

Ryan White CARE Act Part B Services Manual

A Joint Publication of



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INTRODUCTION TO RYAN WHITE FUNDING

Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 on August 18, 1990 to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease. In fiscal year 2008, more than \$2.1 billion in Federal funds was appropriated to all 50 States, the District of Columbia, Puerto Rico, and U. S. territories.

This Ryan White federal program was designed to achieve three major purposes:

- Lessen the burden on states and cities most affected by HIV/AIDS by providing substantial federal funding for the care and treatment of people with HIV disease;
- Foster a coordinated approach to the provision of care, treatment, and support services for people with HIV/AIDS;
- Promote a community-based, strategic response to AIDS by local organizations and advocates, as well as local public entities.

The Ryan White HIV/AIDS Program was enacted in 1990 and, in addition to 2006, was reauthorized in 1996 and 2000. In 2006, the CARE Act was renewed through the Ryan White HIV/AIDS Treatment Modernization Act of 2006, in the Public Health Service (PHS) Act under Title XXVI flexibility, to respond effectively to the changing epidemic. The new law changed how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS across this country. The Modernization Act include the following significant changes:

- **New method for determining eligibility for Part funds** gives priority to urban areas with the highest number of people living with AIDS while also helping mid-size cities and areas with emerging needs.
- **New method for distributing Part A funds directs money to metropolitan areas with the highest number of people who are HIV-positive.** It also encourages outreach and testing, which will get people into treatment sooner and save more lives.
- **More money will be spent on direct health care for Ryan White clients.** Under the new law, grantees receiving funds under Parts A, B, and C must spend at least 75 percent of funds on "core medical services."
- **The new law recognizes that HIV/AIDS has had a devastating impact on racial/ethnic minorities in the U.S.** African Americans accounted for 49 percent of all HIV/AIDS cases diagnosed in 2005. The new law codifies the Minority AIDS Initiative for HRSA's Ryan White programs.

The Ryan White Program funds HIV/AIDS health care and support services under several different parts, or sections:

Part A provides emergency relief assistance to "eligible metropolitan areas" (EMAs) that are disproportionately affected by HIV/AIDS. EMA's are cities that have reported at least 2,000 AIDS cases or have experienced a per capita incidence of AIDS cases surpassing 25 per 10,000 population. The FY 1999 appropriation totaled \$485.8 million in formula and supplemental funds and was awarded to 51 EMAs.

Part B assists States and eligible U.S. territories in improving the quality, availability, and organization of HIV/AIDS health care and support services, and provides access to high-cost pharmaceuticals through the AIDS Drug Assistance Program (ADAP). The FY 1999 appropriation totaled \$710 million, which include \$461 million for ADAP funding. These funds are awarded according to a formula based on the number of reported AIDS cases in each state during the previous two years and taking into account the state level of per capita income.

Part C supports outpatient HIV early intervention services for low-income, medically underserved people in existing primary care systems. In FY 1999, Title III was appropriated \$94.3 million.

Part D enhances access to comprehensive HIV/AIDS care and services for children, youth, women and their families with or at risk for HIV, as well as access to clinical research. The FY 1999 appropriation totaled \$46 million. These funds have been used to establish a pediatric AIDS research demonstration program to develop experimental drugs for pediatric AIDS patients. It also funds research, evaluation, and assessment programs.

Part F

The Special Projects of National Significance (SPNS) Program supports the development and evaluation of innovative HIV/AIDS service delivery models that have potential for replication, locally and nationally. As authorized in the CARE Act, \$25 million was allocated to the SPNS Program for the FY 1999 appropriation.

The AIDS Education and Training Centers (AETC) Program supports education and training for health care providers to counsel, diagnose, treat, and manage care for individuals with HIV infection and to help prevent high risk behavior that cause infection. The FY 1999 appropriation totaled \$20 million.

The HIV/AIDS Dental Reimbursement Program assists accredited dental schools and post-doctoral dental education programs with uncompensated costs incurred in providing oral health treatment to patients with HIV disease. The FY 1999 appropriation was \$7.8 million.

The Health Resources and Services Administration (HRSA) is the federal agency responsible for administration and oversight of the Ryan White Program. HRSA administers the grant application process, disburses Ryan White funds, and provides technical assistance to all grantees under the Act.

The procedures in this manual relate to accessing Ryan White Part B funds, administered by the Delaware Division of Public Health, and the Delaware HIV Consortium.

General Eligibility Criteria For Delaware's Ryan White Part B Programs

In order for persons to receive services funded with Ryan White Part B dollars, they must meet the following criteria:

- **Be diagnosed with HIV disease.** The Western Blot or other equivalent confirmatory test must document an HIV diagnosis. An anonymous HIV test result is NOT considered to meet this standard.
- **Be a resident** of the State of Delaware.
- **Be income eligible.** Ryan White dollars are targeted to meet the needs of low-income persons living with HIV/AIDS. Client Income should be calculated upon Intake into case management services, at subsequent recertifications for eligibility (which should take place every six months), or when there is a significant change in the client's income that might change a client's eligibility for specific services.
 - Client Income is reported as a percentage of the Federal Poverty Level (FPL). The FPL Guidelines are reviewed, updated and published annually by the federal government, typically in January or February of each year. The most recent FPL Chart is available upon request from the Delaware HIV Consortium.
 - Different services within the Ryan White Part B Program have different income limits. For example, a client whose income has been calculated to be 247% of the FPL is eligible for assistance in paying for his medications, but not for assistance in paying for his housing costs.
 - Income should be calculated using the Modified Annual Gross Income (MAGI) methodology. MAGI allows some specific types of income to be excluded from the calculation. It also requires that income assessment be based on household income for legally-married couples.
- **Be program eligible.** Many Ryan White programs have a limit (a "cap") to the amount of service available through those programs in a given year. However, some of these caps may be waived (through a special appeal from the HIV/AIDS Case Manager) if the service is in the client's best interest, is included as part of the Care Plan, and is approved by the Ryan White Program Administrator.
- **Be referred** through an approved HIV/AIDS Case Manager or Case Management Contractor.

Timeframe for Eligibility Determination: Within the first thirty calendar days from the client's intake date, HIV/AIDS Medical Case Managers are expected to complete a financial assessment of the client resources and income. If the financial assessment is not completed by the end of that time period, the case managers must consult their Case Manager Supervisor for a determination of next steps to be

taken. In general, client eligibility for services must then be reviewed, evaluated and documented at least once every six months.

- The 30-day grace period does not apply to clients reapplying for the Ryan White Part B Program after being found ineligible. In such cases, financial assessments must be completed in their entirety before the clients can re-enroll in the Ryan White Program.

Scope of Appropriate Referrals for New Clients: Persons may begin accessing Ryan White services immediately upon their enrollment into HIV/AIDS Medical Case Management Services. However, the types of those services are limited until eligibility determination is complete, based on the method by which a client is referred to an HIV/AIDS Medical Case Management program.

- Internal Referral: This type of referral originates within Delaware's established HIV/AIDS Care System (from one of the HIV Wellness Clinics or an approved HIV testing program, for example). During the first thirty days (or until the client's eligibility determination is completed), the only appropriate referrals for services are ones to HIV medical care and to Delaware's AIDS Drug Assistance Program. If the Eligibility Determination is not completed by the end of the thirtieth day, the client's enrollment in the Ryan White Part B Program will be closed. No further services will be provided through the Program until such time as the Eligibility Determination has been completed and the results reported to the Ryan White Part B Central Office.
- External Referral: This type of referral originates outside Delaware's established HIV/AIDS Care System. It may come from medical or social service providers in another state, a Delaware service provider that does not specialize in serving persons living with HIV/AIDS, or from a client self-referral. Proof of the client's HIV/AIDS status is absolutely necessary before any referral can be made on the client's behalf. No referrals for services should be made until proof of HIV status and determination of financial eligibility is completed.

Ryan White Program as "Payer of Last Resort": Whenever possible, clients and their HIV/AIDS Medical Case Managers must have made reasonable efforts to secure other funding or resources prior to accessing Ryan White Part B funds for the service requested. Ryan White funds are always to be considered to be "the payer of last resort" for HIV outpatient services and related conditions.

- Medicaid: If clients have income of less than or equal to 138% of the Federal Poverty Level, they should apply for health coverage through Medicaid.
- Medicaid AIDS Waiver: Clients who have an AIDS diagnosis and meet certain medical standards are eligible for additional services offered by Managed Care Providers through Medicaid. These services may include HIV/AIDS Medical Case Management, private duty nursing, homemaker services, adult medical day care, respite care, mental wellness services and supplemental

payment for foster care for children and adults with AIDS or HIV related diseases.

- Medicaid AIDS Waiver clients are also eligible for all services normally covered by Medicaid.
- Medicaid AIDS Waiver clients can receive Ryan White Part B services that are not available through Medicaid or the Medicaid AIDS Waiver.
- Affordable Care Act (ACA) Coverage: If clients have income greater than 138% of the Federal Poverty Level, they should seek health insurance coverage through the ACA Marketplace. If ACA insurance coverage is denied to the client, it should be documented in the client file maintained by the client's HIV/AIDS Medical Case Manager.

Ryan White Part B funds are intended to support only the HIV/AIDS related needs of eligible individuals. There must be an explicit connection between any service supported with Ryan White Part B funds and the intended recipient's HIV status, or care giving relationship to a person with HIV/AIDS.

Ryan White Part B funds may not be used for bereavement support for infected and affected HIV/AIDS family members since those services cannot be construed to have direct benefit to HIV-infected individuals.

RYAN WHITE ELIGIBILITY – FREQUENTLY ASKED QUESTIONS

1. What determines if a client is financially eligible for Ryan White Services?

Two criteria are considered when making a determination of financial eligibility for Ryan White services: prior qualification or current/projected income.

Prior Qualification: Proof of current qualification for Social Security Income, Social Security Disability, or Medicaid can establish eligibility for Ryan White Services.

Note: The Ryan White Program is the payer of last resort for low-income clients. Clients must apply for and utilize all other funding sources for which they are eligible.

Current Income: The client's monthly gross income must be within the Federal Poverty Limits for each service. These income criteria vary from program to program.

- A client may be eligible for some Ryan White funded services and not others.
- If client's income is over the noted limits, a co-payment may be required.

2. How is monthly income determined?

A client's total gross income received on a regular basis, such as weekly, monthly, quarterly, is added together. Some examples of income are: wages or salary, Social Security Benefits, Welfare Benefits, Veteran's Benefits, Pensions, Other Employment, Annuities, and Interest Income.

To determine the monthly income for a client/family:

Paid every week:	Multiply income by 4.33	= Monthly Income
Paid every other week:	Multiply income by 2.167	= Monthly Income
Paid two times per month:	Multiply income by 2	= Monthly Income
Paid once per month:	Multiply income by 1	= Monthly Income

The client's income, if consistent, may be verified from one or two pay stubs. If income is from hourly work, and may vary over time, the income should be averaged over a longer period of time. This is very important when the client has recently lost employment. If the applicant is unlikely to be able to work again in the next six months, then using a monthly pay of \$0.00 is acceptable. However, if the applicant is employable (is physically well and has desirable job skills), the income should be averaged over three months.

In the case of seasonal workers (such as farm workers), income should be averaged over a six-month period, in order to include at least one time period of full employment and one time period of low employment.

3. What are resources?

Resources are non-income financial assets owned solely or jointly by the client. While resources do not factor into the determination of a client's eligibility for Ryan White Part B services, gathering such information may be helpful in assessing what tools the client has to meet his or her needs, particularly those needs that fall outside the scope of Delaware's Ryan White Part B Program.

Some examples of resources are:

Property

- Houses or land owned solely or jointly by the client are considered as resources. However,
 - If the property is still occupied by the client (i.e., the house is the client's domicile, the property may be excluded from the resources;
 - If the property is income producing, such as rental property, it may be considered as a resource. In addition, the rent received from any tenants would be considered as income.

- If the property is jointly owned, the value of the resource is based on the equity in the property, split evenly among the co-owners.

Vehicles

- One car per client may be excluded from being counted as a resource. All other cars and vehicles (unless directly related to employment), owned solely or jointly by a client, should be counted as resources. The values of those vehicles are based on the Blue Book value (resale value) of the vehicles in question.

Burial Monies

- A client may set aside up to \$5,000.00 for burial, which can be excluded from resources. These funds may be set in a designated bank account, such as a burial trust fund.

Liquid Assets (Other than Burial Monies)

- The current value of any stocks or bonds would be considered a resource.
- The current balance of any checking or savings accounts, money market accounts, investment accounts or certificates of deposit are considered to be resources.

5. How is the Verification of Income and Resources done?

A client must provide to the HIV/AIDS Medical Case Manager verification of all income. These documents should be photocopied and kept in the client's file. If the client experiences difficulties in obtaining the necessary documentation, the HIV/AIDS Medical Case Manager should offer assistance, as appropriate.

Documents to be considered in determining eligibility for Ryan White Part B services include, but are not limited to:

- Social Security card and Social Security payment information
- Copies of income checks
- Payroll / check stubs from the client's employer(s)
- Financial account statements for two (2) months prior to assessment
- Income tax returns
- Health insurance cards
- Proof of health insurance premiums
- Life insurance policies where the client is the insured
- A PAS Determination Letter from Medicaid, showing approval or denial

The HIV/AIDS Medical Case Manager has the right to request other types of resource or income information, if appropriate and necessary.

As the HIV/AIDS Medical Case Manager completes the financial assessment, the appropriate information should be noted on Page One of the "Eligibility Determination Form" provided by Delaware's Ryan White Program. The Case Manager will calculate the income level as a percentage of the Federal Poverty Level, noting it in the appropriate place on Page Two of the form. The form is then signed by both the client and the client's HIV/AIDS Medical Case Manager. The form, along with the supporting documentation, should be filed together in the client's case management file.

Financial determination takes place at least every six months. If the client's income has not changed when the next determination takes place, the client and the HIV/AIDS Medical Case Manager may attest to that fact in the box at the bottom of Page Two. However, if the client's income HAS changed, then a new "Financial Eligibility Form" should be completed.

Each time a client's financial eligibility has been determined, the HIV/AIDS Medical Case Manager should report it to the Ryan White Program's Central Office using the "Ryan White Enrollment, Update and Termination" form.

- The client's income level should also be entered in the client's CAREWare file, on the "Annual Review" tab.
- The "Recertification of Ryan White Eligibility" should be recorded on the "Service" tab by selecting "Recert" in the drop-down menu in the table.
- This information should be reported for all clients who are or may be receiving services funded by Delaware's Ryan White Part B Program.

AIDS DRUG ASSISTANCE PROGRAM

Delaware's AIDS Drug Assistance Program (ADAP) provides financial assistance to pay medication costs for HIV and related conditions. These programs serve HIV infected persons with low and moderate-incomes.

ADAP FOR CLIENTS WITHOUT HEALTH INSURANCE:

This program serves individuals who cannot have their medications paid for through an insurance plan. These individuals must access their HIV medical care and receive their medications through the Christiana Care HIV Wellness Clinics in order to receive their medications. In the event that a Christiana Care HIV Wellness Clinic does not stock a particular medication needed by a client, arrangements can be made to get the medication through an approved community-based pharmacy. The clinic staff will contact the Central Office of Delaware's Ryan White Part B Program; the Program Staff there will generate an ADAP pharmacy card that the client can use at the community-based pharmacy.

Cap: None

Income Criteria: Up to 500% of the Federal Poverty Level (FPL)

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 500% of FPL	No Charge	No Charge

Application Procedure:

- Refer the client to the Christiana Care HIV Wellness Clinic closest to the client's home.

**ADAP: CLIENTS WITH INSURANCE
AND LIMITED OR FULL PHARMACEUTICAL COVERAGE**

If a client has health insurance but the policy does NOT cover all client’s needed HIV medications, or if the HIV medications have large co-payments associated with them, Delaware’s ADAP Program may provide some financial assistance for these medication costs.

The client’s case manager may make a special request to receive assistance through the Ryan White Part B Program if the following criteria are met:

- The client and Case Manager have tried to obtain the medication directly through pharmaceutical companies and are denied.
- There are sufficient Ryan White Part B funds in the budget to cover the costs for the medication.

If more comprehensive pharmaceutical coverage is available for an increased cost through the client’s employer, the client and Case Manager must access this pharmaceutical coverage using the Ryan White Health Insurance Program, available through the Delaware HIV Consortium. (See “Health Insurance Program”, elsewhere in this manual.)

Cap: None

Income Criteria: Up to 500% of the Federal Poverty Level (FPL)

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 300% of FPL	No charge	No charge
301 to 400% of FPL	5% of medication cost	Up to 5% of annual gross income
401 to 500% of FPL	10% of medication charge	Up to 10% of annual gross income

Co-payments may be waived if program funding allows it. Contact the Ryan White Program Administrator with the Delaware Division of Public Health for more information.

Application Procedure:

- For medications not included on the current Formulary, the case manager must get pre-authorization from the Ryan White Program Administrator.
- The Case Manager must verify the client's Ryan White eligibility and financial status, and document that in the case notes.
- The Case Manager must review the program guidelines and the client's responsibilities for the program in detail with the client.
- The Case Manager should verify that the community-based pharmacy selected by the client is one that participates with Delaware's ADAP Program. This verification can be done by contacting the Ryan White Central Office staff.
- The Case Manager mails / faxes the following documents to the Central Office:
 - A completed Ryan White Enrollment, Update and Termination (EUT) Form requesting approval for client to receive medications through ADAP. Be sure to mark the box for the appropriate level of ADAP services requested.
 - An Interagency Referral Form
 - Consent to release medical information to DHSS signed by client
 - A copy of the client's Health Insurance Card(s).
- Central Office Support staff members review the paperwork for completeness:
 - All appropriate information (e.g. application for Medicaid) must be provided and the form duly signed by the Case Manager.
 - If the client is AIDS Defined, the Ryan White EUT Form must also be signed by the organization's Case Management Supervisor.
 - Incomplete forms are returned to case manager.
- If questions arise regarding the form, the Central Office Support Staff may call the parties involved (case manager, case manager supervisor, or insurance company). For difficult cases, the Support Staff may consult with the Ryan White Program Administrator.
- Appropriately completed forms, which belong to eligible clients, are processed.
- ADAP cards are by the Central Office staff at the Delaware Division of Public Health. The cards are mailed to the client at the most recent address on file at the Central Office. A copy of the ADAP card may be requested by the client's Case Manager, if needed.

Recertification Process:

The documents submitted as a part of the application process must be updated and re-submitted

- whenever there is significant change in their client's financial or medical situation, and
- at the end of the six-month enrollment period, as prompted by the Central Office staff members.

Billing:

- The Delaware ADAP program may designate the pharmacy from which clients obtain medication on a regular basis.
- Community-based pharmacies must enroll in the Delaware ADAP Pharmacy network and register with the ADAP Pharmacy Benefits Manager to receive payments through Delaware's ADAP.

Frequently Asked Questions (FAQ's)

Question: My client's HIV medications were changed. Do I need to submit a new Ryan White payment Authorization form?

Answer: No. As long as the new medications are on the Delaware ADAP Formulary nothing needs to be done. The most recent versions of the ADAP Formulary can be found on the Delaware HIV Consortium's website (www.delawarehiv.org) or through the Ryan White Central Office.

Question: My client selected a pharmacy for his ADAP medications. The pharmacist at the pharmacy branch near the client's place of residence was unfamiliar with the ADAP program and was reluctant to participate. The client, subsequently, opted for a different pharmacy. Should DPH be notified of the change?

Answer: Not necessarily. The ADAP card allows a client to use any pharmacy branch within the state that is willing to participate. A client is not tied to a particular pharmacy chain and/or branch.

Question: Who decides what medications are covered by Delaware's ADAP?

Answer: The Formulary is a list of medications that have been approved for payment through the Ryan White ADAP. The Formulary Committee, facilitated by the Delaware Division of Public Health, maintains the Formulary list. The Formulary is updated semi-annually, or more frequently as circumstances warrant.

Question: What do I do for clients who need drugs that are not on the ADAP Formulary (i.e., non-HIV related medications)?

Answer: There are a number of things that you and your client can work on together to meet that need.

- Consider the use of generic medications, which tend to be less expensive than "brand name" drugs. The client, the case manager, the prescribing physician, and/or the pharmacist should make this decision jointly.
- Explore the use of other financial assistance programs to cover the cost of an immediate prescription of the medication. Check with community-based AIDS Services Organizations, churches, other charitable organizations, etc.
- Contact the pharmaceutical company manufacturing the medication and ask about their indigent client program for expensive medications.
- Strategize about future funding for the medications, such as Medicaid or the Medicaid AIDS Waiver.

Question: Is the Delaware Prescription Drug Program (DPAP) and the AIDS Drug Assistance Program (ADAP) the same thing?

Answer: No. The Delaware Prescription Drug Program is offered through the Delaware Division of Health and Social Services. This program is funded through tobacco settlement funds, and provides up to \$2500 per individual in each calendar year for eligible clients. The goal of the program is to provide prescription assistance to elderly and/or disabled individuals currently without

prescription coverage who have incomes below 200% of the poverty level or have prescription costs exceeding 40% of their income. DPAP covers medically necessary prescription drugs. The program does not pay for any of the drugs or diabetic supplies for Medicare recipients. Medicare currently covers these supplies for both insulin and non-insulin dependent patients. Clients must make a co-payment of \$5 or 25% of the cost of the prescription, whichever is greater. The co-pay is collected by the dispensing pharmacy. To be eligible for DPAP, clients must reside in the State of Delaware, be at least 65 years old or qualify for Social Security Disability benefits. The income eligibility limit is set at 200% of the Federal Poverty Level (FPL). If a client meets these eligibility requirements, the client is expected to apply for the service. For more information about DPAP, call 1-800-996-9969, Option 2, then Option 1. If accepted for DPAP, clients may still get assistance through the AIDS Drug Assistance Program with any co-payments for DPAP.

Question: What is the recertification process for ADAP enrollment?

Answer: Re-certification of all ADAP clients is required at least once every six months. This is a requirement for **all** ADAP clients on ongoing ADAP medication. Support staff members send out reminder letters of the re-certification (ticklers) to the client two months to the anniversary of the card. The letter is copied to the appropriate case management agency. Case managers then complete and send to the central office completed Ryan White Enrollment, Update and Termination forms. Central Office Support staff will review the form for completeness and, if appropriate, process a new card that is then mailed to the client. If recertification is not completed by the anniversary date, the client case should be closed and the client is no longer eligible for services paid for through the Ryan White Program.

Question: How should a case manager terminate a client's participation in Delaware's ADAP?

Answer: The Case manager or service provider will contact the Central Office with a reason as to why a particular client's case needs to be closed. The Central Office will verify the information with the client, if necessary. The client will be advised to destroy the card, give it to the case manager, or mail it to The Ryan White Program in Dover, DE. The client's ADAP enrollment will be closed in the Ryan White database at the Central Office, and the card will be deactivated.

MEDICAL CASE MANAGEMENT

HRSA Definition: Case Management services are a range of client-centered services that links clients with health care, psychosocial and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. The definition includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized services plan; (3) coordination of services required to implement the plan and client monitoring to assess the efficacy of the plan; and (4) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.

Medical Case Management provides a vital linkage to all HIV services needed by a client. Traditional case management is defined as a range of client centered services that link clients with health care, psycho-social and other services to insure the timely, coordinated access to medically appropriate levels of health and support services, continuity of care, and on-going assessment of the client's and other family members needs and personal support systems. Medical case management also includes adherence monitoring, with an expected outcome of improving the health status of the clients receiving the service.

It is important to note that a client must be engaged in HIV medical treatment in order to receive (or continue receiving) HIV/AIDS case management services.

Income Criteria: Up to 500% of the Federal Poverty Level (FPL)

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 500% of FPL	No charge	No charge

Regardless of the client's income, there are no client fees for medical case management services through the Ryan White Program in Delaware.

Program Eligibility:

There are several types of medical case management services available to Delawareans living with HIV disease. They include Ryan White Case Management, Medicaid Managed Care Case Management, Pediatric Case Management, and Transitional Case Management. Each type has its own eligibility criteria and features.

To be eligible for Case Management Services funded by Delaware's Ryan White Part B Program, the following criteria must be met:

- The client must complete an Intake and a Needs Assessment with an approved provider of HIV/AIDS Medical Case Management Services.
- The client must be recertified as being eligible for case management services every six months.
- It must be documented that the client is not eligible for or enrolled in an HIV/AIDS Medical Case Management Program offered by Medicaid or one of its Managed Care Providers.

The goals of case management are to:

- access health and mental health care for clients;
- obtain social support services; and
- empower client, family members and significant others.

These goals are achieved by providing education; creating connections between care seekers and care giver; promoting active participation of the patient, family and significant others in developing care plans, and acknowledging and complementing the important support given by family and significant others.

Key activities include: assessment of the client's needs and personal support systems; development of a comprehensive, individual service plan, coordination of other service required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and adaptation of the plan as necessary.

Record keeping is a critical function of HIV/AIDS medical case management. It streamlines the referral process for needed services, facilitates follow-up and the monitoring of those referrals, and demonstrates the successes and barriers in service delivery. Case management programs are required to keep the records of all active clients in a secure but accessible location, as well as the records of clients who were closed during the previous two years. Older records may be archived in a secure location. Records of clients closed for five years or more may be shredded or destroyed in such a manner that confidential information about clients is not compromised.

More detailed information about HIV/AIDS Medical Case Management can be found in the document "HIV/AIDS Medical Case Management Standards".

FOOD PROGRAMS

HRSA Definition: The provision of actual food, meals or nutritional supplements. It does not include finances to purchase food or meal. The provision of essential household supplies such as hygiene items and household cleaning supplies may be included.

Food programs typically provide actual food or meals, such as food banks, food closets, and hot meal programs. These programs help to meet the nutritional needs of people living with HIV/AIDS. Because a variety of programs fall into this category, Case Managers should check with the agency administering the program to determine hours of operation and food availability.

Income Criteria: Less than 200% of the Federal Poverty Level (FPL)

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 200% of FPL	No Charge	No Charge

Note: Food Programs are limited to clients with a household income up to 200% of the Federal Poverty Level.

Caps on Allowed Services: Each provider determines its program's cap.

Application Procedure:

- The Case Manager must verify Ryan White eligibility, and eligibility for this service and financial status and document in the case notes that this has been done;
- The Case Manager should refer and document the request in progress notes. Add to Care Plan if this is an ongoing need;
- The Case Manager should refer the client to a food program either by phone or written referral depending on the agency's policy.

HEALTH INSURANCE PROGRAM

HRSA Definition: The provision of financial assistance for eligible individuals living with HIV/AIDS to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This service includes premium payments, risk pools, co-payments and deductibles.

Delaware's program provides financial assistance to ensure continued health insurance coverage for HIV infected individuals who are in danger of losing their insurance coverage due to their inability to pay.

The program has been designed to provide as much DIRECT ACCESS to service by the client as possible. Case Managers are asked to complete the Enrollment Application with the client. The client and the Fund Administrator at the Delaware HIV Consortium will coordinate subsequent payment requests during the enrollment period.

The program reserves the right to deny service if it is determined that (1) the client would receive better, more comprehensive coverage through another source of assistance for which the client is eligible, (2) the insurance policy is not cost-effective, (3) the prescription coverage of the plan does not, at a minimum, provide coverage equivalent to the Ryan White Part B ADAP Formulary, or (4) there are inadequate funds available for the program for the remainder of the contract year.

Cap: \$750 per month

Income Criteria: Up to 500% of the Federal Poverty Level (FPL)

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 300% of FPL	No Charge	No Charge
301 to 400% of FPL	5% of service cost	Up to 5% of annual gross income
401% to 500% of FPL	10% of service cost	Up to 10% of annual gross income

Note: There are programs that cover the co-payments for doctor visits, some laboratory costs, medical supplies, etc. for certain eligible clients. See the sections on "Home and Community Based Services" and "State Direct Services" elsewhere in this manual.

Application Procedure:

- The Case Manager must determine the need for this service and the financial eligibility (and co-payment, if applicable) of the client.
- If this service is appropriate, the Case Manager will complete the "Health Insurance Program Enrollment" Form. The Code Numbers for "Transmission" and "Housing" are as follows:

MODE OF TRANSMISSION	CODE
Men who have sex with men (MSM)	1
Injecting drug use (IDU)	2
Men who have sex with men and inject drugs (MSM/IDU)	3
Heterosexual contact	4
Risk not reported/Other	5
Receipt of blood (transfusion), components, or tissue	6
Perinatal Transmission	7
Heterosexual contact with an injection drug user	8

HOUSING TYPE	CODE
Non-permanently housed (homeless [shelters, vehicles, the streets, or other places not intended as a regular accommodation for living] and Transient or transitional housing [stable but temporary living arrangements, regardless of whether or not it is part of a formal program]).	1
Permanently housed (includes apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited).	2
Institutionalized (residential [supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illnesses], health care [hospitals, nursing homes and hospices], and correctional facilities [jails, prisons, and correctional halfway houses]).	3
Other (none of the above)	4
Unknown (unreported)	5

- The following materials should accompany the initial Enrollment Form:
 - a copy of the client's insurance card
 - a copy of the Drug Formulary for the client's insurance plan
 - a copy of the most recent invoice for a premium payment (clearly indicating the monthly or quarterly cost for insurance premiums, the policy or group number for the insurance plan, and the period of coverage)
 - the client's co-payment (a check or money order, typically made out to the insurance company), if applicable
- Enrollment in the program is valid for a maximum of twelve months. A shorter enrollment period may be requested if the situation merits it (i.e., it is expected that the client will be approved for Medicaid or will be covered under an insurance plan at a new job, etc.)

- The Case Manager must submit all of this information to the Fund Administrator at the Delaware HIV Consortium, documenting the referral for this service in the client file as required.

Payments:

- Payments must be made directly to the insurance company or, in some cases to the client's current or previous employer. Payment cannot be made to the client.
- Generally, payments will be made on a monthly or quarterly basis. Premium payments for more than three (3) months in advance must be approved in advance.
- This program may also provide assistance with the premiums for dental and eye coverage, if it is a part of the total health insurance plan and is cost-effective. However, premiums for life insurance will NOT be considered for payment.
- If the health insurance coverage is a FAMILY plan, this program will consider only the cost of SINGLE coverage in the calculation of insurance cost and client co-payments. The client will be responsible for all of the additional costs of the FAMILY plan coverage.
- Great care is taken to protect the confidentiality of clients served in this program. The Delaware HIV Consortium is not named on the checks used to make the premium payments or in the accompanying letter. The check simply reads "Emergency Assistance Fund", followed by the Consortium's mailing address. In the same way, the contact telephone number noted in the letter does not ring directly to the Consortium switchboard, but rather to a separate telephone line.
- For subsequent payments during the enrollment period, it is not necessary for the Case Manager to complete any additional paperwork. Instead it is the client's responsibility to send the invoice and co-payment to the Fund Administrator at the Delaware HIV Consortium within the time limit set by the insurance company. The Delaware HIV Consortium will not be held responsible if the insurance company receives a premium payment past the due date and the client's health insurance plan is terminated.

Re-Enrollment:

- For the service to be provided past the end of the enrollment period, an updated Enrollment Application and accompanying documentation must be re-submitted to the Delaware HIV Consortium (see above).

Ryan White and the Affordable Care Act: Health Insurance for Clients

The introduction of the Affordable Care Act (ACA) provides new opportunities for uninsured persons living with HIV/AIDS in Delaware to secure health insurance coverage. Delaware's ACA Marketplace is found online at www.ChooseHealthDE.com. On this website, clients can compare various health insurance plans being offered, apply for a federal subsidy towards their health insurance premiums, and actually enroll in a health insurance plan online.

Beyond the federal subsidy for premiums, Delaware's Ryan White Program is offering additional financial help. The Delaware HIV Consortium operates a Health Insurance Program that will provide additional assistance with health insurance premiums. Through its AIDS Drug Assistance Program (ADAP), the Delaware Division of Public Health (DPH) can provide financial assistance for some medical costs that would be counted towards the client's deductible and/or out-of-pocket expenses. For clients to be able to participate in these two programs, both the selected plan and the client must meet the following eligibility requirements.

Plans Eligibility:

- Plans eligible for payment include any of the "**Silver**" or "**Gold**" Plans offered by Highmark / Blue Cross Blue Shield available through the Marketplace. These plans are:
 - Shared Cost Blue EPO 3000 (Silver)
 - Health Savings Blue EPO 3000 (Silver)
 - Health Savings Blue EPO 1800 (Gold)
 - Shared Cost Blue PPO 1500 (Gold)
 - Shared Cost Blue EPO 1350 (Gold)
 - Shared Cost Blue EPO 1000 (Gold)
 - Shared Cost Blue EPO 750 (Gold)
 - Shared Cost Blue EPO 0 (Gold)
- Generally, the only plans eligible for payment will be "**individual**" plans, not "family plans". Furthermore, the individual covered must be the person living with the HIV/AIDS diagnosis.
 - The only exception to that rule is for legally married couples (same sex or opposite sex) in which both spouses are persons living with HIV disease and eligible for Ryan White ADAP services.
- If the client is eligible for a federal subsidy towards the cost of the health insurance premiums, the subsidy must be applied **IN FULL** to the monthly premium cost.

Client Eligibility:

- The client must be a resident of Delaware and living with an HIV/AIDS diagnosis.
- The client must have an income greater than 138% of the Federal Poverty Level (FPL) and less than or equal to 500% of FPL.
 - If the client's income is less than or equal to 138% of FPL, the client is eligible for coverage through the Medicaid expansion.
 - If the client's income is more than 500% of FPL, the client is not eligible for financial assistance for the payment of premiums or medical costs through this program.
- The client cannot be eligible for health insurance coverage through the client's employer. If insurance is offered through the employer and the client refuses to accept the coverage, the client is not eligible for assistance through this program.
- The client cannot be receiving his or her medications through a 340B Drug Program such as PharmBlue.

Financial Assistance with Health Insurance Premiums:

The payment of premiums will be handled by the **Delaware HIV Consortium** in Wilmington, DE through its existing "Health Insurance Program (HIP)".

Initial Enrollment: After the client has applied for and (if appropriate) been awarded a federal subsidy towards his or her insurance premiums, the client must then be enrolled in the Consortium's Health Insurance Program.

- The client, working with an HIV/AIDS Medical Case Manager or Social Worker, must complete and submit a HIP Enrollment Form to the Consortium.
 - A copy of the Subsidy Award Letter should accompany the HIP Enrollment Form whenever possible.
 - The Invoice should accompany the HIP Enrollment Form.
 - Make sure that both Page One and Page Two of the invoice is included.
 - The invoice can be the one that was mailed to the client, or it can be the one generated through the ACA Marketplace website.
 - It is not necessary to include a copy of the health insurance plan's drug formulary with the HIP Enrollment Form for these plans from Highmark / Blue Cross Blue Shield.
 - If the client's income level is between 301% and 500% of FPL, the client will be expected to pay a portion of the premium, as detailed on page 7.1 in Delaware's Ryan White Services Manual.
 - If the income level is between 301 and 400% of FPL, the client is expected to pay 5% of the premium amount (after any federal subsidy has been subtracted.)
 - If the income level is between 401 and 500% of FPL, the client is expected to pay 10% of the premium amount (after any federal subsidy has been subtracted.)
 - Client payments towards the premium must be made using personal check or money order, made payable to the insurance company. The check or money order should accompany the invoice when it is sent to the Consortium for processing.

- The Consortium will generate a payment for the premium and send it directly to the insurance company. Often, the Consortium will pay for more than one month of coverage for a client with a single payment.
 - For clients who are expected to pay towards the cost of premiums, payments will be monthly (unless other arrangements are made with HIP staff members.)

Subsequent Invoices: Clients should be encouraged to submit invoices for health insurance premiums to the Delaware HIV Consortium as soon as they are received.

- Clients may turn in their invoices to their HIV/AIDS Medical Case Managers or Social Workers, who in turn will forward them to the Consortium.
- Clients may also submit their invoices directly to the Consortium themselves.
- Whenever possible, the original invoice should be sent to the Consortium for processing.
- Invoices may be submitted:
 - By mailing the invoice to the Consortium office at this address:

Delaware HIV Consortium HIP
100 West 10th Street, Suite 415
Wilmington, DE 19801

- Or by faxing the invoice to (302) 654-5472, Attention: HIP

Clients should remember the following:

- The Consortium is not responsible for late submissions of invoices that do not allow three business days for processing and payment, especially if there is a loss of health insurance coverage as a result.
- Clients should never ignore an invoice for premiums that has a "Balance Due" on it. Clients should be encouraged to verify payment of premiums through their HIV/AIDS medical case manager or social worker.
 - Premiums payments are listed in the table on the "Service" tab in CAREWare.
 - Recent payments can be verified by calling the HIP staff members at the Delaware HIV Consortium.
- If for any reason the client receives a refund from Highmark / Blue Cross Blue Shield due to an overpayment of premiums at the end of the year, the client is expected to turn the check over to the Delaware HIV Consortium immediately. Failure to do so will jeopardize the client's continued participation in the program.

Financial Assistance with Deductibles and Out-of-Pocket Expenses:

The payment of medical costs that would be counted towards the client's deductible and/or out-of-pocket expenses will be handled by the **Central Office Staff (Ryan White Program) at the Delaware Division of Public Health (DPH)** in Dover,

DE. The only medical costs that will be paid through this program are medication costs and HIV lab costs.

- Medication Costs
 - In Kent or Sussex County, clients must receive their medications through a retail pharmacy (such as Walgreens, CVS, Rite Aid, or any other pharmacy working with ADAP.)
 - In New Castle County, clients may receive their medications through the Christiana Care HIV Wellness Clinic (if they are a patient there) or a retail pharmacy (such as Walgreens, CVS, Rite Aid, or any other pharmacy working with ADAP.)
- Lab Costs
 - The lab work must be HIV-related to be considered for payment.
 - The Service Provider must be willing to accept third-party payments.

The handling of medical bills for client deductibles and out-of-pocket expenses will be as follows:

- The charges will be submitted by the Provider to the Insurance Carrier.
- The Insurance Carrier will review the claim.
 - The claim will be paid by the Insurance Carrier, if appropriate.
 - The claim will be returned to the Service Provider if the client has not met the deductible and/or maximum out-of-pocket expense amounts.
 - Unpaid charges will then be billed by the Service Provider to the client. It is likely that retail pharmacies that work with Delaware ADAP will submit the bills directly to ADAP.
 - The client will submit any bills for medication costs and allowable lab costs to the DPH Central Office for review and payment, if appropriate.

NOTE: All other medical costs (including co-payments for office visits, other lab work, etc.) are the responsibility of the client. If the client anticipates having significant co-payments that would not be covered above, the client may wish to select one of the "Silver Plans", which have some cost-sharing features not found in other plans.

Frequently Asked Questions (FAQ's) about the Health Insurance Program

Question: If a client sees a private infectious disease specialist and is eligible for Medicaid, but does not want to go to the Wellness Clinic to receive HIV medical care, will the Health Insurance Program pay for the client's private health insurance?

Answer: No. If a client is eligible for Medicaid, the Health Insurance Program cannot pay for any private health insurance.

Question: Is there a cap on the dollar amount spent for private health insurance plans?

Answer: Yes. If a client's monthly premium exceeds \$750, the Health Insurance Program cannot pay for this health insurance plan. According to the Health Resources and Services Administration (HRSA) the total annual amount spent on insurance premiums cannot be greater than the annual cost of maintaining the client on any other ADAP program (i.e. medical care through the Wellness Clinics and pharmaceutical coverage through ADAP).

Question: What types of health insurance plans can the Health Insurance Program pay for?

Answer: There are five different plans for which the program can pay.

1. COBRA plans: The Health Insurance Program can pay the premiums for a COBRA plan for 18 months after termination of employment. All paperwork and client's co-payments must be received 25 days prior to the deadline for enrollment in the COBRA plan.
2. Employer Health Insurance Plans: If a client responsible for all or part of their monthly premium for their health insurance plan through their employer, the Health Insurance Program can pay their premium. Typically, the program will work directly with the employer to pay the premiums instead of the insurance company. The Health Insurance Program can continue to pay for this plan indefinitely or as long as the client is employed.
3. Private Health Insurance Plans: If a client is not eligible for Medicaid and does not have health insurance coverage through any other means, the Health Insurance Program can pay their premiums. Normally these plans are very expensive and have a time constraint on paying for treatment of pre-existing conditions. If monthly premiums exceed \$750 a month and/or the wait for pre-existing conditions exceeds six months, the Health Insurance Program will not accept this client. If all requirements are met then the Health Insurance Program can continue to pay for the plan indefinitely or until the client is eligible for Medicaid.

4. Temporary Payments. If a client has applied for Medicaid and is waiting to receive their approval or denial, the Health Insurance Program can pay the premiums for a limited amount of time. As soon as the client receives an approval or denial letter from Medicaid it must be forwarded to the Fund Administrator.
5. Medicare Part D Insurance Plans.

Question: What money does the Health Insurance Program use to pay for health insurance premiums?

Answer: Currently, primary funding source is the AIDS Drug Assistance Program (ADAP). In order for ADAP to pay the monthly premiums, the health insurance plan must have a formulary (medications covered by the plan) that is equal to or exceeds Delaware's ADAP Formulary in terms of coverage for HIV anti-retroviral medications. If the plan covers some HIV anti-retrovirals but has not added newly approved medications to their formulary, the insurance plan must have a mechanism by which a client can request a waiver to provide coverage for any 'new' drugs.

Question: What benefits can the Health Insurance Program pay for?

Answer: The Health Insurance Program can pay for health insurance, dental insurance and eye insurance. The Program cannot pay for short-term or long-term disability or life insurance. If the client's plan includes these benefits, the client is responsible for that portion of the premium.

Question: Can the Health Insurance Program help clients find private health insurance plans?

Answer: The Health Insurance Program does not have the ability to help clients find private health insurance plans. The client must work on their own or with the assistance of their case manager to find a plan that is suitable to the requirements of the Program.

Question: Can the Health Insurance Program pay the client's co-payments or deductibles?

Answer: The Health Insurance Program cannot pay a client's co-payment or deductible. However, there may be programs through "Home and Community Based Services" or "State Direct Services" that can pay for these services.

Question: My client's health insurance premiums are paid by ADAP funds, which have been contracted out to the Delaware HIV Consortium for the Health Insurance program. The client's insurance plan has an annual deductible of \$1000 and a medication co-pay of 10% once the deductible has been met. Will the Ryan White program assist with both the deductible and the co-pay?

Answer: Clients will receive assistance depending on their FPL (see eligibility levels in the Ryan White Services Manual) and the type of service provided. Clients that qualify for assistance financially shall receive help with a

deductible cost when the service provided is traditionally reimbursable by the Ryan White Title II program. An example is a deductible towards the cost of a chest X-ray. This expense can be paid with state direct funds. A deductible in the form of fees for an outpatient endoscopy will not be paid with Ryan White funds. A deductible towards the cost of a prescription, which is listed on the ADAP formulary, will be paid using ADAP funds, while that of a medication not on the formulary, such as Viagra, won't be paid. Co-pays will be handled the same way.

HOME AND COMMUNITY BASED SERVICES

HRSA Definition: The provision of skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospital services, nursing home and other long-term care facilities and NOT included.

Delaware's program pays for such services as home health nursing, aide care, homemaker care, ambulatory services (such as outpatient medical services), durable medical equipment, and other homebound support service needed by HIV infected persons in order to function well in their home.

NOTE: Medicaid Waiver clients are not eligible for this service paid for with Ryan White funds, unless Medicaid does not cover the specific service requested.

Income Criteria: Up to 400% of Federal Poverty Level (FPL)

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 300% of FPL	No Charge	No Charge
301 to 400% of FPL	No Charge	No Charge

Cap: \$750.00 per client per contract year

Application Procedure:

- The Case Manager must verify Ryan White eligibility after receiving client referral, and document in the case notes that this has been done.
- The Case Manager must verify that the client has not exceeded cap of \$750.00 for the year.

- The Case Manager should submit a Pre-Authorization Request to the Ryan White Central Office using the Inter-Agency Referral Form. Any relevant estimates or specifications of the supplies needed should accompany the Inter-Agency Form.
- If the Pre-Authorization is approved and all the above is met, the Case Manager may order the service.

Often Medicaid clients are eligible for a service through Medicaid but are required to have a referral from their primary care provider to access this service through Medicaid. Ryan White Part B funds cannot pay for a service usually covered by Medicaid or its Managed Care Programs.

The Ryan White Program will pay for what is medically necessary. If clients would like to have additional services (not medically necessary) or upgraded products, then they are responsible for the difference in cost between what is necessary and what is desired.

Ordering Service:

A wide variety of services and supplies are covered in this Service Category. Most of the ordering and billing for these items must be addressed on a case-by-case basis with the Case Manager, the Service or Supply Provider, and the Ryan White Central Office.

- If it is a medical supply that is being ordered, and if that medical supply is available through a currently-approved vendor (such as a pharmacy), the request can be handled through the ADAP Pharmacy Benefits Manager.

Billing:

- The Support Staff at the Central Office receive invoices/bills from Service Providers or the Case Manager. Client's eligibility is verified to be current. All bills must be the original bill; copies and faxed invoices will not be accepted.
- All invoices/bills require the following information: client's name, date of birth, address, and date of service. The service provider name, mailing address and E.I. number are also necessary. Invoices/bills with incomplete information are returned to the person that submitted the respective bill. Statements with only balance due (i.e., with no service description, no dates of service and no breakdown of charges) will be returned.
- All questions related to the invoice/bill will be referred to the Service Provider. The Ryan White Administrator or Director will resolve complicated cases.

- Changes made to the bill have to be signed and dated.
- As a means of monitoring receipt of services, statement of paid bills will be sent to the clients and copied to the Case Managers in October and May. Clients and/or case managers will have one month to report any discrepancies.

HOUSING ASSISTANCE

Housing Assistance as funded by Delaware's Ryan White Part B Program is provided in a number of different ways. Sometimes it takes the form of episodic payments towards a client's rent or utility bills (traditionally thought of as "Emergency Financial Assistance" or EFA). At other times, it provides financial support for rental vouchers, when used in conjunction with Housing Opportunities for Persons with AIDS (HOPWA) dollars. However it is provided, this service seeks to stabilize the housing situation for clients so that they will be better able to participate in the management of their HIV disease.

EPISODIC ASSISTANCE

HRSA Definition of Emergency Financial Assistance: The provision of short-term payments to agencies or the establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers and food stamps) and medication when other resources are not available.

Delaware's Ryan White Program focuses its EFA and housing dollars on housing costs, specifically rent and utility expenses. Priority is given to rent and utility payments, but in special situations the funds may be used to pay for emergency shelter for clients in crisis. These funds are only available for emergency situations and not for regular on-going hardship. The purpose of these dollars is to prevent clients from becoming homeless. They were never meant to completely eliminate chronic or longstanding debts. Typically clients facing eviction have been delinquent in their rent payments for several months, and the action plan to resolve the debt involves a number of community resources. The Ryan White dollars can only be used to pay the last month of rent that is due, within the parameters of the program.

In Delaware's Program, payments for utilities are reported to the federal government as "Emergency Financial Assistance", while episodic payments for rent are reported as "Housing Services".

Emergency Financial Assistance funds may be accessed for a client when it has been determined that no other source of funds is available to provide needed assistance.

Income Criteria: Up to 200% of the Federal Poverty Level (FPL)

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 200% of FPL	No charge	No charge

Caps on Allowed Services:

Emergency Financial Assistance Programs can provide no more than \$500.00 of financial assistance to an individual client during a single request for assistance. A single request is defined as the consideration of one or more bills for rent, utilities or emergency shelters, which are submitted to the EFA Provider for processing on the same, processed simultaneously, and for which payment to appropriate vendors occur on the same date.

Furthermore, no client can receive financial assistance more frequently than once in any ninety-day period (that is, a request will not be funded with Ryan White Part B dollars if the client received Ryan White EFA in the ninety days prior to the date of the new request being considered).

In addition, the EFA Provider will ensure that no client will receive more than \$1,000.00 of financial assistance during the course of the Delaware's Ryan White fiscal year (April 1st of one year through March 31st of the following year).

PLEASE NOTE THAT THESE CAPS MAY BE MODIFIED IN ANY GIVEN GRANT YEAR, IF PROGRAM FUNDING ALLOWS. Please contact your local Service Provider for information about the caps currently in effect.

HIV/AIDS Medical Case Managers and the EFA Provider are expected to provide adequate documentation that a reasonable number of funding sources were investigated before the client accesses Ryan White Financial Assistance funds. Case managers can help in that work by following these guidelines:

- Identify --- and use --- other community resources for financial assistance. Remember, the Ryan White Program is considered to be "the payer of last resort". The EFA Request Forms ask case managers to list two other resources that were investigated as possible payers of the debt. Case managers should make those two choices count! Case Managers should NOT contact resources that they know would not even consider the type of bill to be paid, resources that are always "out of fund", and so on. Furthermore, if those resources can provide assistance but cannot pay the entire debt, that assistance should be utilized on the client's behalf.
- Case Managers should encourage their clients to make partial payments on their own debts, whenever possible and in whatever amount possible. An empowering model of case management should promote the active participation of clients in meeting their own needs (i.e., "a hand-up, not a hand-out".) Even a small payment by a client, when multiplied by the number of clients using EFA programs, will lessen the demand on the Ryan White Part B dollars.

- Remember that the caps for EFA assistance do not constitute a guarantee of funding. The caps control the maximums allowed; they do not set a minimum. The Ryan White Part B Program does not prohibit an EFA Provider from paying less than that amount, even if the request is reasonable and appropriate. The EFA Providers are trying to use limited resources as wisely as possible.

Application Procedure:

- The Case Manager must verify Ryan White eligibility, and eligibility for this service, financial status, and document in the case notes that this has been done;
- Determine that client regularly has sufficient income to sustain the needed service on a month to month basis;
- Verify that client has not exceeded the service cap for the year;
- Obtain copy of invoice (bill) or statement. The Case Manager may verify cost of service with vendor by phone but must document this information in the case notes and on the request form;
- If the request is for rent assistance, a copy of the client's current lease must accompany the application form.
- Case Manager submits an emergency financial assistance application to the agency that is responsible for Ryan White emergency financial assistance in the county where the client lives.
- Emergency Assistance payments are made to a company or landlord. Payments may not be made directly to the client and members of the client's family.

Other Restrictions for Use of Emergency Assistance Funds:

- Payments from Emergency Assistance funds are to be made directly to the service provider. No payments will be made directly to the client or a member of the client's immediate family. "Immediate family" is defined as a parent, parent-in-law, spouse, sibling, child, or child-in-law of the client for whom the financial assistance request is being considered.
- Ryan White funds may not be used for funeral, burial, cremation, or related expenses;

- Ryan White funds may not be used for payment of mortgages on privately owned residential property and/or privately owned or occupied residential property;
- Ryan White funds may not be used for direct maintenance expenses (such as, fuel, oil, tires, repairs) of a privately owned vehicle or any other costs associated with a vehicle, such as a lease or loan payments, insurance, or license and registration fees. Mileage reimbursement programs to pay actual mileage that enables individuals to travel to needed medical or other support services may be supported with Ryan White Part A or Part B funds (see Transportation);
- Ryan White funds may not be used to pay local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied);
- Ryan White funds may not be used to pay for pet food or pet products.
- Ryan White dollars for Financial Assistance cannot be used to make rent payments that are in arrears, nor can it be used to pay for late charges or other fees. For the purposes of this program, rent payments that were due within the thirty (30) days prior to the EFA request is not considered to be "in arrears" and may be considered for payment.
- Clients receiving rent assistance through the Delaware HIV Consortium's Housing Programs cannot receive additional assistance for rent or utilities using Ryan White Part B funds through its Emergency Financial Assistance programs. However, the EFA Providers may provide emergency financial assistance to those clients using dollars from other funding streams, if they choose to do so.

RENTAL VOUCHERS

Since 1998, the Delaware HIV Consortium has administered a statewide federally funded tenant based rental assistance program for low-income individuals living with HIV/AIDS and their families, serving approximately 150 households per year. Clients are referred to the program by medical case management agencies throughout the state that specialize in services for persons living with HIV/AIDS. The program provides rent subsidies that are based on total household income and housing costs, using HUD Fair Market Rents as a guideline. All assisted households must have incomes that fall within HUD low-to-moderate income limits. Assisted households spend 30 percent of their income on housing costs, including rent and utilities, while the rental assistance program pays the difference to private landlords throughout the state on a monthly basis. Housing units must meet federal Housing Quality Standards and pass pre-rental and annual inspections.

This program is mainly funded by federal grants from HOPWA (Housing Opportunities for Persons With AIDS), that are awarded to the Delaware HIV Consortium from the City of Wilmington and the Delaware State Housing Authority, and Ryan White Part B funds that are awarded from the State of Delaware Division of Public Health. The goal of the Consortium's tenant based rental assistance program is to provide a stable housing environment with access to medical care and support services for low-income persons living with HIV/AIDS in order to promote overall stability and wellness.

More detailed information about this program can be obtained by contacting the Delaware HIV Consortium at (302) 654-5471.

MENTAL WELLNESS COUNSELING

HRSA Definition of Mental Health Services: Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Delaware's program for mental wellness counseling includes psychological and psychiatric treatment and counseling for individuals, provided by a licensed mental health professional authorized in the state of Delaware, including psychiatrists, psychologists, social workers and counselors. Pastoral counseling services are not included in this program.

Any Ryan White eligible client may receive services from a licensed and accredited mental wellness provider. This provider can either be a private practitioner or an agency providing Mental Wellness Counseling services, as long as the Consortium has enrolled them as an approved provider in the program. Since the Ryan White Program is considered to be "the payer of last resort", the costs for mental health services should be submitted to and reimbursed by a client's insurance company, if appropriate, before the Ryan White Program will cover any costs for service that were not reimbursed. Clients with private medical insurance, which covers mental wellness counseling, are ineligible for Ryan White service co-payments.

The Wilmington HIV Wellness Clinic has psychiatric / psychological services available to supplement their medication delivery service. The Georgetown and Kent Clinics provide mental health professionals to assess and assist clients. The Wellness Clinics also provide evaluations for psychiatric medications. If a client is on psychiatric medications and needs appointments with a psychiatrist who can assess the use of the medications, then the client should see a doctor at the HIV Wellness Clinics. Ryan White Part B dollars through this program will not be spent on psychiatric medication evaluations.

Income Criteria: Up to 400% of the federal poverty level (FPL).

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 300% of FPL	No Charge	No Charge
301 to 400% of FPL	5% of service cost	Up to 5% of annual gross income

Caps on Allowed Services: 26 sessions per contract year

Maximum amount per each individual Service Unit: Up to \$75.00

Application Procedure:

- Case Manager must verify Ryan White eligibility, and document it in the client's care plan;
- The Case Manager must verify that the client has not exceeded 26 sessions per contract year;
- The Case Manager will determine the client co-pay, if applicable;
- The Case Manager and the client will choose a licensed, accredited service provider from the provider list distributed by the Consortium. If the client wishes to see a service provider not currently enrolled with the Consortium, the Case Manager and/or client must advise the provider to send copies of their professional license and accreditation to the Consortium for approval.
- If all the above are met, order service.

Note: Medicaid Managed Care clients are not eligible for private therapy paid for with Ryan White CARE Part B funds. Instead, this service is available through their Medicaid Managed Care Provider.

Ordering Service:

Case Managers may order this service after completing the above process. In addition, Case Managers should do the following:

- For approval, submit Fee For Service Pre-Authorization Form to the Delaware HIV Consortium. Be sure to complete all demographic information.
- If the service is approved, a written notification will be sent to the case manager. The notification will include an Authorization Code for that block of services. The Authorization Code is comprised of the Authorization Date (first 6 digits) and the Authorization Number (last 2 digits).
 - After receiving the approval notification, complete the Fee For Service Authorization Form. This form is available in duplicate. Be sure to note the Authorization Code in the appropriate space.
 - Retain the original copy for the client's file.
 - Mail the second copy to the service provider within 5 days of the Authorization Date. The client is responsible for initiating contact with the provider.

- Advise the service provider of the maximum amount paid by the Consortium for services rendered.

Billing:

Once a certified and licensed vendor or contractor has provided service, the vendor will submit a bill directly to the Delaware HIV Consortium. The invoice must contain:

- the name and address of the provider of service,
- the client ID
- the date(s) that the service was provided and type of service provided,
- the Authorization Code (found on the completed Authorization Form), and
- the cost of the service, showing any client co-pay (if applicable).

The Delaware HIV Consortium will review the bill, verify service (if necessary) and send payment for services.

Note: If the payment required by the provider exceeds the maximum amount allowed by the Consortium, the client or the Service Provider will be responsible for the difference.

Closing a Referral:

If the client no longer wants or needs the service, and if there remains unused sessions in the block of pre-approved sessions, the Case Manager must initiate contact with the HIV Supportive Services Coordinator at the Consortium and the Service Provider. Contact can be made by telephone or email. When the Case Manager contacts the above parties to close a referral, the following information must be given:

- date of closing,
- reason for closing, and
- last date that service was received by the client (if known).

NUTRITIONAL COUNSELING

HRSA Definition of Medical Nutrition Therapy: The provision of nutrition education and/or counseling by a licensed registered dietitian outside of a primary care visit.

In Delaware's program, Registered Dietitians offer nutritional counseling in-home or in the field. This service is available for clients with a documented nutritional need. In order to access these services, written acknowledgement by the client's primary health care provider (physician, nurse practitioner, physician's assistant) in the form of a prescription for counseling is required.

Income Criteria: Up to 400% of the Federal Poverty Level (FPL)

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 300% of FPL	No Charge	No Charge
301 to 400% of FPL	5% of service cost	Up to 5% of annual gross income

Cap: \$300.00 or 4 counseling sessions per contract year, whichever is less

Application Procedure:

In order to access these services, written acknowledgement by the client's primary health care provider (physician, nurse practitioner, physician's assistant) in the form of a prescription for nutritional counseling is required.

- Case Manager must verify Ryan White eligibility, and document it in the client's care plan;
- The Case Manager must verify that the client has not exceeded the Cap for the contract year. The Case Manager may order additional sessions if it is determined to be necessary, is included as part of the Care Plan, and if funds are available through the Delaware HIV Consortium;
- The Case Manager must determine client co-pay, if applicable;
- The Case Manager must verify provider's certification status in Delaware. This verification can be done by referring to the current list of Ryan White approved Service Providers or by calling the Delaware HIV Consortium. All provider certifications must be current for the service to be covered in this program.
- If all the above are met, order service.

Note: Medicaid Managed Care clients are eligible for nutritional counseling paid for through Ryan White Part B funds, provided the above information has been verified.

Ordering Service:

Case Managers may order this service after completing the above process. In addition, Case Managers should do the following:

- For approval, submit a Fee For Service Pre-Authorization Form, as well as a copy of the written acknowledge from the client's health care provider, to the Delaware HIV Consortium. Be sure to complete all demographic information.
- If the service is approved, a written notification will be sent to the case manager. The notification will include an Authorization Code for that block of services. The Authorization Code is comprised of the Authorization Date (first 6 digits) and the Authorization Number (the last 2 digits).
 - After receiving the approval notification, complete the Fee For Service Authorization Form. This form is available in duplicate. Be sure to note the Authorization Code in the appropriate space.
 - Retain the original copy for the client's file.
 - Mail the second copy to the service provider within 5 business days of the Authorization Date. The client is asked to initiate contact with the provider.
 - Advise service providers of the maximum amount paid by the Consortium for service rendered.

Billing:

Once a certified and licensed vendor or contractor has provided service, the bill should be sent directly to the HIV Supportive Services Manager at the Delaware HIV Consortium. The invoice must contain:

- the name and address of the provider of service,
- the client ID
- the date(s) that the service was provided and type of service provided,
- the Authorization Code (found on the completed Authorization Form), and
- the cost of the service, showing any client co-pay (if applicable) .

The Delaware HIV Consortium will review the bill, verify service (if needed) and send payment for services.

Note: If the payment required by the provider exceeds the maximum amount allowed by the Consortium, the client or the Service Provider will be responsible for the difference.

Closing An Open Referral:

If the client no longer wants or needs the service, and if there remains unused sessions in the block of pre-approved sessions, the Case Manager must initiate contact with the Delaware HIV Consortium and the Service Provider. Contact can

be made by telephone, email or fax. When the Case Manager contacts the above parties to close a referral, the following information must be given:

- date of closing,
- reason for closing, and
- last date that service was received by the client (if known).

State Direct Services

State Direct Services (through the Division of Public Health) provides clients with a variety of services to improve their quality of life. These services include:

- Miscellaneous Services
 - Nutritional Supplements
 - Disposable Medical Supplies
 - Laboratory Costs at Lab Corp Laboratories
 - Insurance Co-Pays (for medical visits)
 - Eye Exams
 - Eyeglasses (no more than \$150.00 per contract year)
 - Dental Care (no more than \$500.00 per contract year)

Income Criteria: Up to 400% of the Federal Poverty Level (FPL)

Individual/Family Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 300% of FPL	No Charge	No Charge
301 to 400% of FPL	No Charge	No Charge

Service Cap: \$750.00 per client per contract year for all State Direct Services combined (including eye care and dental services).

GENERAL SERVICES

Nutritional Supplements include such products as "Ensure". In Kent and Sussex Counties, Ryan White Part C dollars may be available to pay for these items for clinic patients. If the supply is exhausted, the Case Manager can arrange for delivery from American Home Patient in Salisbury, MD. American Home Patient will arrange for direct billing to the case management agency (therefore, each case management agency should set up its own billing account). Staff members of the HIV Wellness Clinics may arrange this service for patients receiving medical care in their clinics. For non-clinic clients, the client or case manager must obtain a prescription from a private physician before the Ryan White Program will pay for the supplement.

Disposable Medical Supplies include such items as adult diapers, disposable syringes, latex gloves, etc. Please check with the Ryan White Program Administrator at the Division of Public Health to see if a particular medical supply is covered.

Laboratory Costs at Lab Corp Laboratories is offered through a special arrangement with Lab Corp Laboratories.

Insurance Co-Payments include the client's portion of costs for some doctor's visits and laboratory expenses. Co-payments for inpatient medical services are not included.

Referrals:

- The Case Manager assesses the client and documents the need for the service on both the care plan and in the progress notes.
- The Case Manager verifies the client's eligibility for the service using the Ryan White Services Manual.
- The Case Manager determines the client's previous expenditures for the services for the current Ryan White fiscal year. The Case Manager may need to call the Ryan White Program to verify the client's eligibility based on previous service utilization. The Case Manager may also verify service utilization by checking the client's file in CAREWare.
- An Inter-Agency Form is completed and a copy is faxed or mailed to the Central Office. The original is attached to the "billing form" and sent to the Service Provider via the client.
- The Case Manager instructs the client on the process for scheduling an appointment, service caps, covered and non-covered procedures.
- The Case Manager will track and follow-through with referrals.

Billing:

- The Support Staff at the Central Office receive invoices/bills from Service Providers or the Case Manager. Client's eligibility is verified to be current. All bills must be the original bill; copies and faxed invoices will not be accepted.
- All invoices/bills require the following information: invoice number, client's name, date of birth, address, and date of service. The service provider name, mailing address and E.I. number are also necessary. Invoices/bills with incomplete information are returned to the person that submitted the respective bill. Statements with only balance due (i.e., with no service description, no dates of service and no breakdown of charges) will be returned.

- All questions related to the invoice/bill will be referred to the Service Provider. The Ryan White Administrator or Director will resolve complicated cases.
- Changes made to the bill have to be signed and dated.
- As a means of monitoring receipt of services, Case Managers are encouraged to review service utilization by reviewing the client's file in CAREWare.

EYE EXAMS AND EYEGASSES

The Ryan White Program will pay for what is medically necessary. If clients would like to have additional services (not medically necessary) or upgrades in product, then they are responsible for the difference in cost between what is necessary and what is desired. For example, if a client has a prescription to get bifocals, this service will be covered under the Ryan White Program. However, if the client would like to have variflux (infinitely graded) lenses or photosensitive lenses, the client would be responsible for those additional costs. Ryan White funds will only pay for basic glasses, inexpensive frames, simple lenses, or lined bifocals. The Ryan White Program will NOT pay for contact lens.

In New Castle County, eye exams are handled through the Christiana Care – HIV Wellness Program and other clinics (refer to the current Delaware HIV/AIDS Resource Guide). These costs are paid directly through the Division of Public Health.

In Kent and Sussex Counties, eye exams are covered if the client does not have any insurance, including Medicaid. Refractive exams are usually not covered by insurance and can be paid for by Ryan White.

Application Procedure:

- The Case Manager must verify Ryan White eligibility after receiving client referral, and document in the case notes that this has been done;
- The Case Manager will determine that the service requested is part of the Care Plan;
- The Case Manager will verify that client has not exceeded cap of \$750.00 for all State Direct Services for the contract year. If the client exceeds \$750.00, the Case Manager is required to provide a care plan to Ryan White Program Administrator at the Division of Public Health indicating ongoing need for approval;
 - A client will be eligible for change in eyeglasses (lenses and/or frames) once every two years unless requested otherwise by the eye specialist.

- After completing the above procedures, the Case Manager may order service.

Ordering Eyeglasses:

- In Kent or Sussex County, the Case Manager completes an Eyeglass Authorization Form. This form should include a maximum cost for eyeglasses, usually \$150.00 for lenses and frames. The form should also indicate that the Ryan White Program would pay for only what is medically necessary. Costs for additional services or upgraded in the product will be borne by the client.
Not covered: varilux lenses, coating, contacts, and photosensitive lenses
- In New Castle County, eyeglasses must be accessed through the Catholic Charities. Case Managers must complete a Catholic Charities Client Referral Form.

Billing:

- The Support Staff at the Central Office receive invoices/bills from Service Providers or the Case Manager. The client's eligibility is verified to be current. All bills must be the original bill; copies and faxed invoices will not be accepted.
- All invoices/bills require the following information: invoice number, client's name, date of birth, address, and date of service. The service provider name, mailing address and E.I. number are also necessary. Invoices/bills with incomplete information are returned to the person that submitted the respective bill. Statements with only balance due (i.e., with no service description, no dates of service and no breakdown of charges) will be returned.
- All questions related to the invoice/bill will be referred to the Service Provider. The Ryan White Administrator or Director will resolve complicated cases.
- Changes made to the bill have to be signed and dated.

Frequently Asked Questions about Eyeglasses

Question: What is the cap for eye examination?

Answer: There is no cap for an eye exam. However, expenditure on eye examination counts towards the annual \$750 cap for State Direct Services.

Question: What is the cap for eyeglasses?

Answer: Clients can spend up to \$150 on frames and lenses (optical) in a two-year period. Replacement for eyeglasses will, therefore, be allowed once in two years unless a written request is received from the eye care specialist or primary care provider with a medical justification for an earlier change. The program administrator or director will then pre-approve the service depending on the availability of funds.

Question: My client received eyeglasses paid by the Ryan White program two months ago. She has misplaced them. Could she receive another set through the program?

Answer: This is not an uncommon scenario but the answer is "No". Limited federal funding implies that those enrolled in the program are required to be thrifty. To prevent misuse and/or abuse of federal funds received by the program; clients will be allowed to replace eyeglasses once in two years. An exception may be granted at the receipt of a medical request from the client's primary health care provider or eye specialist for an earlier change in eyeglasses.

DENTAL SERVICES

Dental Care services may be accessed through the Delaware Technical and Community College's Dental Health Center and/or private providers.

Cap: \$500.00 per client per contract year (and combined total of all State Direct Services cannot exceed \$750.00)

Individual Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 300% of FPL	No Charge	No Charge
301 – 400% of FPL	No Charge	No Charge

Clients with dental insurance are ineligible for Ryan White dental services.

Only emergency dental services, routine cleaning and dental x-rays can be performed without prior approval, within the cap. Emergency dental services include bleeding, pain or infection within the oral cavity. Other services require pre-approval. Periodontal charting, x-rays and a narrative justification should accompany requests for pre-approval.

Application Procedure:

- The Case Manager must verify Ryan White eligibility, and eligibility for this service and document in the case notes that this has been done;
- Case Manager determines that dental service is part of the Care Plan. If client has no primary Case Manager, either refer to agency who performs this role or if authorized, complete intake form and assess need through completion of the Care Plan;
- Verify that client has not exceeded cap of \$500.00 for the contract year;
- For work exceeding \$500.00 at a private provider, or for expensive work at the Dental Health Center at the Delaware Technical and Community College, the Case Manager will contact the Ryan White Program Administrator at the Division of Public Health for prior approval; pre-approval is needed for any dental spending that would exceed \$500.00 for a client within the same Ryan White fiscal year
- Ongoing preventive visits (teeth cleaning) do not require pre-approval.

- The Ryan White program will pay for fitting of dentures at a maximum of once every four years.

Note: Medicaid clients are eligible for this service provided the above information has been verified.

At the time of the initial or periodic needs assessment, Ryan White clients identified as requiring dental services will have their inaugural appointment arranged by the case manager thereby the latter confirming the continued participation of the dental provider in the program.

The case manager will explain the dental referral process to the client: procedures covered, caps for individual dental procedures, client annual cap, policy on missed appointments, dentures, preauthorizations, and some of the procedures not reimbursable by the program.

The case manager will complete an Interagency Referral Form to the dentist. A copy of the form and the client's consent should be mailed or faxed to the Central Office in Dover, DE. The consent allows sharing of medical and financial information between the Division of Public Health (DPH) and the dental provider.

It is important that the case manager verifies client's knowledge of the location of the dental practice and the date of the appointment. Both the referral and the billing forms will be forwarded to the dentist via fax, mail, or hand-delivered by the client. The billing form directs the provider on the handling of Ryan White invoices.

The referral form will include the client's name, date of birth, the dental provider's address, dental cap, and if available, the date of the inaugural appointment.

In respect to new clients, a dental practice will call Central Office before service provision to verify client's enrollment in the program. Clients are allowed up to \$500 for dental services per fiscal year unless the central office approves the dentist's pre-authorization request for additional spending.

Clients are required to continue using one provider for all their dental needs except when that provider makes a referral. The Central Office will approve referrals. Likewise, clients that want to change their dental provider are required to notify the Central Office. Payment may be denied for bills received from dentists not officially known to be providing services to a client.

The provider will send bills directly to the Central Office. As a means of monitoring receipt of services, Case Managers are encouraged to review service utilization by reviewing the client's file in CAREWare

Dental Spending Greater Than \$500 Within a Fiscal Year:

Because of the high cost of dentures, all necessary pre-denture procedures such as extractions, amalgams, and/or alveoplasty will need to be undertaken in the fiscal year preceding that for which dentures are planned.

Emergency dental work that puts a client above the allowable annual cap of \$500 requires central office pre-approval. Pre-approval requests will be submitted by the dental provider directly to the central office and will include copies of periodontal charting, X-rays, and a narrative justification. Requests will not be considered until all the necessary documents have been received. The only exception may be in the case of emergency dental services.

Ordering Service:

Delaware Technical and Community College's Dental Health Clinic: Case Manager will submit a dental authorization letter to the dental clinic staff prior to the client receiving any dental services. The Case Manager should make the initial appointment for the client at the Dental Health Center. Clients will be responsible for making any necessary follow up appointments. Case Managers may provide assistance as needed.

Private Dental Offices: The Case Manager will arrange for an oral evaluation for the client, after which the dentist will submit a dental care plan. The Case Manager can then submit the care plan to the Ryan White Program Administrator for approval. The dental practice must be willing to accept third party payments and be enrolled with the Delaware Ryan White Part B Program.

Billing:

- The Support Staff at the Central Office receive invoices/bills from Service Providers or the Case Manager. The client's eligibility is verified to be current. All bills must be the original bill; copies and faxed invoices will not be accepted.
- All invoices/bills require the following information: client's name, date of birth, address, and date of service. The service provider name, mailing address and E.I. number are also necessary. Invoices/bills with incomplete information are returned to the person that submitted the respective bill. Statements with only balance due (i.e., with no service description, no dates of service and no breakdown of charges) will be returned.
- All questions related to the invoice/bill will be referred to the Service Provider. The Ryan White Administrator or Director will resolve complicated cases.
- Changes made to the bill have to be signed and dated.

- As a means of monitoring receipt of services, Case Managers are encouraged to review service utilization by reviewing the client's file in CAREWare

Termination of Dental Services:

Dental services will stop when:

- The most recent reassessment date (as available in the Ryan White database) is great than six months.
- The client has reached the allowable dental cap for the fiscal year and no preauthorization is available on file. Ryan White dental services will then resume the succeeding fiscal following re-enrollment in the program. An exception will be made for clients that have reached their dental cap but need emergency dental services. X-rays, periodontal charting, and a narrative justification will accompany all pre-approval requests.
- The client has missed two dental appointments in the same fiscal year. When that occurs, the client becomes ineligible for dental services for the twelve months following the date of the second missed appointment (except for dental emergencies).
- Ryan White Part B services are earmarked for Delaware residents only. Moving out of state, therefore, makes a client ineligible.

Frequently Asked Questions about Dental Services

Question: What is the cap for dental services?

Answer: The annual dental cap is \$500 per client. A dental treatment plan that would exceed \$500 in a year requires the dental provider to submit a pre-authorization request to the central office. Pre-authorization requests should be submitted with copies of the treatment plan, X-rays, periodontal charting, and a narrative justification. Dental care will be reimbursed up to the maximum approved by the completion of the planned work. However, bills with an aggregate total of >\$500 per year per client and have no prior approval on file will be reimbursed up to the \$500 annual maximum. The dental provider and/or the client will be responsible for the balance. It is important for both the client and the dentist to understand issues related to Ryan White dental reimbursement. Emergency dental services for clients that have maxed out the annual dental cap also need pre-approval, which may be submitted by the dental provider. Copies of X-rays, periodontal charting, and a narrative justification must accompany the pre-authorization requests. Pre-approvals will be granted depending on whether the procedures are medically necessary, funds are available, and the client did not use more than \$500 on dental services the previous year.

Question: Dentures often cost more than the \$500 cap: how is reimbursement handled?

Answer: The Central Office will pre-approve a number of dentures per given year on a first come first served basis. Clients that need dentures will be encouraged to have all necessary preparation (extractions, amalgams etc) the period preceding the fiscal year dentures are requested.

Question: How does a client secure a pre-authorization approval for a dental treatment plan that cost more than \$500?

Answer: The dental provider will draw up a treatment plan after examining the client. Treatment plans that cost more than \$500 and need to be completed within the fiscal year will need pre-approval from the central office. The dental provider will submit copies of the plan, X-rays, periodontal charting, and a narrative justification describing the urgency of the plan implementation. The central office will review the request once all the documents have been received. Medically necessary procedures may be approved depending on the availability of funds.

Question: My client spent \$1,800 on amalgams and dentures this fiscal year subsequent to a preauthorization by DPH. The client now needs \$300 for excision of exostoses from the maxillary bone. Can I submit the request to DPH for another pre-approval?

Answer: Dental providers are strongly encouraged to develop one treatment plan for each Ryan White fiscal year (4/1/** to 3/31/**+1. Consequently, an annual maximum of one pre-approval request per client is expected except for dental emergencies. Approved dental plans that are changed may be accepted

but only if the total cost is at most equal to the earlier approved plan. Extra dental work outside the approved plan will not be paid for and should wait for subsequent years.

Question: A dental treatment plan was approved for my client for \$1,000. However, the dental provider has revised the plan. Do I need to submit an alternative pre-approval request for the change?

Answer: Yes. A copy of the revised treatment plan is necessary including a written justification for the change. However, the cost should be kept at most equal to the earlier approved plan.

Question: The program paid for my client's dentures last year. She now needs a new set this year and is wondering if the program will pay?

Answer: The program will pay for dentures once in four years. A waiver may be provided to clients whose dental or primary care providers submit a written request, accompanied by a medically necessary justification, for an earlier change.

Question: What dental procedures does the Ryan White dental program not cover?

Answer: The Ryan White program will endeavor to reimburse all medically necessary procedures for eligible clients depending on the availability of funds. Among procedures not currently covered by the program are dental crowns, bridges, root canal treatment, and adult general anesthesia.

Question: How many missed appointments are clients allowed?

Answer: A maximum of two per fiscal year and, thereafter, receipt of Ryan White dental services is suspended for the subsequent twelve months except for dental emergencies.

Question: How does a client secure a pre-authorization approval for a dental treatment plan that cost more than \$500?

Answer: The dental provider will draw up a treatment plan after examining the client. Treatment plans that cost more than \$500 and need to be completed within the fiscal year will need pre-approval from the central office. The dental provider will submit copies of the plan, X-rays, periodontal charting, and a narrative justification describing the urgency of the plan implementation. The central office will review the request once all the documents have been received. Medically necessary procedures may be approved depending on the availability of funds.

TRANSPORTATION

HRSA Definition: Conveyance services provided, directly or through a voucher, to a client so that he or she may access health care services.

Income Criteria: Up to 300% of federal poverty level (FPL).

Individual/Family Income: Annual Gross Income	Per Service Charge	Total Allowable Charges
0 to 300% of FPL	No charge	No charge

Cap: None

Application Procedure:

- Each transportation agency has policies describing the services available and how to access them. Contact your local provider for more information.

In Delaware's program, transportation services provide assistance by enabling clients to travel to medical appointments or other supportive services. These programs exist in the form of rides provided by volunteers or through agency vehicles.

Because Delaware's Medicaid Program pays for transportation services to clients enrolled in Medicaid, and because the Ryan White Program is considered to be the "payer of last resort", determining client eligibility for transportation services paid for with Ryan White Part B dollars can be tricky. The following guidelines should be helpful in making that determination:

1. As a general rule, clients with Medicaid are not eligible to use Ryan White transportation services. Medicaid Transportation Providers should be willing to take clients to access services that are funded by Medicaid, including:

- Outpatient medical services (including outpatient x-rays)
- Pharmacies for HIV medication pick-up
- Appointments with their HIV/AIDS case manager
- Laboratory appointments
- Mental wellness sessions
- Nutritional counseling sessions

If a Medicaid Transportation Provider refuses to take a client with Medicaid to one of the destinations listed in #1 above, the client and/or the case manager are encouraged to file a grievance about the Service Provider with Medicaid. The

LogistiCare Complaint Form is available from the Delaware HIV Consortium or through other sources.

2. Clients with Medicaid can use a Ryan White Transportation Provider for the following destinations ONLY:

- Eye appointments
- Dental appointments

If a Ryan White Transportation Program provides service to a client with Medicaid, the destination must be indicated in the Client Utilization Report as a part of the invoice to the Ryan White Part B Program.

The bottom line is that as much as possible, Medicaid clients need to use Medicaid transportation services. The client may use a Ryan White-funded transportation provider if there are insurmountable obstacles in using the Medicaid Provider(s) or if the need for transportation does not fall within Medicaid parameters." The fact that a client does not want to pay the \$1 each way fee charged by many Medicaid Transportation Providers does not constitute an "insurmountable obstacle". If the fee becomes a barrier to service, the client's case manager should appeal to Medicaid, which may decide to waive the fee for a particular client. Such an appeal also provides important feedback to Medicaid about the services it funds.

Medicaid clients CAN use Ryan White-funded transportation programs, but only (1) if the destination is not appropriate for Medicaid reimbursement, but is appropriate for Ryan White funding, or (2) if it is impossible to arrange Medicaid transportation to meet the client's need.

3. Clients without Medicaid can use a Ryan White Transportation Provider for the following destinations:

- Outpatient medical appointments (including outpatient x-rays)
- Laboratory appointments
- Dental appointments
- Eye appointments

If resources allow, transportation may also be provided to the following destinations, at the discretion of the Transportation Provider:

- Pharmacies for HIV medication pick-up
- Appointments with their HIV/AIDS Case Manager
- Mental wellness sessions (with a licensed mental health professional)
- Nutritional counseling sessions

If HIV/AIDS Case Managers are not sure of a client's eligibility for transportation services through the Ryan White Part B Program, they are encouraged to contact their local Service Provider for more information.

Introduction to the Standards of HIV Case Management

Individuals living with HIV infection and their friends and families face a complex, fragmented, and sometimes-unfamiliar service delivery system. The needs of people with HIV infection are compounded by the complexities of their medical care, and the likelihood of precipitous changes in physical and emotional status throughout the course of the illness that result in frequent modifications in service needs.

The first and highest priority of all HIV/AIDS case management systems must be to ensure persons living with HIV/AIDS are enrolled and sustained in coordinated health care that optimizes clients' health and well-being. As a service well-equipped to coordinate a wide-array of multiple, often fragmented services necessary to access health care, HIV Case Management has both the potential and the obligation to impact quality and longevity of life. Through a holistic, integrated, and coordinated approach to service provision, Case Management can ensure that all persons living with HIV/AIDS have access to appropriate health care and the opportunity to obtain optimal health.

The goal of Case Management is enhanced independence and increased quality of life for individuals with HIV infection. Case management services should be provided in the appropriate place by appropriate providers in a manner that is culturally and linguistically competent. Case management should be flexible to accommodate the particular medical and social needs of clients with different backgrounds and in various stages of health and illness. The services delivered should reflect a philosophy that affirms a client's right to a high quality of life, privacy, confidentiality, self-determination, nondiscrimination, compassionate and non-judgmental care, and dignity and respect.

In an advisory capacity, Case Managers are a valuable source of information on the continuum of services available to persons living with HIV/AIDS. A small percentage of time spent by a Case Manager can be expected to be related to non-client specific activities, such as interagency coordination for the purpose of development of needed, non-existent resources in the community, reorganization of access to existing services, and development of referral agreements and relationships between existing agencies. Case Managers may also serve a useful purpose in the development of the continuum of care and in community efforts to bring attention to the problems associated with the lack of services.

The goals of the HIV/AIDS Case Management Service are to:

- Provide access to services that increase independence and self-sufficient functioning;
- Provide access to services that prevent or delay institutionalization;
- Increase universal access to HIV information, counseling, testing and services;
- Monitor clients to insure access to medical and social services in order to promote early medical intervention;
- Assure continuity of care and follow-up of clients;
- Promote coordination among service providers and other support systems to eliminate duplication and foster resource development; and
- Increase access to appropriate services for, and promote the functioning of the family unit, recognizing that the family constellation is a constant in the client's life.

Please note that the term "family" is used in its broadest sense to include family, partners, co-residents, and other significant supports in an individual's life.

Definition & Overview of Case Management

CASE MANAGEMENT: A range of client-centered services that links clients with primary medical care, psycho-social and other services to ensure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, through on-going assessment of the client's and other family member's needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. (HRSA Glossary of HIV-Related Service Categories, 2002)

Case Management consists of services that link clients with health care and psychosocial services in a manner that ensures timely, coordinated access to appropriate levels of care. Key activities include: (1) initial assessment of service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of services required to implement the plan, (4) client monitoring to assess the efficacy of the plan, and (5) periodic re-evaluation and revision of the plan as necessary. It may also include client-specific advocacy and/or review of utilization of services.

Case management services are home and community-based. Case Managers will encounter clients in their environment, which may include a residence, a public facility, in the streets, or in the facilities of the Case Management service provider agency. Case management shall provide for regular face-to-face or phone contact, and a minimum of one home visit per year, as determined by client need.

In general, Case Management provides the following functions:

- Intake into care;
- On-going assessment of client needs;
- On-going service planning;
- Coordination of and referral to primary care;
- Coordination and referral to other medical and support services;
- Monitoring and follow-up; and
- Discharge/Transition planning.

A client may need assistance with obtaining housing or legal services or any other combination of supportive services. However, the provision of housing assistance or legal services is not case management; rather *identifying the need* for housing assistance, legal assistance, or other services and *arranging to have that assistance provided* is case management.

Except under special circumstances, clients will have only one primary Case Manager at any one time throughout their care. The primary Case Manager is responsible for providing the seven functions described above. This structure does not preclude the clients from receiving services at other provider locations. In fact, Case Managers shall work to assist clients with accessing any number of services at any number of different agencies, but these are discrete services (such as housing, legal assistance, etc.); clients will not need to receive case management services at every agency to which they present, and should not receive HIV/AIDS Case Management at more than one Ryan White CARE Act-funded agency.

How to use this Document

The standards of HIV case management are divided into the following sections:

- 1.0 Personnel;
- 2.0 Clients' Rights & Responsibilities;
- 3.0 Intake;
- 4.0 Assessment/Reassessment;
- 5.0 Service Planning;
- 6.0 Coordination and Referral;
- 7.0 Monitoring and Follow Up;
- 8.0 Crisis Management
- 9.0 Discharge planning, and
- 10.0 Re-entry Procedures.

Each section begins with the objectives, followed by an explanation or justification. The actual standards and measures (i.e., how to adhere to the standards) follow the objectives and explanation. The measures are meant to provide guidance as to the documents or systems the agency may utilize to demonstrate adherence to the standards. If the agency already has a source other than the listed measures that provides demonstration of adherence, it will not be necessary to implement the measures listed here; simply note it as a substitution.

This listing of standards and measurements can be used as a self-assessment tool for provider agencies and Case Management Supervisors to identify where they are successful in meeting standards of care and areas in which they may require some assistance. HIV/AIDS Program staff members are available to provide assistance to any agency that may have difficulty implementing any of the standards listed in this document.

1.0 Personnel

The standards of care for personnel ensure that:

- Clients have access to the highest quality of care through experienced and trained Case Managers;
- Case Managers/Case Management Supervisors are clear about their job responsibilities; and
- Case Managers are provided the training and supervision to equip them to perform their jobs well.

An HIV/AIDS Services Case Manager must be able to work with clients and develop a supportive relationship with them, empower clients to make the best choices for their well being, and facilitate access to and use of available services. In order to be effective in their work, Case Managers need to have certain skills and a certain level of compassion and caring for others. At a minimum, all Case Managers hired by provider agencies will have a bachelor's degree in a human service field. Case Managers shall demonstrate the ability to coordinate services, information and referrals for clients in need of case management services, the ability to complete documentation as required by their position, and previous experience in the human service delivery field. All HIV Services Case Managers and Case Management Supervisors will be given a written job description with specific minimum qualifications outlined.

HIV Services Case Manager

Minimum Qualifications: Master's or Bachelor's degree in health, human or education services or social work, and one year of qualifying experience: OR Licensure as an R.N. or L.P.N. and two years of qualifying experience. For this position, qualifying experience means verifiable full or part-time work in a human services related field. Prior work with persons with HIV infection, and/or persons with a history of mental illness, homelessness, or chemical dependence is preferred.

The Case Manager is responsible for providing intensive case management for clients and their families/support system and advocates for clients to obtain the full range of needed services and ensures coordination of these services. The Case Manager promotes linkage development and monitors the effectiveness of linkages with other service providers. The Case Manager ensures community follow-up to engage the client in care, promotes attendance at appointments and adherence to treatment regimes, and encourages client self-sufficiency and empowerment. The Case Manager is responsible for keeping their documentation and billing records complete and up to date.

Case Management Supervisors

Minimum Qualifications: Master's degree in Health or Human Services, six months of supervisory experience and one year of qualifying experience; OR Bachelor's degree in Health or Human Services, six months of supervisory experience and two years of qualifying experience. For this position, qualifying experience means verifiable full or part-time work performing case management or casework in a human services related field. Prior work with persons with HIV infection, and/or persons with a history of mental illness, homelessness, or chemical dependence is preferred.

Case Management Supervisors will provide the case managers on their staff with ongoing and consistent clinical and administrative supervision (2 hours of supervision per month, at a minimum). Clinical supervision addresses anything directly related to client care (e.g., specific client issues, boundaries and appropriate interactions with clients, etc.) This

supervision may include a spot check of a random sample of records, or review of all case management records through observation, through monitoring of caseloads, and through client feedback. Administrative supervision addresses issues relating to staffing, job performance, policy, client documentation, reimbursement, scheduling, trainings, quality enhancement activities, and the overall administration of the program. Supervision may be provided in individual or group sessions, as deemed appropriate by the provider agency. Case Management Supervisors also oversee program development and evaluation, and ensure quality client services.

Case Management Supervisors must participate in the quarterly Case Management Supervisors Meeting. The Delaware HIV Consortium and the Delaware Division of Public Health jointly facilitate these meetings. They provide a forum to identify broad issues facing the HIV/AIDS Case Management System and to address them proactively.

Continuing Education and Training

Case Managers shall be afforded adequate opportunities to attend professional development or continuing education that may enhance job performance. These trainings should be documented in personnel files. Before beginning work, a new case manager should receive instruction in HIV confidentiality and privacy issues. In the first month of work as a HIV Services Case Manager, training in the following topics should occur:

- Documentation and billing;
- Basic HIV (AIDS 101);
- Accessing entitlement systems, identifying and accessing services;
- Basic Case Management as listed in these case management standards;
- Communication and interviewing skills.

On-going education and training is crucial to HIV Services Case Managers. Trainings are offered by a variety of Service Providers. Check the HIV/AIDS Trainings Central Registry on the Delaware HIV Consortium's web page (www.delawarehiv.org) for courses endorsed by the Consortium. Desirable topics for continuing education include, but are not limited to:

- HIV epidemiology and health care
- HIV and Its Co-morbidities (tuberculosis, hepatitis, etc.)
- HIV prevention/risk reduction education
- Child abuse and neglect - mandatory reporting
- Psychosocial aspects of HIV infection
- Substance use issues
- Maternal and child health issues
- Legal issues (e.g. permanency planning)
- Cultural sensitivity/attitudes/values
- Death, dying and bereavement
- Mental health issues
- Family issues (e.g. domestic violence)
- Stress / burnout reduction
- Disclosure.

If the case manager/case management technician received related required training during other employment, it may be verified and substituted and documented in the personnel file.

Standard**Measure**

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|-----|---|--|
| 1.1 | Case Management Supervisors and newly hired HIV Case Managers will meet the educational and work experience standards for their positions. | Performance Evaluations
Applicable licenses/certificates/diploma |
| 1.2 | Case management provider organizations will give a written job description to all newly hired Case Managers and Case Management Supervisors. | Written job description on file signed by the Case Manager/Case Manager Supervisors.

Documentation of completed training on file. |
| 1.3 | Newly hired Case Managers will receive 12 hours of HIV specific training within the first 6 months of employment. | Documentation of completed training on file. |
| 1.5 | Case Managers and Case Management Supervisors will attend trainings endorsed by the Delaware HIV Consortium. | Review of the minutes for the Case Management Supervisor Meetings as distributed by the Delaware Division of Public Health. |
| 1.6 | Case Management Supervisors will participate in the Quarterly Meetings of Case Management Supervisors. | Documentation on file of date of supervision, type of supervision (one on one, group), and content of supervision. |
| 1.7 | Case Managers will receive at least two hours of supervision per month to include client care, Case Manager job performance, and skill development. | |

Resume
Reference Checks

2.0 Clients' Rights & Responsibilities

The objectives of establishing standards of care for clients' rights and responsibilities are to:

- Guarantee client confidentiality;
- Ensure that the clients' decisions and needs drive the case management process;
- Ensure a fair process of case review if the client believes s/he has been mistreated, poorly served or wrongly discharged from case management services; and
- Clarify clients' responsibilities, which help facilitate communication and service delivery.

The case management standards of care are based on respecting the inherent dignity of each client. Case management services should be made available to all who wish for and are in need of services. Emphasis is placed on encouraging client autonomy and independence in daily living. However, should a client not be physically or emotionally capable of independent functioning, the Case Manager will provide appropriate assistance. All provider agencies offering case management services must have the following items in place:

1. Rights and Responsibilities

Rights and Responsibilities clarify the role of the client in the service delivery process.

2. Service Guidelines

Service Guidelines communicate to the client the regulations specified by the agency in order to provide services in a safe, secure manner (e.g., clients shall not present to the agency while under the influence of alcohol or drugs).

3. Confidentiality Agreement/Policy, including Limits to Confidentiality

Confidentiality assures protection of information regarding HIV status, behavioral risk factors, or use of services. Limits to Confidentiality describe the instances under which agency personnel are required to report certain conditions (e.g., homicidal or suicidal tendencies, intent to harm, danger to self or others).

4. Release of Information

A release of information ensures that the client has the ultimate decision regarding what information may or may not be released, to whom, and for what purpose. A Release of Information form should describe under what circumstances client information can be released, name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature. A release of information should always be obtained before any client information is made available to another service provider.

5. Grievance Procedure

A provider agency grievance procedure ensures that clients have recourse if they feel they are being treated in an unfair manner or do not feel they are receiving quality services. Each agency will have a policy identifying the steps a client should follow to file a grievance and stating how the grievance will be handled. The final step of the grievance policy will

include information on how the client may appeal the decision if the client's grievance is not settled to his/her satisfaction within the provider agency. A grievance procedure should guarantee that no punitive action will be taken against a client, and services will not be negatively impacted should he/she file a grievance.

6. Consent to Case Management

A consent to case management form is utilized to ensure that clients understand the above listed items, have the choice to accept or decline services, and agree to receive case management services from only one HIV Case Management Agency at a given time.

All items listed above shall be discussed with the client at least once during intake. Continued discussion over time is encouraged. The Delaware HIV Consortium can provide technical assistance in the development of these policies, as well as provide samples of appropriate forms if provider agency does not have existing, written policy or applicable forms in place.

Standard	Measure
2.1 Clients' Rights and Responsibilities exist.	Written policy on file at provider agency, with signed copy in each client's file.
2.2 Service Guidelines are in place.	Written policy on file at provider agency, with signed copy in each client's file, and updated as necessary.
2.3 Confidentiality Policy exists, including Limits to Confidentiality	Written policy on file at provider agency, with signed copy in each client's file.
2.4 Release of Information is obtained prior to release of confidential information.	Release of information forms signed by client in client's record. Releases are considered no longer binding if more than one year old.
2.5 Grievance policy and procedure exist.	Written policy/procedure on file at provider agency, with signed copy in each client's file.
2.6 Client has consented to receive case management services at provider agency.	Documentation in client's chart (e.g., signed consent)
2.7 Client was informed of and received copies of above listed items.	Documentation will be in client's record indicating that client has been informed of and received a copy of above listed items, or has signed off that the client has refused the items.

3.0 Intake

The objectives of the intake process are to:

- Inform the client of what can be expected if s/he enrolls in case management services;
- Establish client eligibility for services;
- Establish whether client wishes to enroll in case management services or is interested only in a discrete service offered by the HIV Service System;
- Collect required state/federal client data for reporting purposes; and
- Collect basic client information to facilitate client identification and client follow up.

All clients who request or are referred for HIV case management services will participate in the intake process. A Case Manager, preferably one who has had training or experience in the intake process, must conduct the Intake. During Intake, the role of the Case Manager is explained to the client, the client's rights and responsibilities are reviewed, the agency's client confidentiality and grievance policies are explained to the client, eligibility is determined, consent for case management is obtained, immediate client needs are established, permission is secured from client to release information (if there is an immediate need to release information), and the uniform intake form is started. In addition, the procedures for termination of case management and re-entry must be explained. The intake process will be started as soon as possible, but at a maximum of 72 hours from first client contact with the agency.

Information to be collected includes:

- The referral source and date of referral;
- Identifying and demographic information;
- A list of family members and co-residents, including children not currently living at home, identification of the primary caregiver and legal guardian(s) of the children;
 - confidentiality concerns;
- HIV diagnosis;
- Medical status, housing status, financial status and other issues requiring immediate attention for the client;
- Emergency contact;
- Health insurance;
- Languages spoken; and
- Date completed.

If the only client needs identified during the intake are available through Direct Access Programs, and if the client has adequate skills to use those programs on his/her own, the HIV Services Case Manager should enroll the client in the necessary program(s). Once the referrals are complete, the client's file should be moved to an inactive status. The case manager should assure the client that, if the client's situation changes and the need for additional services develop, the client should contact the Case Manager for assistance.

A client who chooses to enroll in case management services is then assigned a Case Manager. The Case Manager will be responsible for making contact with the client within 5 working days to set up a time for a more thorough assessment and the creation of a Service Plan. If deemed necessary, an assessment may be conducted at the time of intake; however, consideration should be given to the time burden for both client and Case Manager

of completing an intake and assessment in one session. Immediate needs that are identified as a result of the intake should be addressed by the Case Manager and services implemented promptly.

The full intake process should be completed within fifteen (15) calendar days of the individual's referral to the case management agency.

<p style="text-align: center;">Factors to Consider:</p> <ul style="list-style-type: none">• Involvement with Primary Medical Care• Client's ability to access services without case management support• Support systems• Mental health and substance abuse history• Cognitive ability (Functional status)• Housing status
<p style="text-align: center;">Client's Role</p> <ul style="list-style-type: none">• To maintain the scheduled intake appointment.• To provide all applicable demographic and support service information• To provide information on insurance coverage if applicable• Participate with Case Manager in determining the level of case management services needed• To follow-up on services as required.
<p style="text-align: center;">Case Manager's Role</p> <ul style="list-style-type: none">• To provide an intake within 15 days• Complete all necessary paper work• Assess the clients need for case management (i.e., full case management)• Arrange and confirm any appointments for programs to address immediate needs• Schedule follow up appointments as necessary
<p style="text-align: center;">Outcome Criteria</p> <ul style="list-style-type: none">• Client involvement in Direct access services• Appropriate assignment of case management acuity level• Completed intakes

Standard**Measure**

- | | | |
|-----|---|--|
| 3.1 | Complete uniform intake tool within 15 days of first seeing client. | Completed uniform intake tool in client's record. |
| 3.2 | Determine eligibility for HIV case management services if client chooses to enroll in case management services. | Supporting documentation ensuring eligibility for services is maintained in client file. |
| 3.3 | Update eligibility determination annually. | Supporting documentation verifying eligibility is updated annually and in client's record. |
| 3.4 | Determine client's wishes for release of information if there is an immediate need to release information. | Signed Release (or No-Release) of Information in client's record. |
| 3.5 | Update release of information annually. | Updated release signed by client and in client's record. |
| 3.6 | Complete all documentation as outlined in Section 2.0 ("Client Rights and Responsibilities".) | Documentation in client's record. |

4.0 Assessment/Reassessment

The objectives of the assessment/reassessment process are to:

- Identify the client's/family's problems and service needs,
- Identify what service needs are being met and by whom,
- Identify what services have not been accessed or are not adequately coordinated,
- Evaluate the strengths/resources of the client and support system which can be utilized during service planning,
- Evaluate the level of monitoring that the client needs,
- Begin to establish a trusting client relationship.

Assessment/Reassessment is the review of information about the client's medical, physical and psychosocial condition, resources and needs. It allows the Case Manager to gather appropriate client information in order to determine client needs on an on-going basis. Assessment activities should be finalized no later than 30 days from the date of the completed intake.

The client will be the primary source of information, but assessments may include information gathered from family members, medical and psychosocial providers and other sources of information, if the client grants permission to access these other sources. These sources can provide important information about the family's ability to function as a unit; a notation of psychosocial, medical, financial and other problems affecting the family; and include information about preventing the transmission of HIV. In order to discuss an individual's case with a provider, agencies must first secure the client's documented permission to release necessary information to that agency. Release of information forms should be dated and filled completely. Release forms should be dated to expire at a maximum of one year after the permission date or when the client's case is closed, whichever comes first.

The initial assessment should focus on immediate health and social services needs and address the client's history of utilization of care. The following information should be included in the assessment:

- Health status, which includes but is not limited to TB, OB/GYN, disease staging, medications, other known medical conditions; nutritional status (these areas should be regularly monitored);
- Employment/education;
- Financial resources, entitlements;
- Housing;
- Transportation;
- Support systems;
- Parenting/children's needs;
- Substance abuse status;
- Emotional/Mental health issues;
- Need for legal assistance (e.g. health care proxy, guardianship arrangement).

Once a psychosocial assessment has been completed, the client's case should be reviewed by the HIV/AIDS Case Manager and , when appropriate, by the Case Management Supervisor. They should pay particular attention to the severity of the client's needs and the ability of the client to participate in meeting those needs. This review will result in the classification of the client as either "monitored" or "non-monitored". Monitored clients will

require more intensive involvement with the case manager in order to access needed services. Non-monitored clients will require only minimal involvement with the case manager. There are five life circumstances that automatically merit a "monitored" classification: current mental illness, active substance abuse, pregnancy, homelessness, and/or a recent history of clinic no-shows. Delaware's "Intake Assessment Scoresheet" is a valuable tool in making this classification.

Appropriate referral sources should be identified through these periodic assessments. When requested, or when high-risk behavior is reported or suspected, periodic testing of other family members should also be encouraged and arranged by the Case Manager. For newly diagnosed clients, disease management education may be indicated. This client education may address such topics as a review of HIV transmission, risk reduction for re-infection, safe sex practices, acknowledgement of HIV+ status to future partners, early symptom identification and disclosure to a medical provider, understanding lab values, options for medical care, consideration of mental health interventions, thoughts about support groups, coping with HIV disease and being one's own best advocate. Depending upon the extent and type of education needed, this service may be provided by the Case Manager directly or by referral to other programs such as Peer Education, Prevention Case Management (as funded with Prevention dollars through the Division of Public Health), and others.

Provider agencies must use the assessment form approved by the HIV/AIDS Program. Agencies may add additional questions if they are needed to assess the eligibility and need for other programs that are offered by the Provider Agency.

The assessment process is dynamic. As a client's status changes, his/her needs may change. It is the responsibility of the Case Manager to reassess a client's needs continually. A formal reassessment should occur on an as needed basis, as determined by the Case Manager, but at least every six (6) months.

A client has the right to be given access to a fair and comprehensive assessment of his/her health, functional, psychological, and cognitive ability. The focus of the assessment is to evaluate client needs, and is a cooperative and interactive endeavor between the Case Manager and the client. The assessment should be conducted face to face and at a location that is mutually acceptable to the client and the Case Manager. Ideally the assessment process should include a home visit to evaluate the client's needs, informal supports, and general living condition. During the assessment, clients should be assessed for linkages to HIV medical care.

For non-monitored clients, the client should be contacted, at minimum by phone, once every twelve (12) months to determine whether his or her needs have changed. Monitored clients must be reassessed every six (6) months, and that reassessment should be documented in the client file.

Factors to Consider:

- Health status
- Employment education
- Financial resource, entitlements
- Housing
- Mental Health/substance abuse
- Legal

Client's Role:

- To maintain scheduled appointments for completion of the intake
- Identify family members/significant others to participate in the assessment process (if applicable)
- To provide honest responses to the assessment questionnaires or identify areas where he/she may be uncomfortable
- To make Case Manager aware of any significant changes (i.e., illness, change in clinical functioning, loss of housing, incarceration).
- To provide signature for the release to assessment information as necessary to access other HIV/AIDS services.

Case Manager's Role:

- To complete assessment within 30 days from the initial intake for clients receiving case management with monitoring.
- To conduct periodic reviews of the assessment and provide follow up as necessary.
- Provide referrals for service needs that emerge as a result of the intake process.
- Receive clients written consent for the release of information prior to disclosing assessment information to outside providers
- Conduct a formal review as a part of the re-assessment (i.e., clients situation, functioning, clinical and psychosocial).

Outcome Criteria:

- Identification of unmet need
- Increase in family member/significant other support system
- Identification of barriers to care
- Identification of the need for long term case management

Standard**Measure**

4.1 Conduct client assessment within 30 days of beginning intake.

Completed assessment form in client's record, covering at least the following areas:

- * Medical history and current health status;
- * Available financial resources (including insurance status);
- * Availability of food, shelter, transportation, and financial resources;
- * Available support system (family, friends, partners, others);
- * Need for legal assistance;
- * Substance use status; and
- * Emotional/mental health status.

4.2 Conduct reassessment of the needs of monitored clients on an on-going basis (at minimum, every six (6) months). For non-monitored clients, the reassessment should be conducted once every twelve (12) months.

Documentation (in form of progress notes, updated notes on initial assessment, or new assessment form) in client's record.

5.0 Service Planning

The objectives of the service plan are to identify:

- Client goals, based on his/her needs;
- Action steps necessary to meet the client's goals; and
- Time frame for meeting client goals.

Development of the service plan is the translation of assessment information into specific goals and objectives, with defined activities, services, providers and time frames to reach each objective. It should be completed immediately following the assessment and within 30 days of the date of intake.

This plan detailing client goals and objectives based on the needs identified in the assessment should be developed collaboratively between the Case Manager and client. Ideally, professionals from relevant disciplines and agencies are also involved in the development of the service plan. The service plan should outline short and long term goals and action steps needed to address each goal. The plan should include specific services needed and referrals to be made, including clear time frames and an agreed upon plan for follow-up. Unforeseen situations (e.g., illnesses, incarcerations, etc.), may alter the normal time frames on delivery of services. The service plan is for clients to achieve their medical and social service goals. Two important aspects of the plan are the client's personal goals and goals that the Case Manager and client together decide would be capacity building goals.

The service plan will reflect services to be accessed on behalf of the client and family members and identify expected outcomes toward goal attainment. If services actually provided differ, a note explaining the difference should be made. Goals for family members should be clearly identified as such. The client's participation in the development of the plan and agreement with the plan and/or declination of any part of the plan must be indicated by their (or family representative) signature. A copy of the plan should be given to the client. At a minimum, the service plan should include:

- Description of the challenge(s);
- Goals for resolving each challenge;
- Resources to meet each need including client's resources and support network, nature and level of service need, time frames in which services are to be provided, and who will be the provider of the service;
- Activities (actions to be taken);
- The individual/agency who will perform the activity (e.g., Case Manager, client, family member, agency representative);
- Notes on the availability and appropriateness of each service and alternative plans, if necessary;
- Anticipated time frame for completion;
- Expected outcomes, and
- Signature of the Case Manager and client, and the date.

The plan should be documented on forms developed or approved by the Ryan White Program or the Delaware HIV Consortium. However, provider agencies which choose electronic record keeping may create their own format as long as it contains the above elements. Service plans will be completed within 30 days of the initial intake date.

As with the assessment process, service planning is an ongoing process. It is the responsibility of the Case Manager to continually review and revise a monitored client's

service plan. Service plans should be reviewed and revised on an as needed basis, as determined by the client and Case Manager, but at a minimum of every six (6) months.

It is the intent of the Delaware HIV/AIDS Program that case management provided under the Program represents a fully integrated case management approach. The HIV/AIDS Case Manager coordinates all necessary services along the continuum of care, institutional and community based, by directly arranging access to services or by establishing linkages with other service programs.

The role of the Case Manager is to reduce service, agency and administrative barriers to ensure that clients obtain needed services. Services accessed by the client should include institutional and non-institutional medical and non-medical services, social and other support services and linkages to existing community resources.

<p style="text-align: center;">Factors to Consider:</p> <ul style="list-style-type: none">• The realistic nature of the client's request(s)• Client's ability to perform proposed activities• The client's mental health, substance abuse and functional status• Expected Outcome• Time Frame for completion
<p style="text-align: center;">Client's Role:</p> <ul style="list-style-type: none">• To actively participate in service plan development• To identify activities that he/she can perform• To provide Case Manager with changes in the health status, housing etc.• To follow through with appropriate referrals• To provide feedback to the Case Manager on the services that has been received
<p style="text-align: center;">Case Manager's Role:</p> <ul style="list-style-type: none">• To complete the approved forms for the Ryan White program• To set realistic goals with the client• To invite the clients participation in the development of service plans• To assist client identifying tasks that he/she is able to complete as a part of service delivery• To follow-up with client to determine if services have been received• Identify appropriate resources in the community
<p style="text-align: center;">Outcome Criteria:</p> <ul style="list-style-type: none">• Client access to primary medical care and support services• Improvement in the client functional status (i.e., substance abuse, quality of life indicators, and self esteem)• Improvement in client's knowledge of the service delivery system

Standard

Measure

5.1 Develop service plan collaboratively with client within 30 days of beginning intake.

Completed service plan signed by client, Case Manager, and Case Management Supervisor and in client's record.

5.2 Review and revise service plan at least every six (6) months for active clients.

Documentation of the review of the revised service plan signed by client, Case Manager, and Case Management Supervisor and included in the client's record.

Note: Documentation of the review of the revised service plan does not need to be signed by clients receiving direct services only. However, documentation should be maintained when client contact is made, indicating that client will remain on the services-only caseload.

6.0 Coordination and Referral

The objective of coordination and referral is to:

- Follow through on the strategies for addressing client needs as outlined in the service plan.

Coordination and referral includes:

- on-going client support and encouragement;
- coordination of services and clarification of roles of service providers;
- referral to needed services; and
- advocacy for services if client is unable to advocate on his/her own behalf.

Service plan implementation is the ongoing responsibility of the Case Manager and the client, and should begin immediately after service needs are assessed. The Case Manager will assist the client and family as needed, in contacting support persons and agency providers to negotiate the delivery of planned services. The service plan may be modified to accommodate the client, family members, co-residents, and service providers. Any changes from the original plan should be noted in the record. Clients, consistent with the responsibilities identified in the service plan, should be encouraged to carry out the tasks to which they agreed. Case management staff should take into consideration client strengths and encourage active client participation to promote empowerment. Family members as identified in the service plan, also take part in service acquisition. It is, however, for all service needs identified in the service plan, the responsibility of the Case Manager to ensure and/or perform the following activities:

- Contact providers, including support persons, by phone, in writing, or in person;
- Assist the client and family members in making applications for services and entitlements, including basic needs such as transportation, child care, food stamps, etc.;
- Confirm service delivery dates with providers and supports;
- Schedule multiple visits by family members on the same day if such scheduling better accommodates the needs of the family;
- Document services that aren't available or cannot be accessed;
- Obtain assurance from other care providers that services will be initiated, and confirm the delivery of these services;
- In conjunction with the client and other providers, determine and articulate the ongoing responsibilities of each provider;
- Advocate for services on behalf of the client, if the client is unable to advocate on his/her own behalf.
- Give other service providers accurate and complete information about the service(s) they are expected to provide and the services provided by others; and
- Assist the client to maintain optimal physical health and well being as defined by the client.

Coordination of service delivery involves frequent contact with providers and clients to ensure that services have been arranged and received. Guidelines for such contact include:

1. Upon determination of service need, assist client with any necessary applications, or forms that need to be completed if appropriate, and
2. Confirm approval of services to be provided and if possible set a date for service delivery, and
3. Continue contacts to attempt to confirm service delivery and quality, and
4. Provide immediate contact and follow-up for
 - a. Services targeted to children, and in certain cases adults, that are necessary to assure the immediate safety and health of that individual, and
 - b. Life-sustaining services that have been arranged through nursing or other home care referral, case management staff should coordinate with hospital or health center Case Managers to confirm receipt of services within 24 hours after agreed upon service delivery date.

Factors for consideration:
<ul style="list-style-type: none">• Family support• Available resources in the community
Client's Role:
<ul style="list-style-type: none">• To provide feedback to the Case Manager• To follow through on agreed upon tasks
Case Manager's Role:
<ul style="list-style-type: none">• Contact providers, including support persons, by phone, in writing, or in person• Assist the client and family members in making applications for services and entitlements, including basic needs such as transportation, child care, food stamps, etc.• Confirm service delivery dates with providers and supports• Document services that aren't available or cannot be accessed• Obtain assurance from other care providers that services will be initiated, and confirm the delivery of these services• In conjunction with the client and other providers, determine and articulate the ongoing responsibilities of each provider
Outcome Criteria:
<ul style="list-style-type: none">• Empowerment of client to participate in on-going activities• Mobilization of client resources• Identification of barriers to service delivery

Standard**Measure**

6.1 Implement client's service plan.

Documentation in client's record of progress toward resolution of each item in client's service plan.

6.2 Make appropriate referrals to address goals identified in service plan (e.g., housing services).

Documentation of referrals in client's record.

6.3 With consent of the client, identify and communicate on a regular basis with other service providers with whom the client may be working.

Documentation of communication or correspondence in client's record.

7.0 Monitoring and Follow Up

The objectives of monitoring and follow up are to:

- Ensure that clients are accessing needed referrals and services;
- Identify and resolve barriers clients may have in following through with their service plan;
- Reassess client needs and/or goals;
- Determine if clients are still in need of case management services; and
- Assist provider agencies to monitor caseloads more easily.

Monitoring is contact between the Case Manager and the client or representative, support persons and service providers. The purpose of these contacts is to assure that services are being delivered according to the service plan. Contacts may include encounters in the agency, home, hospital or outpatient department, and other community providers' office setting. Contacts may occur by phone, mail or in person. Any problems noted during monitoring contacts will be followed up immediately with the client, support person or provider, as needed, to address the problem. Case coordination with other service providers should be evident in the progress notes.

Greater frequency of contacts should reflect the client's needs. The schedules of HIV Case Managers should be flexible enough to allow for intense intervention when it is needed. Clients with whom a case management relationship has been established and who experience periods of stability, or for clients who are non-adherent to their service plan, and/or are lost to follow-up, may receive less intensive case management.

Although Case Managers will determine the extent of follow up, face to face or phone contacts will ideally occur one time monthly; in order for a case to be considered active, Case Manager contact with the client should occur at a *minimum* of every six (6) months. All case management clients should receive at least one home visit per year, as determined by client need. If the client refuses a home visit, Case Managers will attempt to schedule a face-to-face meeting with the client in another setting. Contacts may include, but are not limited to, such settings as at the Provider Agency, hospital or outpatient departments, and other community providers' office settings.

The client's progress in obtaining services will be noted, as applicable in the record. Documents needed by service providers in order to initiate services are completed and forwarded, and a copy placed in the record. Copies of service schedules for all services provided to the client shall be given to the client or family member.

Problems noted during monitoring contacts should be followed up immediately with the client, support person or provider, as needed, to address the problem. Monitoring and follow up also provides for the opportunity to reassess client needs, and review and revise the clients' care plan. Case coordination with other service providers should be evident and noted in the progress notes.

Factors for consideration:

- Service referrals that have been provided
- Outstanding social service needs
- Mental health status
- Substance abuse/usage
- Support system
- Housing status

Client's Role:

- To respond to telephone message and other attempted contacts
- To maintain scheduled appointments
- To initiate contact with the Case Manager when crisis occurs
- To ensure the Case Manager has appropriate contact information

Case Manager's Role:

- Schedule telephone and face to face contacts with case management clients
- To document case management contacts in the client file and database
- To provide crisis intervention as necessary
- To facilitate on-going discussion leading up to the termination process
- Facilitate a move toward independence for the client

Outcome Criteria:

- A proactive response to client crisis
- Improved access to social support services
- Improvement in quality of life among clients

Standard**Measure**

7.1 Contact is attempted with a client on a monthly basis, and is made at a minimum of every six (6) months.

Documentation in client's record of contact made either in person or over the phone.

7.2 Conduct client monitoring and follow-up.

Documentation of ongoing monitoring and appropriate follow-up in client's record.

7.3 Conduct at least one home visit per year, as determined by client's need.

Documentation that home visit was conducted in client's record.

Or, if client prefers not to have a home visit: documentation of refusal and attempts to meet client face to face in another setting are maintained in client's record.

8.0 Crisis Management

The objective of crisis management is to:

- Provide assessment and referral for acute medical, social, physical or emotional distress.

Crisis services may be needed for a variety of reasons, such as an emergency medical need, drug use, loss of housing, domestic violence or child abuse. Irrespective of the nature of the crisis, it is the responsibility of the Case Manager or provider agency to assist the client in obtaining the appropriate response to the situation, keeping in mind the need to maintain the client's dignity and rights to privacy and confidentiality. In addition, the crisis interventions should be designed to decrease inappropriate utilization of emergency rooms by targeting the response more appropriately to the identified crisis.

All incidents requiring crisis intervention shall be documented in the client record and reported to the Case Manager. The Case Manager, in turn, should review the service plan to determine what revisions, if any, are necessary to assist the client.

It is not envisioned that HIV/AIDS Case Management would provide client service 24 hours a day, seven days a week. However, case management programs are encouraged to take steps to promote the accessibility of its services and the efficient referral to the proper emergency resources. These steps may include, but are not limited to:

- HIV/AIDS Case Managers should contact their offices at least once a workday for messages.
- If a case management agency has two or more Case Managers, they should work out a coverage schedule between themselves for crisis intervention.
- Case Managers should supply their office with an itinerary in case of client crises and for their own safety.
- Case Management Programs may schedule walk-in times (no appointment necessary) for quick access to a Case Manager.
- Case Managers should include Crisis Helpline numbers on answering machine or voice mail messages.
- Case Managers may provide at-risk clients with a customized listing of Emergency Service Providers, depending upon the life situation and potential emergency needs of those clients.

Crisis intervention planning can be an important part of a client's service plan. The client record should reflect consideration of specific responses for each type of intervention that may be necessary in the particular case. The plan should contain instructions for clients on how and when to identify the appropriate crisis response for a given emergency need. These responses should be discussed with the family and informal caregivers as well. The agency should take steps to assure that crisis services are utilized only when necessary.

Standard**Measure**

- | | | |
|-----|---|--|
| 8.1 | Case Management Programs will institute steps to provide maximum access to information about emergency resources. | Site visits
Documentation in client files
Client surveys |
| 8.2 | Case Managers will document incidents requiring crisis intervention, including client success or failure in accessing emergency services. | Documentation in client files |

Factors for consideration:

- The nature of the client crisis
- The ability/skills of the Case Manager to handle the clients crisis
- The resources available in the community to address the crisis
- Client strengths/resources to manage the client crisis

Client's Role:

- To notify the case management organization of the crisis

Case Manager's Role:

- Assist the client, family, or co-resident in obtaining the appropriate response to the situation.
- Protect the clients right to privacy and confidentiality while handling the client crisis.

Outcome Criteria:

- Alleviation of client crisis

9.0 Discharge and Transition Planning

The objectives of discharge/transition planning are to:

- Ensure a smooth transition for a client no longer needing services at the provider agency;
- Accurately track only clients receiving active case management services; and
- Assist provider agencies to more easily monitor caseload.

Discussion on the termination of client services should begin at the time of intake. Re-entry procedures should be discussed with the client at the time of the intake and throughout the case management process.

Exit planning procedures are initiated when:

- the client expires;
- the client declines the case management services of them Ryan White Program;
- the client desires to be referred to a different Ryan White case management provider agency or other case management program that would meet their/family case management needs;
- the client will be institutionalized for greater than 30 days;
- the client fails to provide financial documentation within sixty (60) days of the client's initial intake into Ryan White funded case management services;
- the client relocates out of the case management agency's service area; or
- the client cannot be located after repeated documented attempts, or does not become engaged in service planning for six months.

A client may be discharged from case management services through a systematic process that includes a discharge or case closure summary in the client's record. The Case Management Supervisor must sign-off on all terminated files. The discharge/case closure summary will include a reason for the discharge/closure and a transition plan to other services or other provider agencies, if applicable. If client does not agree with the reason for discharge, s/he should be informed again of the provider agency's grievance procedure.

In all cases, Case Managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. For example, if a client were moving to another area, the Case Manager would ideally refer the client to an appropriate provider in that area; or if the client had to be discharged from services, the Case Manager may, as is appropriate to the circumstance, provide the client with a list of alternative resources.

Terminated files should be maintained in the agency for six (6) months in an inactive status and then archived for five (5) years.

Factors for consideration:

- Client accomplishes case management goals and objectives;
- Client becomes eligible for Medicaid Waiver;
- Client will be institutionalized for greater than 30 days;
 - The client declines the case management services of the Ryan White Program;
 - The client desires to be referred to a different Ryan White case management provider agency or other case management program that would meet their/family case management needs;
 - The client fails to provide financial documentation within sixty (60) days of the client's initial intake into Ryan White funded case management services;
 - The client relocates out of the case management agency's service area; or
 - The client cannot be located after repeated documented attempts, or does not become engaged in service planning for six months.

Client's Role:

- Discuss any concerns regarding termination with the Case Manager
- Participate in termination session with the Case Manager
- Contact the case management organization if additional services are needed after the case has been closed.

Case Manager's Role:

- Assess the clients readiness for termination
- Assess the clients ability to function independently
- Complete the termination summary for inclusion in the client file
- Provide information on direct access services that are still available to the service.

Outcome Criteria:

- Increased access to case management services by vulnerable populations
- Reduction in case load size
- More empowered case management clients.

Standard**Measure**

9.1 Discharge a client from case management services if any of the following conditions apply:

- client dies;
- client requests a discharge;
- a client's actions put the agency, Case Manager, or other clients at risk;
- client moves/re-locates out of service area; and/or;
- if after repeated and documented attempts, a Case Manager is unable to reach a client for six (6) months.

9.2 Implement plan for discharge and ensure client is connected with needed services.

Documentation of case closure in client's record.

Documentation of reason for discharge/case closure (e.g., case closure summary)

Documentation in client's record of all attempts that were made to reach the client.

Documentation in client's record (i.e., on case closure summary) indicating referrals or transition plan to other providers/agencies.

10.0 Re-Entry Procedures

The objective of re-entry procedures is to:

- provide a quick and efficient admission into full case management services for inactive clients experiencing a significant change in their life situation.

Some situations merit the speedy reclassification of a client file from a closed or inactive state to one of full case management. One example is a previously stable, high functioning client who has experienced a drastic change in his/her physical or financial condition. Another example is a client previously lost to the system who reappears with immediate and critical needs. Re-entry procedures allow for a quicker response to these types of clients under proscribed circumstances.

- If occurring less than 6 months since an intake or formal assessment was completed, re-entry may be completed with a minimum of paperwork. The circumstances of the re-entry should be noted in the progress notes, and the appropriate changes to the service plan should be made.
- If occurring 6 months or later than the last intake or formal assessment, re-entry into service requires a thorough update of intake and assessment information. Again, the circumstances of the re-entry should be noted in the progress notes.

Individuals should be provided with information on the process of re-entry at the time of initial intake.

Standard**Measure**

10.1 Case Managers will explain the process of termination and re-entry to clients at the time of initial intake.

Review of client files.

10.2 Case Managers will update the intake and assessment forms for clients re-entering full case management services after a period of 6 or more months of inactivity.

Review of client files.

Factors for consideration:

- Changes in the client functional status
- Loss of housing
- Clients need for on-going service versus short-term case management
- Changes in the clients support system

Client's Role:

- To contact the case management organization to notify of the need for continuing services
- To provide updated information (i.e., demographics, contact information, changes in status, primary care needs etc.)
- Maintain scheduled appointments to complete the re-entry process.

Case Manager's Role:

- To complete necessary paperwork to facilitate re-entry into the case management system.
- Re-assess the level of case management that is necessary to meet the client's needs.
- Review available resources and make referral to service as appropriate.
- Document all referrals and services provided to the clients.

Outcome Criteria:

- Increased access to case management services by vulnerable populations
- Reduction in case load size
- More empowered case management clients.