance can change based upon client's work, insurance, residence and income
- How clients will know referrals have been approved and how to access those services

Prior to the completion of the appointment, case managers will explain next steps for which the client is responsible. The next steps could include, but are not limited to, obtaining required documents and bringing those documents to the initial intake appointment. Clearly defined deadlines and potential consequences of not completing application requirements should be explained to the client.

After the client intake is complete, case managers will complete all applications and referrals on behalf of the client. Case managers will complete those referrals within 24 hours of the intake completion. It is highly encouraged that case managers keep fax confirmation sheets and/or emails to be included in client record as evidence of task completion. Case notes of the initial intake and all referrals will be completed within the same 24 hour period. A client chart will be created and all sections will be completed.

CHAPTER 2:

INTAKE WITH CLIENTS WHO SWITCH CARE SITES

For a client who is currently enrolled in the MCPHD RWSP (within the 6 month period of active eligibility) and wishes to switch care coordination sites and/or medical sites, the following process will be followed. Active eligibility is confirmed by checking the Active/Inactive client lists. During the first appointment with the new case manager, a RWSP Notice of Change form will be completed and faxed to the RWSP office (specified fax number depending on the RWSP Business Coordinator). The case manager will contact the RWSP office and request the application(s) and proof of eligibility (proof of HIV status, income, and residency in the TGA*) for the new client (new to the agency) to be sent via fax.

If a client is at the end of their six month enrollment period and wishes to switch to another care coordination site, the following process will be followed. The case manager will determine the appropriate application to be completed by reviewing the Active/Inactive client list. If the client is still active within 30 days of recertification or recently inactive (30 days or less post expiration date) a recertification application will be completed by the new care coordination site. If the client has been out of the RWSP for more than two years post expiration date, a re-entry application must be completed. In instances, recertification and re-entry, the case manager should collect current proof of residency within the TGA and current proof of income from the client. The case manager may contact the RWSP for proof of HIV status.*

**It is the responsibility of the provider to maintain proof of client eligibility for RWHAP services*

To ensure correct application type for client enrollment, please see Attachment E for Scenarios and Attachment F for Flow Chart. Please use the Active/Inactive client lists to determine client's current eligibility status.

A case manager will then complete the following (in addition to discussing referral processes and available provider):

- Explain and obtain a signed consent/rights and responsibilities form
- Explain and obtain a signed confidentiality form
- Conduct a mental health evaluation
- Conduct a substance abuse evaluation
- If client is re-certifying and a self-attestation is needed, staff will:
    - Collect eligibility documents, or
    - Receive the original application and proof of eligibility documents from the other care site or Ryan White Services Program Staff
- Complete application requirements if inactive
- Complete a change form if the client is active with Ryan White
- Review page of how a client can become involved with the TGA Planning Council

Depending on the current client situation, you may have to do a midyear, annual, or re-entry application. Please see those sections for specific information on required documents.

CHAPTER 3:

ATTESTATION
FOR
MID-YEAR RECERTIFICATION PROCESS

To maintain eligibility for HRSA RWHAP services, clients must be recertified at least every six months. The primary purposes of the recertification process are to ensure that an individual's residency, income, and insurance statuses continue to meet the recipient eligibility requirements and to verify that the HRSA RWHAP is the payor of last resort. The recertification process includes checking for the availability of all other third party payers.[1]

A self-attestation is not able to be used if client is already expired from the RWSP. During attestation, case managers will reassess the client's current situation and then explain the various programs for which the client may be eligible. Case managers will assess any changes and create a new care plan based on the client's current needs. Case managers are to fill out the attestation completely, even if no change has occurred. Case managers will assess use of past referrals, discuss referral process, and identify available providers. If needed, case managers will complete new referrals after the appointment is complete. Case managers will explain next steps that the client is responsible for completing, including but not limited to required documents. Clearly defined deadlines will be explained to the client and potential consequences of not completing applications requirements. Attestations cannot be submitted more than 30 calendar days in advance of the end date for the previous recertification. Case Managers should educate clients about what is required for the next 6 month recertification.

Attestations can only be billed under Non-Medical Case Management.

To ensure correct application type for client enrollment into the Ryan White Services Program, please see Attachment E for Scenarios and Attachment F for Flow Chart.

Staff will then complete the following activities:

- Complete application requirements
    - If there are no changes, then no supporting documents are required AND if there are changes, provide those supporting documents.
- Explain and obtain a signed consent/rights and responsibilities form
- Explain and obtain a signed confidentiality form
- Conduct a mental health evaluation
- Conduct a substance abuse evaluation
- Complete application requirements
- Signature page on Ryan White Recertification Self Attestation
- Review page of how a client can become involved with the TGA Planning Council

There are other documents that an agency may complete

[1] Policy Clarification Notice (PCN) #13-02 (Revised 5/1/2019)
https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1302clienteligibility.pdf

- An agency signed release of information as needed
- Signed client conduct statement
- Signed informed participation agreement
- Signed client conduct
- Signed confidentiality form

Staff will ensure that they cover the following:

- Ways to contact case manager and set appointments in the future
- Recertification periods for each program
- Return phone call policies
- Ways to obtain referrals in the future
- How to request assistance for other funded programs (utilities, transportation assistance, food pantry access, food vouchers, boost, legal services, dental, vision, and housing)
- How to become involved with the Ryan White Planning Council if residing in the TGA
- How assistance can change based upon client's work, insurance, residence and income
- How clients will know referrals have been approved and how to access those services

After the client appointment, case managers will complete signatures on self-attestation and referrals. You may choose to keep the fax confirmation pages to aid with proof of submission. Case notes of the initial intake and all referrals will be completed within the same 24-hour period. A client chart should be created with all sections completed.

The RWSP will accept an enrollment application with a client's expired identification. Appropriate proof of residency must be submitted with the application. The anticipation is that at the six-month attestation the client will have a valid ID with an in-TGA address. At the yearly recertification the client must have a valid ID with an in-TGA address or recertification will not be processed, unless there are extreme circumstances that are documented that have prevented the client from obtaining an ID for an entire year. If the barrier to obtaining a valid ID is that severe, it should be noted at the six-month recertification and the RWSP should be notified.

CHAPTER 4:

YEARLY RECERTIFICATION PROCESS FOR CLIENTS ENROLLED AT CURRENT CARE SITE

Clients will need to complete a recertification application once a year. This application must include documents indicated below. A recertification must be used if the last application type used was a self-attestation. Recertification will be completed if a self-attestation was not completed before the six months period expiration date.

Recertification applications can only be billed as Non-Medical Case Management.

To ensure correct application type for client enrollment into the Ryan White Services Program, please see Attachment E for Scenarios and Attachment F for Flow Chart.

A case manager will then complete the following (in addition to discussing referral processes and available provider):

- Explain and obtain a signed consent/rights and responsibilities form
- Explain and obtain a signed confidentiality form
- Conduct a mental health evaluation
- Conduct a substance abuse evaluation
- Signature page on Ryan White Application
- Complete application requirements
- Review page of how a client can become involved with the TGA Planning Council

APPLICATION REQUIREMENTS

To complete the Ryan White Services Application, staff will have to obtain all of the documents required to determine eligibility. During the initial appointment scheduling, staff will inform clients what is needed to enroll in the RWSP. Clients will be instructed to bring the required documents to the initial intake. This process should ensure that applications can be completed in a timely manner in an effort to reduce barriers to care. All change forms, re-certification, re-entry, and return-pending applications must be sent to the RWSP office within one business day of client signature. At the time of application submission to the RWSP office, the primary agency should also send the application to the secondary medical agency if there is one listed on the application.

-Photo Identification/Other Identification

A. State or federally-issued identification is the preferred proof of identification.
B. Other acceptable documentation could include consulate cards or letters from a refugee agency.
C. If no identification document is available, a letter must be written by the case manager explaining why the preferred identification is unavailable and how it will be obtained.

D. Case Managers should work with clients to ensure they have preferred/acceptable identification by their 6-month recertification/attestation.

The RWSP will accept an enrollment application with a client's expired identification. Appropriate proof of residency must be submitted with the application. The expectation is that at the six-month attestation the client will have a valid ID with an in-TGA address. At the yearly recertification the client must have a valid ID with an in-TGA address or recertification will not be processed, unless there are extreme circumstances that are documented that have prevented the client from obtaining an ID for an entire year. If the barrier to obtaining a valid ID is that severe, it should be noted at the six-month recertification and the RWSP should be notified.

-Proof of Residence (POR)

To be eligible for services, the client must live in one of the following counties: Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam, or Shelby. The client must have at a minimum 1 proof of residence within the TGA.

POR may include the following:

D. Current (within one year) lease.
E. Current Social Security Award Letter.
F. Bill or official letter dated within the last 60 days.
    - Official letters are signed, on professional letterhead, or from a local, state, or federal governmental entity.
    - It must be the official letter; envelopes will not be accepted.

D. If no residence document is available, a letter must be written by the Case Manager explaining why and what is being done to obtain that document (e.g. client is literally homeless, etc.).

E. For immigrants, undocumented or otherwise, the RWSP will accept whatever documentation is available explained by a letter from the Case Manager. The Case Manager letter should include information about steps to be taken to help the client obtain appropriate documentation. The goal is to link individuals to care as rapidly as possible and for the Case Manager to work with the client to help them obtain appropriate documentation so they can access other services, programs or essentials for which they may be eligible.

A client who is in the Indiana Department of Corrections (IDOC) community work release program is eligible for services under the RWSP and must meet all eligibility requirements. The IDOC has determined that the client is responsible for medical issues/concerns.

Check stubs being used for proof of income will no longer be accepted for proof of residence.

-Proof of Income (POI)

To be eligible for services, a client must be under 300% Federal Poverty Level (FPL). Please ensure that you are using the most up to date FPL Guidelines sent out by Ryan White Program Staff.

Self-employed clients will provide the following:

A. Most recent tax return.
B. If a client did not file in the current year, an I-NET ('Workforce One Statement'- also referred to as 'employment verification statement') must be provided.
C. Any additional income must be documented. This could include pension, long term disability or other retirement statements.
D. If no income document is available, a letter must be written by the case manager to explain why and what is being done to obtain that document.

Proof of submission of the I-NET is acceptable as long as the agency submits proof of documentation once it is received. Both proof of the submission and the actual I-NET should be kept on file at the agency submitting the application.

Currently employed clients will provide the following:

A. Most recent check stubs. All income will be counted with the exception of one time payments, overtime and bonuses. All other income including tips, commission, shift differential and holiday pay shall be counted. If a client has overtime, the difference in pay for the overtime is not counted. However, the number of hours at the base rate should be counted as income. This is considered the last 28 days of income.
B. The number of pay stubs required: one for clients paid monthly, two for clients paid bi-weekly, four for clients paid weekly. This must include all pay stubs during the most recent 28 days.
C. A 'year-to-date gross income divided by 12 months' or 'calculating a missing stub' cannot be used if any documented proof is missing.
D. If a client receives any other income, they must also provide documentation of this income. This could include pension, long term disability or other retirement statements.
E. If no income document is available, a letter must be written explaining why and what is being done to obtain that document.

Non-Working clients will provide the following:

A. Most recent Social Security Income/Social Security Disability Income (SSI/SSDI) statement.
B. If a client does not receive SSI/SSDI and is not employed, an I-NET must be submitted.
C. If no income document is available a letter must be written explaining why and what is being done to obtain that document.
D. If a client receives any other income, they must also provide documentation of this income. This could include pension, long term disability or other retirement statements

Proof of submission of the I-NET is acceptable as long as the agency keeps proof of documentation once received.

A client becomes eligible for services at the point when they no longer have the income that would make them ineligible. The case manager can obtain an I-NET on the first day a client is no longer receiving income. A letter must be submitted explaining that the client just lost their employment/income.

-Insurance Verification

Proof of the client's current insurance cards should be photocopied, including any public or private insurance. In addition, Medicaid Eligibility Documentation (often referred to as a "verification") is needed to determine if the client is eligible on the date of the application. A second "verification" is needed to determine the Medicaid eligibility date, and a third "verification" is needed to show the last date a client did not have Medicaid Coverage (this would be to show a start date).

The employer insurance verification forms should be completed if possible. A proof of employer verification will be requested; however, if one cannot be obtained, a letter from the case manager can be submitted indicating the refusal of the employer to complete. A client will not be denied enrollment based solely on not having a completed employer verification form. The form needs to be completed only once per employer. After it has been received by the RWSP for the first time, it will not need to be requested at each recertification.

The Insurance section on the application/recertification cannot be left blank (even if no insurance). RWSP should be listed even though it is not insurance. This section should specify the type of insurance (not just Medicaid or HIP [Healthy Indiana Plan]). The type of insurance should be the exact type indicated on the Medicaid verification.

If no insurance document is available, a letter must be written by the case manager explaining why and what is being done to obtain that document.

If a client just lost their job, correct information should be included in the Ryan White Application. If/when the insurance changes, a change form should be submitted with documentation to prove the change.

-Proof of Status (POS)

All re-entry applications must contain proof of HIV status (Medical Services ISDH [Indiana State Department of Health] verification, Confirmatory test documentation, IDOC ISDH Form, Completed HIV Case Report, Certification by HIV provider statement, Hospital discharge summary, HIV status lab report with detectable viral load, Progress note with physician signature).

There are other documents that an agency may have a client complete:

- An agency signed release of information as needed
- Signed client conduct statement
- Signed informed participation agreement
- Signed client conduct
- Signed confidentiality form
- Complete ISDH Care Coordination Intake on paper form to enter into a computer after appointment

A case manager will also review the following with the client:

- Eligibility requirements for Ryan White Services Program and the need for updates from client as they occur.
- Ways to contact case manager and set appointments in the future
- Recertification periods for each program
- Return phone call policies
- Ways to obtain referrals in the future
- How to request assistance and referrals for other funded programs (utilities, transportation assistance, food pantry access, food vouchers, boost, legal services, dental, vision, and housing)
- How to become involved with the Ryan White Planning Council if residing in the TGA
- How assistance can change based upon client's work, insurance, residence and income
- How clients will know referrals have been approved and how to access those services

Prior to the completion of the appointment, case managers will explain next steps for which the client is responsible. The next steps could include, but are not limited to, obtaining required

documents and bringing to the initial intake appointment. Clearly defined deadlines and potential consequences of not completing application requirements should be explained to the client.

After the client intake is complete, case managers will complete all applications and referrals on behalf of the client. Case managers will complete those referrals within 24 hours of the intake completion. Case managers may keep fax confirmation sheets to be included in client record as evidence of task completion. Case notes of the initial intake and all referrals will be completed within the same 24 hour period. A client chart will be created and all sections will be completed.

CHAPTER 5:

CLIENT FILES

General Client File Use

Agencies should have policies describing how they will keep all records in a safe and secure space within their agency. Policies regarding document destruction and management proposed in the agency request for professional services (RPS) should be followed and be reviewed by program staff, quality management and administration within the agency. Charts with client information should be stored in a secure location within agency space. Only those who are directly involved in the Ryan White Program or support staff should have access to the charts associated with Ryan White Eligible and enrolled clients. Case managers should only take out a client chart while work is being done on that specific client. Charts should never be left out in an unsupervised area, and charts must be secured prior to leaving office space for any period of time. All client charts should be kept for monitoring purposes for at least seven years. Staff should move client charts to an inactive area if a client is no longer receiving services, no longer eligible per agency policy or no longer eligible for services based on eligibility requirements.

Per agency policy, electronic storage of client information must be protected and secured. This can include the use of secure messages, passwords, multiple layers of access protection, and the use of screen protectors in public areas. Additionally, client information should not be accessible to the general public on agency provided technology.

Client File Setup

It is suggested that sites set up client files in a way that makes it easy to obtain documents. This will allow case managers to be more efficient with client services and ensures ease of monitoring by Ryan White Program Staff. File set up in the following description is not a requirement for any site. Those who are using electronic medical records may have other systems in place.

Storing files electronically can vary between agencies. Most will probably use a shared and secure data storage file to house the client records. Typically these are accessible to the agency and not to Ryan White Staff. For Ryan White Staff to access these files during a monitoring, an agency will have to accommodate by saving a copy of each document into a file that does not have such restrictions. The system the agency puts in place for documentation should ensure ease of use for agency staff and Ryan White Staff to obtain needed information. In addition, the setup should be explained in the agency RPS to Ryan White Staff of how documents will be set up, secured and used.

Client File Sections for Paper Charts

The suggested method for organizing a paper chart will follow the Indiana State Department of Health Care Coordination Suggested Chart. The description below outlines sections used in the chart as described above. If additional assistance is needed, an agency should request assistance from Ryan White TGA Staff. Many agencies find that using a classification folder with two dividers is the easiest way to follow this format.

Client name and any other identifying information as required by agency policy should be printed on the visible tab. Agencies should attempt to not reuse folders by whiting out names or relabeling the charts.

Section 1- Client Intake/Assessment
Section 2- Printed Case Notes
Section 3- Medical Related Documents/Miscellaneous
Section 4- Lease, Identification and Insurance Cards
Section 5- Applications
Section 6- Signed Documents

- Section 1 Client Intake/Assessment
This section should include the initial intake of the client into your agency. This intake will be as described in RPS response to Ryan White TGA staff. This intake must include several assessments that may indicate immediate services are needed, including a substance use/abuse assessment and mental health assessment. These assessments must be completed annually and may be kept in Section 5 Applications. The assessment should be completed on paper with the client present, rather than entered into the computer so the case manager can give the client his/her full attention. This can be typed and printed later if needed.

- Section 2 Printed Case Notes
This section should include all notes related to the client and the client's care plan. This section should be kept up to date to ease transfer of care within or outside of an agency. More about case notes and care plans can be found in a later section.

- Section 3 Medical Related Documents/Miscellaneous
This section should include any medically related documentation needed to provide care to the client. This section may also include other documents which may not fit in other sections of the client chart, such as client hour extensions, assistance logs and financial documents may be some examples.

- Section 4 Lease, Identification and Insurance Cards
This section should include the most current identification, lease and insurance cards. By keeping these documents in this tab, it may help provide easy access to obtain services that clients need.

- Section 5 Applications
This section will contain the largest amount of material. This section should include all Ryan White Applications and Ryan White Recertifications. This section could also hold: change

forms, referrals, medical case management intakes/care plans, ongoing assessments (substance use/mental health/medical case management), care coordination information, assistance forms, housing applications and Direct Emergency Financial Assistance (DEFA) requests. Documents should be filed under each tab with the newest document on the top. These sections should be easily identifiable for agency staff use for client support and Ryan White Staff for monitoring requirements. Many sites have these divided by tabs.

- Section 6 Signed Documents

This section should include proof of status and any documents the client has signed. This should include release of information, consent forms, confidentiality agreement and client rights and responsibilities. It may also include other forms such as a client conduct statement.

CHAPTER 6:

ASSESSMENTS, REFERRALS, AND NOTIFICATIONS OF CHANGE

Assessments are utilized to identify specific needs a client may have. These assessments are utilized at intake, recertification, re-entry and as needed. Mental health and substance abuse assessments are required. Agencies may also implement other assessments to further identify client needs. When assessments indicate services may be needed for the client, the case manager should discuss these indicators and explore the possible referral process that can be initiated.

Agencies are required to monitor client mental health and substance use annually to identify issues that may put a client's health at risk. Each agency responded how they would monitor, assess client needs, and identify potential referrals in their grant application. This can be done by the use of assessments during a client initial intake and the recertification process.

If the referral occurs during the initial intake process – to alleviate any barriers – the MCM can complete the referrals and bill as MCM; however, if it is at a routine visit then the MCM can complete the referral but must bill as NMCM or they can refer to the clients NMCM for completion – this is an agency determination – but the billing must be as NMCM.

Process to complete and submit referrals

The referring provider will complete the Ryan White HIV Services Program Core and Support Services Referral Form. The completed Referral Form will be sent directly to the sub-recipient/provider that will deliver the service. Forms should be faxed or emailed to the provider. The sub-recipient/provider who delivers a Ryan White service to a client is responsible for ensuring the client is eligible and enrolled in the Ryan White/HIV Services Program. In addition to the Referral Form a Plan of Care should also be sent to the provider. Exceptions to this are Referrals to Substance Abuse-Residential Services, and requests for medications from Walgreens. These will be sent to RWSP.

After the referral is submitted

Once the referred provider has received a referral, it should be approved or denied within three working days. As well, the referred provider should send back any denied referrals to the case management site within three working days. If the referral was not denied in that time frame, then the case manager should call the client and inform them that they can now access services through that provider. A client scheduling an appointment without a secured referral is not suggested or recommended and any services rendered without the approved referral can be subject for payment by the client. This may mean that the service being provided will not be covered by the program and the client will be financially responsible.

In-House and Out-of-House Referrals

For in-house referrals, the agency must ensure that the client is active prior to providing the service. If the client is not eligible, an in-house referral should not be made. An outside agency

must submit requested documentation for direct assistance to the agency supplying food, utilities, housing, or medical nutrition. These documentation requirements must be negotiated with Ryan White during contract process. The receiving agency must ensure all NMS and eligibility requirements are met. Referrals for Emergency Financial Food, Emergency Financial Utilities, and Emergency Financial Housing may be fulfilled by the providing agency with appropriate supporting documentation. The provider must thoroughly document in a CAREWare case note the provision of the service such that it substantiates the cost and the identified need and the steps taken to secure funding before applying to the RWSP. The Case Manager is also responsible for documenting the process for securing funding for the identified needs should such need for the service continues, especially if there is a consideration for re-applying to RW for additional fiscal assistance.

Medical Referrals

Approved HIV-related medical referrals during the 7-day window period will never be denied. Other services for which referrals are made at the time of a pending application may be approved if the referral is completed during the initial pending period, or if a request for an extension has been approved during the extension period. If the referral is not completed within the 21-day maximum pending period, and the client has not been deemed eligible, then the referral is null and void.

Other Referrals

A client may have a need for a service not usually funded by Ryan White. A referral needs to be submitted for that specific service. In these cases, documentation should include details of the service requested and how the service ties to a client's care plan. These requests will be evaluated by Ryan White Staff and approval or denial will be documented by Ryan White Staff. There needs to be an approval for the service that is outside of normal eligibility. One example of this is a client wanting to use medical transportation to go to an Alcoholics Anonymous meeting, which is not a fundable service category. However, a case manager may link the requested transportation to attend the meeting to the client's care plan.

Notice of Change

Part of each agency condition of award is to document reasons why clients are no longer a part of the program. These reasons can be documented within a case note prior to services being stopped (expiration of application) for the client. This does not relieve the agency from completing any change forms. However, an expiration case note must be entered if a client does not recertify in time due to moving, becoming ineligible, not coming to appointment, or failing to supply eligibility determining documents. The note should include what was done to get the recertification process completed.

Clients Moving from Active to Inactive Status in the RWSP

An important element of each agency's condition of award is to document reasons why clients are no longer active in the RWSP. This documentation is an important element in the RWSP's ability to accurately complete the annual Ryan White HIV/AIDS Program Services Report (RSR). The RSR is a condition of award from HRSA to the RWSP for Ryan White TGA grant funds. This information is also important for RWSP program evaluation and improvement related to client retention in care.

A Notification of Change form will be submitted to the RWSP when any of the following changes occur with a client. Several of these changes also require a change in CAREWare, as noted below.

- Name – whether through marriage, divorce, or legal change by client. Legal documentation of name change (updated ID or similar document) should accompany NOC form. The RWSP CAREWare Manager should be notified directly (through secure email or phone call) to update CAREWare. Note: Providers do not have permissions granted to change name, date of birth, or gender in CAREWare.
- Gender – Legal documentation of gender change, if available, should be submitted with NOC form. RWSP CAREWare Manager should be contacted to update CAREWare.
- HIV Status - conversion to AIDS and date, documentation (if available) should be submitted with NOC form. Corresponding change should be made in CAREWare (providers have permissions to make these changes).
- Change in residence within TGA – Documentation should be submitted with NOC form, corresponding change should be made in CAREWare (providers have permissions to make these changes).
- Change of residence resulting in client no longer living in TGA – NOC form does not require accompanying documentation. A move out of the TGA should be noted in CAREWare in a case note and in the common note memo field.
- Change in income – Documentation should accompany the NOC form, corresponding change should be made in CAREWare (providers have permissions to make these changes).
- Change in insurance – Documentation should accompany the NOC form, corresponding change should be made in CAREWare (providers have permissions to make these changes).
- Deceased client – Date of death should be included with the NOC form, corresponding change should be made in CAREWare (providers have permissions to make these changes).
- Change in care coordination site or HIV primary medical site – NOC form should include previous and new care coordination site and/or HIV primary medical site.

If a client fails to recertify or requests to be removed from the RWSP, please indicate this in a CAREWare case note, including documentation of efforts to contact the client about need to recertify.

CHAPTER 7:

CARE PLAN DEVELOPMENT/ CASE NOTES

Case notes should be written to ensure the best care possible for a client. Notes should be accurate and reflective of the clients overall status so that if any other case manager takes over the client's situation, they would be able to read the previous case note and pick up where the other case manager left off in fulfilling the needs of the client. Case notes must be an accurate representation of the date of service, amount of time spent on the service, type of service, how the service was provided, service provider, problem, service and outcome. This care plan is the core to delivering services and achieving undetectable viral loads. The case note should ideally be entered immediately after the client visit. The case note and service must be entered prior to submission of invoices to Ryan White TGA Staff. These must be submitted on or before the 20th of the month following service delivery.

Case notes should be entered into CAREWare and adheres to the following requirements. Case note templates may be used but must cover the required documentation.

Date of Service
The date of service entered into CAREWare should be the date that the service was provided to the client. This service should match service data entry and billing data.

Length of Service
This should indicate how much time (units) were spent with the client. As indicated within their scope of work. For most agencies, the unit of service is equivalent to one hour. If a case manager provides 15 minutes of service, the billing should indicate that the unit of service was .25 units.

Type of Service
This should indicate what category of service was provided. If medical case manager provides a MCM service, the case note should indicate MCM as the type of service at the top of the case note. If that same MCM provider provides a service considered a normal NMCM service, then NMCM should be billed.

How the Service was Provided
This section should provide documentation of how the billed service entry was provided, including: Was the service through a phone, in person, or email?

Service Provider
A case note author should be selected to indicate who provided the service to the client. The case note author should be the same person who provided the service to the client. If entering a note for another provider/colleague, the final line of the case note should read “entered by John Doe for Jane Roe.” A case note author should be selected from the drop down menu. Sites must notify the RWSP Data Manager of staff changes so the drop down menu can be kept current.

Problem
This section should be a brief description of the problem or issue the case manager is addressing with the client.

Service
This section should be the detailed description of the services that were provided. This section should be detailed enough that any case manager could continue services for the client. In addition, this should justify the amount billed for the service.

Outcome
This should indicate the outcome that is directly linked back to the problem.

By having the above sections in each case note, agencies will be in compliance with NMS, the standard will be met and QA activities can be conducted.

Part of each agency condition of award is to document reasons why clients are no longer a part of the program. These reasons can be documented within a case note prior to services being stopped (expiration of application) for the client. However, an expiration case note must be entered if a client does not recertify in time due to moving, becoming ineligible, not coming to appointment, or failing to supply eligibility determining documents. The note should include what was done to get the recertification process completed.

CHAPTER 8:

BILLING FOR SERVICES

All services that are provided to a client must have a case note that details the service provided and all other elements required for case noting. The case note needs to match the corresponding billing request in order to be considered reimbursable. This billing data must be entered into CAREWare prior to billing before reimbursement can occur. If a reimbursement request does not match the associated CAREWare service entry, then that reimbursement request will not be completed until such time that CAREWare is current (compatible with the reimbursement request). Each reimbursement request/entry must reflect what was done and the true time to complete the service, with accompanying documentation of established need and outcome.

Services should be billed appropriately. If a Medical Case Manager provides a service that is billable under the description above for NMCM, that category should be used at the lower rate. NMCM services are not billable under MCM. Recertification applications and six-month attestations are not eligible for MCM billing. In addition, referrals completed outside of the intake and re-entry process may not be billed under MCM. **Falsification of any documents will result in the client or funded agency reimbursing all costs for services rendered.**

Since case notes are entered as services are provided, billing should be entered at the same time. This can be accomplished within CAREWare by checking the box within the case note to add service. By entering case notes and service billing as the service is provided, the documentation and services will be more accurate. These notes and services should be entered within 24 hours of delivery.

Some services are not billable. Calling a client and leaving a message can be documented with a case note. However, the billing amount should be set to zero on the case note and be billed at zero within the service section. Leaving a client a message is not an allowable service. In addition, services can be documented within case notes if a client is no longer eligible for Ryan White Services. The service must be set to zero in these cases.

When billing, it is essential to select the correct contract and service within the service section. Please check with your supervisor on the correct contracts and Ryan White Part that should be billed within your agency (Ryan White Part A, MAI, or Ryan White Part C). If a service is added incorrectly, the service must be changed to provide correct information for billing and reporting guidelines. Please consult your supervisor on how to add, edit, or delete a service. Remember that on the current CAREWare version, a change in contract will change the unit of service to the default. If you edit a service, please ensure that you correct the units delivered after the change.

If a bill submitted to Ryan White Staff is determined to be ineligible for payment, the business coordinator will contact the agency to ensure the information currently received is correct. If the service is truly ineligible, agency staff will need to change the service to a denial within CAREWare for RSR purposes.

Units of services used for billing are based on the grant application from the agency. The units correspond to time spent on the delivery of the service. For medical and non-medical case management, a unit of service is defined as the provision of one hour of service and is as indicated within their scope of work. If you provide a service for 15 minutes then the billing should be set as .25 units. The units must match the description entered into the case note and be realistic with what is documented. Once 15 minutes is reached, all services should be rounded up or down based on the total time taken to provide the service. This should include all case noting, filing, case conferencing, and all services conducted on behalf of the client.

As stated in the grant agreement, all billing should be complete and filed with the Ryan White Office by the 20th of the following month.

The case note author should be the same person who provided the service to the client. If entering a note for another provider/colleague, the final line of the case note should read "entered by John Doe for Jane Roe." A case note author should be selected from the drop down menu. Sites must notify the RWSP Data Manager of staff changes so the drop down menu can be kept current.

A Medical Case Manager can bill for the initial intake or re-entry as a Medical Case Management service into the RWSP. If it is a recertification, attestation or any referral needs, the time spent assisting with those activities is to be billed as Non-Medical Case Management. For example, if a client is being seen for a routine MCM visit and it is discovered that they need to recertify or needs any referrals, the MCM staff may complete the application and/or referral process but the billing must be to non-medical case management and not medical case management

CHAPTER 9:

INACTIVE CLIENTS

A client is considered inactive if the client is no longer eligible for services. This could happen due to any reason that the client does not meet program requirements. Non-active Ryan White charts should be kept in a different section of client charts following agency protocol for secure record keeping. Client charts should be kept for a minimum of seven years. If a client reactivates with an agency, the chart should be removed from inactive and used for current services.

If a client is no longer eligible for services, an expiration case note should be completed explaining the situation. If a lapse in recertification occurs, documentation should be in the note explaining what has happened in an attempt to prevent the lapse.

Inactive clients are ineligible to receive RW-funded services. If an inactive client is billed to a RW contract then that charge will be subject to a denial of funds.

In the case of death, a notice of change should be filed with Ryan White Staff. Within CAREWare the vital status should be changed, enrollment status should be "relocated/referred", date of death should be added and the client should be closed. The chart should then be moved to the inactive section within the agency.

ATTACHMENT A:

NATIONAL RYAN WHITE INFORMATION AND INFORMATION SPECIFIC TO THE TGA

Attachment A
National Ryan White Information and information specific to the TGA

The Ryan White HIV/AIDS Program is the largest Federal program focused exclusively on providing HIV care and treatment services to people living with HIV. Working with cities, states and local community-based organizations, the Program provides a comprehensive system of care for people living with HIV who are uninsured or underinsured. The legislation was first enacted in 1990 as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. It has been amended and reauthorized four times: in 1996, 2000, 2006, and 2009. The Ryan White HIV/AIDS Program legislation has been amended with each reauthorization to accommodate new and emerging needs, such as an increased emphasis on funding core medical services and changes in funding formulas.

Medical Model: Major focus on core medical services (medical model) in which 75% of service funds must be spent on core medical services, newly defined (waiver available) and up to 25% of service funds may be spent on support services that contribute to positive clinical outcomes.

Parts of the Ryan White Modernization Act
A, B, C, D, F
Part A provides funding to:
– EMA: Eligible Metropolitan Areas
– 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000
– TGA: Transitional Grant Areas
– 1000 to 1,999 new AIDS cases in the most recent 5 years

Part B provides funding to:
– States and Territories
Base Grant, ADAP, and Supplemental funding

Part C provides funding to outpatient early intervention services and are most often awarded directly to service providers

Part D provides funding to family-centered comprehensive care to children, youth and women and their families

Part F provides funding to SPNS, AIDS Education and Training Centers (MATEC) and Minority AIDS Initiative

More Detailed Information

The Ryan White HIV/AIDS Program provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The Program works with cities, states, and local community-based organizations to provide HIV care and treatment services to more than half a million people each year. The Program reaches approximately 52% of all people diagnosed with HIV in the United States.

The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training, and the development of innovative models of care. The Program serves as an important source of ongoing access to HIV medication that can enable people living with HIV to live close to normal lifespans.

August 18, 2015 marked the 25th anniversary of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, the legislation that created the Ryan White HIV/AIDS Program. First authorized in 1990, the Program is funded at $2.32 billion in fiscal year 2016. The Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

About The Ryan White HIV/AIDS Programmatic Parts

The Ryan White HIV/AIDS Program is divided into five Parts, following from the authorizing legislation.

• Part A provides grant funding for medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are population centers that are the most severely affected by the HIV/AIDS epidemic.

• Part B provides grant funding to states and territories to improve the quality, availability, and organization of HIV health care and support services. Grant recipients include all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the 5 U.S. Pacific Territories. In addition, Part B also includes grants for the AIDS Drug Assistance Program (ADAP).

• Part C provides grant funding to local community-based organizations to support outpatient HIV early intervention services and ambulatory care. Part C also funds planning grants, which help organizations more effectively deliver HIV care and services.

• Part D provides grant funding to support family-centered, comprehensive care to women, infants, children, and youth living with HIV.

• Part F provides grant funding that supports several research, technical assistance, and access-to-care programs. These programs include:

• The Special Projects of National Significance Program, supporting the demonstration and evaluation of innovative models of care delivery for hard-to-reach populations;

• The AIDS Education and Training Centers Program, supporting the education and training of health care providers treating people living with HIV through a network of eight regional centers

and three national centers;
• The Dental Programs, providing additional funding for oral health care for people with HIV through the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program; and
• The Minority AIDS Initiative, providing funding to evaluate and address the impact of HIV/AIDS on disproportionately affected minority populations.

Part A: Grants to Eligible Metropolitan and Transitional Areas
Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009 provides assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely impacted by the HIV epidemic.

Eligibility
The boundaries of EMAs and TGAs are based on the U.S. Census designation of Metropolitan Statistical Areas and may span more than one state.
• To qualify for EMA status, an area must have reported at least 2,000 AIDS cases in the most recent five years and have a population of at least 50,000.
• To be eligible for TGA status, an area must have reported 1,000 to 1,999 AIDS cases in the most recent five years and have a population of at least 50,000.
Funding Considerations
Part A grants to EMAs and TGAs include formula and supplemental components as well as Minority AIDS Initiative (MAI) funds, which support services for minority populations.

Services Available under Part A and MAI
Part A funds must be used to provide core medical and support services for people living with HIV. Core medical services include the following:
• AIDS Drug Assistance Program
• AIDS pharmaceutical assistance
• Early intervention services
• Health insurance premium and cost sharing assistance for low-income individuals
• Home and community-based health services
• Home health care
• Hospice services
• Medical case management, including treatment-adherence services
• Medical nutrition therapy
• Mental health services
• Oral health
• Outpatient and ambulatory medical care
• Substance abuse outpatient care
Support services must be linked to medical outcomes and may include outreach, medical

transportation, linguistic services, respite care for caregivers of people living with HIV, referrals for health care and other support services, non-medical case management, and substance abuse residential services. Recipients are required to spend at least 75% of their Part A grant funds allocated for services on core medical services and no more than 25% on support services, unless they receive an approved waiver to this requirement.

HIV Health Services Planning Councils

Each EMA Planning Council sets HIV-related service priorities and allocates Part A funds on the basis of the size, demographics, and needs of people living with HIV.

Planning Council membership must reflect the demographics of the local epidemic and include members with specific expertise in health care planning, housing for the homeless, health care for incarcerated populations, and substance abuse and mental health treatment and members who represent other Ryan White HIV/AIDS Program Parts and other federal programs. At least 33% of members must be unaligned and receive Ryan White HIV/AIDS Program services.

TGAs are required to implement a comprehensive community planning process, but the Planning Council structure and process, while strongly encouraged, is optional.

Part B: Grants to States & Territories

Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) provides grants to States and Territories to improve the quality, availability, and organization of HIV health care and support services. Within the RWHAP Part B grant there is:

• a base grant for core medical and support services;
• the AIDS Drug Assistance Program (ADAP) award;
• the ADAP Supplemental award;
• the Part B Supplemental award for recipients with demonstrated need;
• Minority AIDS Initiative funding for education and outreach to improve minority access to medication assistance programs, including ADAP; and
• Supplemental grants to states with "emerging communities."

Services Available under Part B

Part B funds core medical services and support services. The specific allowable services funded by each State/Territory are determined at the State/Territory level based on needs assessment and available funding. Core medical services include outpatient and ambulatory health services, ADAP, AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost-sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, outpatient substance abuse care, and medical case management, including treatment-adherence services. Support services must be linked to medical outcomes and may include outreach, medical transportation, linguistic services, respite care for caregivers of people with HIV/AIDS, referrals for health care and other support services, non-medical case management, and residential

substance abuse treatment services. Grant recipients are required to spend at least 75% of their Part B grant funds on core medical services and no more than 25% on support services.
In addition, all Part B recipients and sub-recipients must vigorously pursue enrollment in available health coverage options for eligible clients.

Recipients
Grant recipients are the chief elected official of a State/Territory who designates the state department of health or another state entity to implement and manage the RWHAP Part B grant.

Eligibility
All 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the five U.S. Pacific Territories/Associated Jurisdictions are eligible for Part B funding. Emerging Communities funding is distributed to the state or territory for communities that report between 500 and 999 cumulative reported AIDS cases over the most recent five years.

Funding Considerations
• Part B Base and ADAP base awards are determined using a formula based on reported living cases of HIV in the state or territory in the most recent calendar year for which data is available.
• The ADAP base awards provide access to HIV-related medications through the purchase of medication and the purchase of health insurance coverage. A limited amount of ADAP funds can be pay for services that enhance access, adherence, and monitoring of drug treatments. Of the ADAP appropriation, 5% is reserved for additional funding to states and territories that have a severe need for medication assistance, which they can apply for through ADAP Supplemental.
• A competitive supplemental grant program, ADAP Emergency Relief Funds, was authorized in 2006 is also available based on demonstrated need criteria.

Part C: Early Intervention Services and Capacity Development Program Grants
Part C of the Ryan White HIV/AIDS Program provides grant funding to local community-based organizations to support outpatient ambulatory health service and support services through Early Intervention Services (EIS) program grants. Part C also funds planning grants, which help organizations more effectively deliver HIV care and services through Capacity Development grants.

Early Intervention Services Grants
The Part C EIS component of the Ryan White HIV/AIDS Program funds comprehensive primary health care in outpatient settings for people living with HIV. Grant recipients are organizations seeking to enhance their response to the HIV epidemic in their area through the provision of comprehensive primary HIV medical care and support services.
Early Intervention Services Grant Eligibility

The following organizations are eligible to receive Ryan White HIV/ AIDS Program Part C EIS grants:

• Federally Qualified Health Centers funded under Section 1905(1)(2)(b) of the Social Security Act
• Family planning grantees (other than states) funded under Section 1001 of the Public Health Service Act
• Comprehensive Hemophilia Diagnostic and Treatment Centers
• Rural health clinics
• Health facilities operated by or pursuant to a contract with the Indian Health Service
• Community-based organizations, clinics, hospitals, and other health facilities that provide early intervention services to people living with HIV
• Nonprofit private entities providing comprehensive primary care to populations at risk of HIV, including faith-based and community-based organizations

Services and Implementation for Early Intervention Services Grants

Grant recipients must allocate costs using the following Part C cost categories: EIS, core medical services, support services, clinical quality management (CQM), and administrative.

The RWHAP statute requires that no more than 10% of a Federal Part C EIS award can be allocated to administrative costs; at least 50% of the total award should be allocated to EIS; at least 75% of the balance remaining after subtracting administrative and CQM costs must be used for core medical services.

Capacity Development Grants

The Part C Capacity Development Program assists public and nonprofit entities in efforts to strengthen their organizational infrastructure and their capacity to develop, enhance, or expand access to high-quality HIV primary health care services for people living with HIV or at risk of infection in underserved or rural communities. For the purposes of the program, capacity development refers to activities that promote organizational infrastructure development leading to the delivery or improvement of HIV primary care services.

Grant recipients are organizations seeking to expand or enhance their capacity to respond to the HIV/AIDS epidemic in their area.

Eligibility for Capacity Development Grants

Applicants must be public or private nonprofit entities that are or intend to become comprehensive HIV primary care providers. Current Ryan White HIV/AIDS Program service providers as well as faith-based and community-based organizations are eligible to apply for funding.

Services and Implementation for Capacity Development Grants

In FY 2015, funding was available to support one or more activities that address gaps in

applicants' local HIV Care Continuum for a one-year project period. Funding was available to support training, skills building activities, and innovative interventions, which could be rapidly implemented to allow follow-up evaluation of impact on the recipient's HIV Care Continuum. Proposed activities were required to be linked directly to a specific stage of the HIV Care Continuum with a target level of improvement.

Part D: Services for Women, Infants, Children, and Youth

Ryan White HIV/AIDS Program Part D grant recipients provide outpatient ambulatory family-centered primary and specialty medical care and support services for women, infants, children, and youth living with HIV.

Grant Recipients

Part D grant recipients are local, community-based organizations seeking to enhance their response to the HIV epidemic in their area through providing family-centered primary medical care and support services to women, infants, children, and youth living with HIV when payments for such services are unavailable from other sources.

Eligibility

The following organizations may apply for funding:

• Public or private nonprofit entities that provide (directly, through contracts, or through memoranda of understanding) primary medical care for HIV-positive women, infants, children, and youth.

• State and local governments and their agencies, as well as Indian tribes or tribal organizations with or without federal recognition.

• Faith-based and community-based organizations.

Services and Implementation

Part D divides allowable costs among four cost categories: medical services, clinical quality management, support services, and administrative.

• Medical Service Costs are associated with providing family-centered care, including access to primary medical care services for women, infants, children, and youth living with HIV.

• Clinical Quality Management (CQM) Costs are costs required to maintain a CQM program, including quality improvement activities, data collection for CQM purposes, and training and technical assistance for staff.

• Support Service Costs are associated with services needed for individuals with HIV to achieve their HIV medical outcomes, including case management, patient transportation to medical appointments, and outreach to recruit and keep women, infants, children, and youth living with HIV in care.

• Administrative Costs are those costs not directly associated with service provision. By RWHAP statute, no more than 10 percent of a Part D budget can be allocated to administrative costs.

Part F: Minority AIDS Initiative

The Ryan White HIV/AIDS Program Part F grants support several research, technical assistance, and access-to-care programs, which includes the Minority AIDS Initiative (MAI). MAI was established in 1999 by Congress under the Ryan White HIV/AIDS Program Parts A, B, C, and D to improve access to HIV care and health outcomes for disproportionately affected minority populations, including black populations.

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit HIV/AIDS.

Under Part B, MAI formula grants fund outreach and education services designed to increase minority access to needed HIV/AIDS medications through Part B AIDS Drug Assistance Programs (ADAP).

Under Part C, MAI funds are used by community health centers and other service providers to improve access to early intervention HIV services. Other examples include technical assistance to expand the capacity of agencies to deliver HIV care to minority populations and training to expand the pool of minority providers in underserved communities.

Part F: Dental Programs

Funds from all Ryan White HIV/AIDS Program Part recipients may support the provision of oral health services. However, two programs specifically focus on funding oral health care for people living with HIV: the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP). The key program elements are funding of services and funding of education and training for oral health providers**.**

Eligibility

Eligible applicants for both the DRP and the CBDPP are institutions that have dental or dental hygiene education programs accredited by the Commission on Dental Accreditation (for example, dental schools, hospitals with postdoctoral dental residency programs, and community colleges with dental hygiene programs).

Grant Recipients

Grant recipients are dental education programs seeking to improve their response to the HIV epidemic in their area.

Dental Reimbursement Program (DRP) Implementation

First funded in 1994, the Dental Reimbursement Program assists institutions with accredited dental or dental hygiene education programs by defraying their unreimbursed costs associated with providing oral health care to people living with HIV.

Community-Based Dental Partnership Program (CBDPP)

First funded in 2002, the Community-Based Dental Partnership Program increases access to oral

health care services for people living with HIV while providing education and clinical training for dental care providers, especially those practicing in community-based settings.
To achieve its goals, CBDPP works through multi-partner collaborations between dental education and dental hygiene education programs and community-based dentists and dental clinics. Community-based program partners and consumers help design programs and assess their impact.

Part F: AIDS Education and Training Centers (AETC) Program
The AIDS Education and Training Centers (AETC) Program of the Ryan White HIV/AIDS Program supports a network of eight regional centers (and more than 130 local affiliated sites) and three national centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV. The AETC Program is a national network of leading HIV experts serving all 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, and the 6 U.S. Pacific Jurisdictions. The AETC Program increases the number of health care providers who are educated and motivated to counsel, diagnose, treat, and medically manage people living with HIV and to help prevent behaviors that lead to HIV transmission.
The AETC Program focuses on training a diverse group of clinicians, including physicians, advanced practice nurses, physician assistants, nurses, oral health professionals, and pharmacists. The AETC Program also works with other multidisciplinary HIV care team members working in Ryan White HIV/AIDS Program and sexually transmitted disease clinics, hospitals, community-based organizations, health departments, mental health and addiction treatment facilities, and other health care facilities.

AETC Provider Training Network
Three national centers within the AETC Program support and complement the regional training centers:
AETC Education for Nurse Practitioner/Physician Assistant (NP/PA) Program: The purpose of the NP/PA Program is to expand the number of culturally competent nurse practitioners and physician assistants with capacity/capabilities to provide primary care to individuals living with HIV.

Part F: Special Projects of National Significance (SPNS) Program
The Special Projects of National Significance (SPNS) Program supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by Ryan White HIV/AIDS Programs. SPNS advances knowledge and skills in the delivery of health care and support services to underserved populations living with HIV.
Through its demonstration projects, SPNS evaluates the design, implementation, utilization, cost, and health related outcomes of treatment models while promoting the dissemination and

replication of successful interventions. The SPNS Program also funds projects to build capacity in the health information technology (HIT) systems of Ryan White HIV/AIDS Program grant recipients and provider organizations to report client-level data and to improve health outcomes along the HIV care continuum.

Our History

First received Part C funding in 1991 – the first year of funding for the Ryan White CARE Act;
First received Part A funding in 2007
Since 2007 the RWSP has expended $44, 869,175 inclusive of Parts A, C and MAI and representative of all awarded dollars. No unspent funding.
The program has enrolled 3000+ new clients – averaging 300 per year
Current active client number is 2,002

• The Indianapolis TGA Ryan White/HIV Services Program (RWSP) is comprised of Part A, MAI, and Part C funding. Health and Hospital Corporation of Marion County's (HHC's) Marion County Public Health Department (MCPHD) has received Part C funding since 1991, and Part A and MAI funding since 2007.
• RWSP is designed to address the needs of people living with HIV (PLWH), including those out of care, and who are historically underserved or uninsured.

Who We Serve

• People living with HIV/AIDS in the Indianapolis Transitional Grant Area:
    - Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam and Shelby Counties
• Resident of one of the covered counties; documentation of HIV status; and 300% of Federal Poverty Level
• Average 300 new clients per year entering program

List of Services Provided

1. Outpatient Ambulatory/ Health Services
2. Medical Case Management, Including Treatment Adherence Services
3. Oral Health Care
4. Local Pharmacy Assistance Program
5. Mental Health Services
6. Substance Abuse Outpatient Care
7. Health Insurance Premium and Cost Sharing Assistance
8. Early Intervention Services
9. HIV Counseling and Testing (Part C)
10. Optometry Services (Part C)
11. Medical Nutrition Therapy
12. Non-medical Case Management Services

13. Other Professional Services (Legal Services)
14. Linguistic Services
15. Emergency Financial Assistance - Housing
16. Emergency Financial Assistance - Utilities
17. Emergency Financial Assistance - Food
18. Emergency Financial Assistance - Pharmacy
19. Medical Transportation
20. Health Education and Risk Reduction
21. Substance Abuse Services (residential)
22. Outreach Services

ATTACHMENT B:

RYAN WHITE HIV/AIDS PROGRAM SERVICES: SERVICE CATEGORIES FOR ELIGIBLE INDIVIDUALS & ALLOWABLE USES OF FUNDS

Attachment B
Ryan White HIV/AIDS Program Services: Service Categories for Eligible Individuals & Allowable Uses of Funds

AIDS Drug Assistance Program Treatments
AIDS Pharmaceutical Assistance
Child Care Services
Early Intervention Services (EIS)
Emergency Financial Assistance
Food Bank/Home Delivered Meals
Health Education/Risk Reduction
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
Home and Community-Based Health Services
Home Health Care
Hospice Services
Housing
Legal Services
Linguistic Services
Medical Case Management, including Treatment Adherence Services
Medical Nutrition Therapy
Medical Transportation
Mental Health Services
Non-medical Case Management Services
Oral Health Care
Other Professional Services
Outpatient/Ambulatory Health Services
Outreach Services
Permanency Planning
Psychosocial Support Services
Referral for Health Care and Support Services
Rehabilitation Services
Respite Care
Substance Abuse Outpatient Care
Substance Abuse Services (residential)

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight.

Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:
• Medical history taking
• Physical examination
• Diagnostic testing, including laboratory testing
• Treatment and management of physical and behavioral health conditions
• Behavioral risk assessment, subsequent counseling, and referral
• Preventive care and screening
• Pediatric developmental assessment
• Prescription, and management of medication therapy
• Treatment adherence
• Education and counseling on health and prevention issues
• Referral to and provision of specialty care related to HIV diagnosis
Program Guidance:
Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

AIDS Drug Assistance Program Treatments
Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the RWHAP to provide FDA-approved medications to low-income clients with HIV disease who have no coverage or limited health care coverage. ADAPs may also use program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. RWHAP ADAP recipients must conduct a cost effectiveness analysis to ensure that purchasing health insurance is cost effective compared to the cost of medications in the aggregate. Eligible ADAP clients must be living with HIV and meet income and other eligibility criteria as established by the state.

AIDS Pharmaceutical Assistance
Description:
AIDS Pharmaceutical Assistance services fall into two categories, based on RWHAP Part funding.
1. Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or sub-recipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria. RWHAP Part A or B recipients using the LPAP service category must establish the following:
• Uniform benefits for all enrolled clients throughout the service area
• A recordkeeping system for distributed medications

• An LPAP advisory board
• A drug formulary approved by the local advisory committee/board
• A drug distribution system
• A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at a minimum of every six months
• Coordination with the state's RWHAP Part B ADAP
o A statement of need should specify restrictions of the state ADAP and the need for the LPAP
• Implementation in accordance with the requirements of the 340B Drug Pricing Program and the Prime Vendor Program
2. Community Pharmaceutical Assistance Program is provided by a RWHAP Part C or D recipient for the provision of long-term medication assistance to eligible clients in the absence of any other resources. The medication assistance must be greater than 90 days.
RWHAP Part C or D recipients using this service category must establish the following:
• A financial eligibility criteria and determination process for this specific service category
• A drug formulary consisting of HIV primary care medications not otherwise available to the client
• Implementation in accordance with the requirements of the 340B Drug Pricing Program and the Prime Vendor Program
Program Guidance:
For LPAPs: Only RWHAP Part A grant award funds or Part B Base award funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.
For Community Pharmaceutical Assistance: This service category should be used when RWHAP Part C or D funding is expended to routinely refill medications. RWHAP Part C or D recipients should use the Outpatient Ambulatory Health Services or Emergency Financial Assistance service for non-routine, short-term medication assistance.

Oral Health Care
Description:
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.
Program Guidance:
None at this time

Early Intervention Services (EIS)

Description:

The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:

The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

• RWHAP Parts A and B EIS services must include the following four components:

o Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected

Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts

HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources

o Referral services to improve HIV care and treatment services at key points of entry

o Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care

o Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

• RWHAP Part C EIS services must include the following four components:

o Counseling individuals with respect to HIV

o High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)

Recipients must coordinate these testing services under Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts

The HIV testing services supported by Part C EIS funds cannot supplant testing efforts covered by other sources

o Referral and linkage to care of HIV-infected clients to Outpatient/Ambulatory Health Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals

o Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost-sharing assistance, a RWHAP Part recipient must implement a methodology that incorporates the following requirements:

• RWHAP Part recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the Department of

Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services
• RWHAP Part recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective
The service provision consists of either or both of the following:
o Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients
o Paying cost-sharing on behalf of the client
Program Guidance:
Traditionally, RWHAP Parts A and B funding support health insurance premiums and cost-sharing assistance. If a RWHAP Part C or D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective and sustainable.

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include:
• Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
• Preventive and specialty care
• Wound care
• Routine diagnostics testing administered in the home
• Other medical therapies
Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
• Nutrition assessment and screening
• Dietary/nutritional evaluation
• Food and/or nutritional supplements per medical provider's recommendation
• Nutrition education and/or counseling
These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professionals. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:
• Mental health counseling
• Nursing care
• Palliative therapeutics
• Physician services
• Room and board
Program Guidance:
Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.
To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Home and Community-Based Health Services
Description:
Home and Community-Based Health Services are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:
• Appropriate mental health, developmental, and rehabilitation services
• Day treatment or other partial hospitalization services
• Durable medical equipment
• Home health aide services and personal care services in the home
Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purpose of providing home and community-based health services.

Mental Health Services

Description:

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:

Mental Health Services are allowable only for HIV-infected clients.

Substance Abuse Outpatient Care

Description:

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Program Guidance:

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific guidance.

Medical Case Management, including Treatment Adherence Services

Description:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

• Initial assessment of service needs
• Development of a comprehensive, individualized care plan
• Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
• Continuous client monitoring to assess the efficacy of the care plan
• Re-evaluation of the care plan at least every 6 months with adaptations as necessary
• Ongoing assessment of the client's and other key family members' needs and personal support systems
• Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
• Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:

Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Non-Medical Case Management Services

Description:

Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

• Initial assessment of service needs
• Development of a comprehensive, individualized care plan
• Continuous client monitoring to assess the efficacy of the care plan
• Re-evaluation of the care plan at least every 6 months with adaptations as necessary
• Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:

Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving healthcare outcomes.

Child Care Services

Description:

The RWHAP supports intermittent child care services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

• A licensed or registered child care provider to deliver intermittent care
• Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:

The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

Emergency Financial Assistance

Description:

Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Program Guidance:

Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous

provision of an allowable service to a client should not be funded through emergency financial assistance.
See AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, and other corresponding categories

Food Bank/Home Delivered Meals
Description:
Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:
• Personal hygiene products
• Household cleaning supplies
• Water filtration/purification systems in communities where issues of water safety exist
Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.
See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the RWHAP.

Health Education/Risk Reduction
Description:
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:
• Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
• Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
• Health literacy
• Treatment adherence education
Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.
See Early Intervention Services

Housing
Description:
Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services.

Eligible housing can include either housing that:

• Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or

• Does not provide direct core medical or support services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.

Program Guidance:

RWHAP recipients and subrecipients must have mechanisms in place to allow newly identified clients access to housing services. RWHAP recipients and subrecipients must assess every client's housing needs at least annually to determine the need for new or additional services. In addition, RWHAP recipients and subrecipients must develop an individualized housing plan for each client receiving housing services and update it annually. RWHAP recipients and subrecipients must provide HAB with a copy of the individualized written housing plan upon request.

RWHAP Part A, B, C, and D recipients, sub-recipients, and local decision making planning bodies are strongly encouraged to institute duration limits to housing services. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients and subrecipients consider using HUD's definition as their standard.

Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.4

Housing services, as described here, replaces the guidance provided in PCN 11-01.

Legal Services

See Other Professional Services

Linguistic Services

Description:

Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These

services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.
Program Guidance:
Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of non-emergency transportation services that enables an eligible client to access or be retained in core medical and support services.
Program Guidance:
Medical transportation may be provided through:
• Contracts with providers of transportation services
• Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
• Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
• Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
• Voucher or token systems
Unallowable costs include:
• Direct cash payments or cash reimbursements to clients
• Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
• Any other costs associated with a privately-owned vehicle such as lease, loan payments, and insurance, license, or registration fees

Other Professional Services
Description:
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:
• Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
o Assistance with public benefits such as Social Security Disability Insurance (SSDI)
o Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP
o Preparation of:
Healthcare power of attorney
Durable powers of attorney

Living wills
• Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers is deceased or is no longer able to care for them, including:
o Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
o Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
• Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits
Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

Outreach Services
Description:
Outreach Services include the provision of the following three activities:
• Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
• Provision of additional information and education on health care coverage options
• Re-engagement of people who know their status into Outpatient/Ambulatory Health Services
Program Guidance:
Outreach programs must be:
• Conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior
• Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness
• Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort
• Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection
Funds may not be used to pay for HIV counseling or testing under this service category.
See Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services. Outreach services cannot be delivered anonymously as personally identifiable information is needed from clients for program reporting.
See Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services

Description:

Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

• Bereavement counseling
• Caregiver/respite support (RWHAP Part D)
• Child abuse and neglect counseling
• HIV support groups
• Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
• Pastoral care/counseling services

Program Guidance:

Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals).

RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under RWHAP Part D.

See Respite Care Services

Referral for Health Care and Support Services

Description:

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:

Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Rehabilitation Services

Description:

Rehabilitation Services are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care.

Program Guidance:

Examples of allowable services under this category are physical and occupational therapy.

Respite Care

Description:

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

Program Guidance:

Recreational and social activities are allowable program activities as part of a respite care service provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

See Psychosocial Support Services

Substance Abuse Services (residential)

Description:

Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:

• Pretreatment/recovery readiness programs
• Harm reduction
• Behavioral health counseling associated with substance use disorder
• Medication assisted therapy
• Neuro-psychiatric pharmaceuticals
• Relapse prevention
• Detoxification, if offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:

Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the RWHAP.
Substance Abuse Services (residential) are not allowable services under RWHAP Parts C and D.
Acupuncture therapy may be allowable funded under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the RWHAP.
RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

ATTACHMENT C:

INDIANAPOLIS TGA STANDARDS OF CARE FOR MEDICAL AND NON MEDICAL CASE MANAGEMENT

Available at

http://www.ryanwhiteindytga.org/File/Standards_of_Care_-04-28-2017-_Final.pdf

ATTACHMENT D

COMMON ABBREVIATIONS

AACRN	Advanced HIV/AIDS Certified Registered Nurse
ADA	Americans with Disabilities Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
CARE Act	Comprehensive AIDS Resources Emergency Care Act
CDC	Centers for Disease Control and Prevention
CEU	Continuing Education Unit
CLAS	National Standards for Culturally and Linguistically Appropriate Services
CLIA	Clinical Laboratory Improvement Amendments
CPR	Cardiopulmonary Resuscitation
DHHS	Department of Health and Human Services
EFA	Emergency Financial Assistance
EIS	Early Intervention Services
FDA	Food and Drug Administration
FPL	Federal Poverty Level
HAB	HIV/AIDS Bureau
HIP	Healthy Indiana Plan
HIPAA	Health Insurance Portability and Accountability
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources and Services Administration
IDOC	Indiana Department of Corrections
ISDH	Indiana State Department of Health
LPAP	Local AIDS Pharmaceutical Assistance Program
MCPHD	Marion County Public Health Department
MCM	Medical Case Management
NMCM	Non-medical Case Management
OSHA	Occupational Safety and Health Administration
PC	Planning Council
PCP	Primary Care Provider
PHS	Public Health Service
PLWH	People Living with HIV/AIDS
PPC	Public Passenger Chauffeur
PrEP	Pre-Exposure Prophylaxis

QM	Quality Management
RPS	Request for Professional Services
RWSP	Ryan White Services Program
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SOC	Standards of Care
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
TGA	Transitional Grant Area

ATTACHMENT E

RYAN WHITE APPLICATION SCENARIOS

Scenario 1: John Doe presents for his appointment today after being out of care for over three years. John brought his current Indiana ID, insurance cards, his pension statement (his only source of income at this time), a bill dated 20 days prior, and his medical records were transferred to showcase his proof of status. What type of application do you do?

Answer: **RE-ENTRY**

Scenario 2: John Doe presents for his appointment today for his 6-month follow-up appointment. John still has active Ryan White coverage for 15 more days from his previous attestation application. John brought his current Indiana ID, insurance cards, past 30 days of paystubs, and a letter signed by his roommate stating that he is living with him and one of the roommate's bills' from the past 30 days with their current address. What type of application do you do?

Answer: **Recertification.** The roommate letter serves as proof to the care site. The care coordinator must write a letter to the Ryan White Services Program (see p. 13).

Scenario 3: John Doe presents for his appointment today for his 6-month follow-up appointment. John does not have active Ryan White coverage- he has been in a gap for about a month. John brought his current Indiana ID, insurance cards, and his current social security statement which indicates his current address. What type of application do you do?

Answer: **Recertification**

Scenario 4: John Doe presents for his appointment today for his 6-month follow-up appointment. John still has active Ryan White coverage for 4 more days from his previous recertification application. John brought his current Indiana ID and his insurance cards but he did

not bring any proof of residence or income since it has not changed since his last appointment. What type of application do you do?

Answer: **Attestation**

Scenario 5: John Doe presents for his appointment today. John is a newly HIV diagnosed client who wasn't sure what to bring with him today. He brought his current Indiana ID and his insurance cards. John was diagnosed at this care site prior to his appointment so his proof of status is on file. What type of application would you do?

Answer: **NEW 7-DAY**

Scenario 6: John Doe from scenario 5 returns to the clinic 4 months after he first presented and a Ryan White application was initiated. He has brought sufficient proof of residency and proof of income with him so now he has all the documents needed to complete the application process. What type of application would you do?

Answer: **Enrollment application** using the RW ID number given with his first NEW 7-day application. This number can be found on the demographics page in CAREWare.

ATTACHMENT F:

FLOW CHART

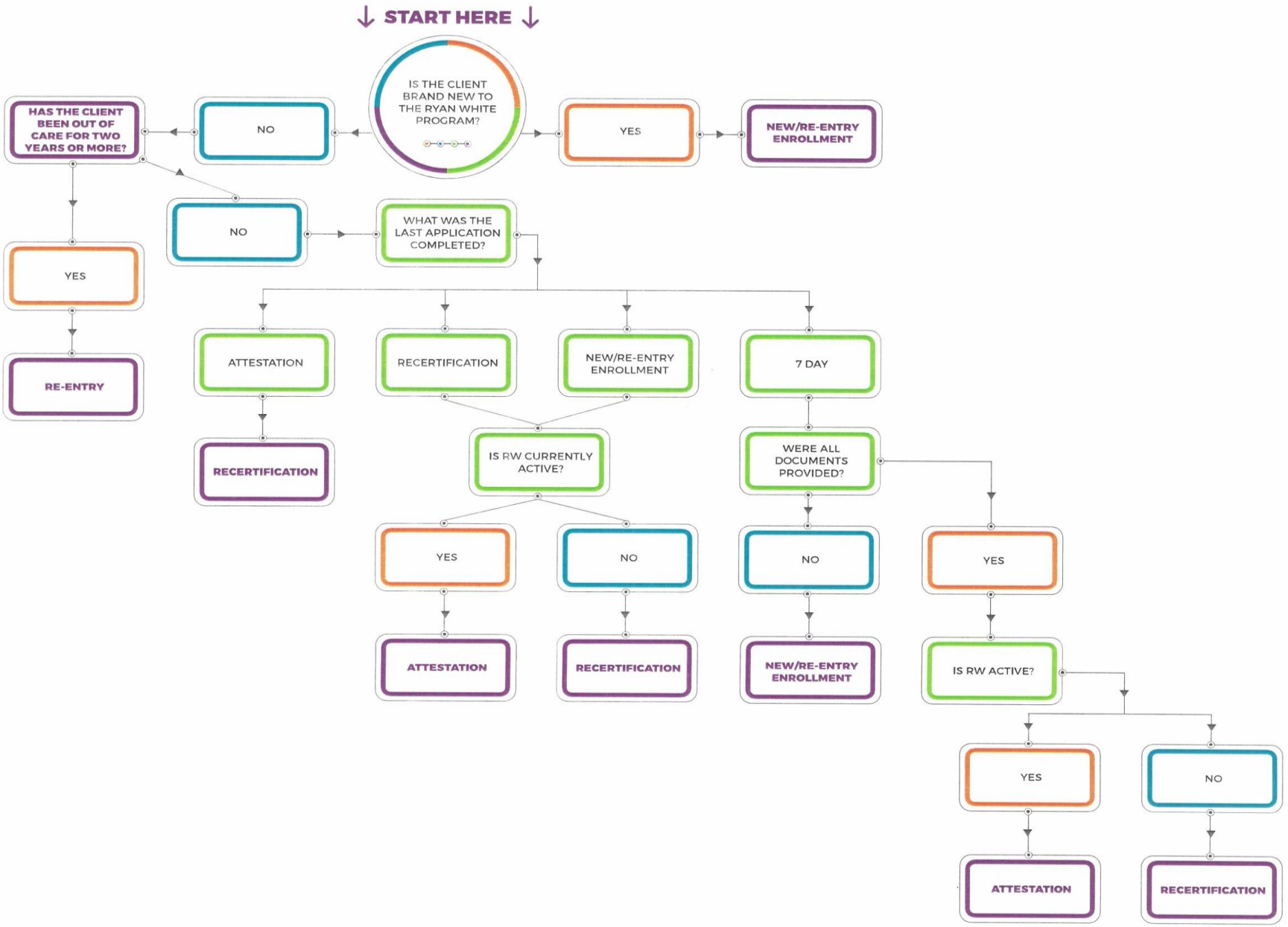
Types of Applications

Enrollment/Re-Entry: to be done for clients new to the RW program or returning clients who have been out of care for 2 or more years, who have all required documents.

> **7 Day:** to be done for brand new clients or clients who have been out of care for 2 or more years, who do **NOT** have all required documents. (This allows for 7 days of RW coverage for the client to get the initial care/labs needed.)

Recertification: to be done 6 months after the client's last Attestation or to be done if the client's RW status is Inactive for less than 2 years.

Attestation: to be done 6 months after a RW New Enrollment/Re-Entry or Recertification, as long as the client's RW is considered still active.


START HERE
IS THE CLIENT BRAND NEW TO THE RYAN WHITE PROGRAM?
YES
NEW/RE-ENTRY ENROLLMENT
NO
HAS THE CLIENT BEEN OUT OF CARE FOR TWO YEARS OR MORE?
YES
RE-ENTRY
NO
WHAT WAS THE LAST APPLICATION COMPLETED?
ATTESTATION
RECERTIFICATION
RECERTIFICATION
NEW/RE-ENTRY ENROLLMENT
IS RW CURRENTLY ACTIVE?
YES
ATTESTATION
NO
RECERTIFICATION
7 DAY
WERE ALL DOCUMENTS PROVIDED?
NO
NEW/RE-ENTRY ENROLLMENT
YES
IS RW ACTIVE?
YES
ATTESTATION
NO
RECERTIFICATION