HIV COMMUNITY SERVICES PROGRAM

Support Services Guide

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SECTION 1: Program Policies

PROGRAM PRIORITIES

The program follows the core medical services requirement of the HIV/AIDS Bureau (HAB) of the Health Services and Resources Administration (HRSA), the federal administrative agency of the Ryan White HIV/AIDS Treatment Extension Act of 2009. HRSA requires that Ryan White Program grantees assure that the core medical services are adequately met before spending resources on other support services. Per HRSA policy, remaining funds may be spent on support services. **Services funded by the HIV Care and Treatment Program*

Core Medical Services	Support Services
• Outpatient/Ambulatory Health Services • AIDS Drug Assistance Program Treatments * • AIDS Pharmaceutical Assistance • Early Intervention Services • Oral Health Care* • Health Insurance Premium and Cost Sharing Assistance • Home Health Care* • Home and Community Based Health Services • Hospice Service • Mental Health Services* • Medical Nutritional Therapy* • Medical Case Management, including Treatment Adherences* • Substance Abuse Care (Outpatient)*	• Non-medical Case Management* • Child Care Services • Pediatric Development Assessment • Emergency Financial Assistance* • Food Banks/Home Delivered Meals • Health Education/Risk-Reduction • Housing* • Other Professional Services • Linguistic Services* • Medical Transportation Services* • Outreach Services • Psychosocial Support Services* • Referral for Health Care/Supportive Services • Rehabilitation Services • Respite Care • Substance Abuse Services (Residential)*

Additionally, the program is committed to developing and maintaining an HIV Continuum of Care that meets the Ryan White Program principles. The Ryan White Program is intended to:

- Assure that all persons with HIV/AIDS have access to appropriate and high-quality health, medical care, and other related and required support services.
- Coordinate services with other health care delivery systems, thus ensuring that available resources are expended in a matter such that efficiency, effectiveness, and accountability are optimized, both with the Ryan White Program and across other delivery systems.
- Revise systems as needed to meet emerging needs.
- Evaluate the impact of Ryan White Program funds and make improvements as needed.

CAREWARE

It is required that all case management and support service units related to each actively enrolled client must be entered into the CAREWare data system per the Oregon CAREWare User Guide. Unduplicated units of service provided on behalf of the Ryan White program, including staff meetings, trainings and/or conducting administrative activities on behalf of all clients must be reported on the Quarter Report Form.

GENERAL PROGRAM REQUIREMENTS

1. Services must be provided in accordance with OAR 333-022-2000.
2. Ryan White Program funds must be used as dollars of last resort. No expenditures will be incurred with Ryan White Program funds for any item or service which can be reasonably paid through medical insurance, or other state, federal or private benefits programs. However, use of Ryan White Program funds may be allowable when significant access or other barriers are identified and documented in the client file. Veterans and Native Americans are exempt from the payer of last resort policy. They are not required to seek medical services from the entitlement programs they qualify for (i.e. VA and Indian Health Services) and may receive eligible medical services through the Ryan White Program.
3. Affected family members or partners of HIV positive clients are eligible for some services in the following circumstances:
    - The service's primary purpose enables the non-infected individual to participate in the care of someone with HIV disease or AIDS.
    - The service enables the infected individual to receive needed medical or support services by removing an identified barrier to care.
    - The service promotes family stability for coping with the unique challenges posed by HIV/AIDS.
4. There is no income requirement to receive HIV case management services and no charges are imposed. It is the intent of the program to ensure access and retention in services necessary to maintain HIV medical care regardless of income.
5. Use of Ryan White Program funds for emergency assistance must be for limited amounts, limited use, and limited periods of time: provider(s) will be expected to establish clear eligibility standards for access to assistance and a limit for the amount of assistance a client may receive. Generally, emergency assistance should not be provided for more than 3 months total in a 12 month period of time.
6. Clients with unconfirmed diagnosis or whose eligibility hasn't been determined, are only eligible for Ryan White funded medical case management, psychosocial case management/care coordination and medical transportation services to connect with medical care or Medical Case Management services until the HIV diagnosis is confirmed.
7. In no case may Ryan White Program funds be used to make direct payments of cash or checks to a client. Where direct provision of the service is not possible or effective, store gift cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or

transportation) must be used. Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the Ryan White Program are allowed as incentives for eligible program participants. RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment.

8. Stored value cards and other items allowed per this guidance may be purchased in bulk and dispersed to clients as needed. Bulk purchases are intended to be utilized in the same fiscal year they are purchased. Therefore, quantity projections must be considered when making bulk purchases. Any remaining items left over at the end of the fiscal year must be reported to the program on the Quarter 4 Administrative Fiscal Form, under the section explaining discrepancies between total expenditures reported and the data entered in CAREWare. If purchasing items in bulk, the service should be recorded in the client's CAREWare record at the time provided, including the cost of the service provided.
9. The Ryan White Program is a needs-based program; clients with the highest needs receive the greatest amount of service. Additionally, clients are not required to participate in case management if they do not require any Ryan White Program services. The Ryan White Program is not a federal entitlement program.
10. Clients receiving only CAREAssist services are not required to be in case management unless specifically required by the CAREAssist program. However, clients receiving Oregon Housing Opportunities in Partnership (OHOP) housing assistance services must be enrolled in case management as a requirement of program eligibility.
11. Service expenditures are expected to meet the minimum assessed need for the client. If the HIV case manager is faced with authorizing a basic service/item versus a more costly service/item that serves the same purpose, the HIV case manager should select the basic service/item.
12. Ryan White Program funds may not be used to pay for professional licensure or meet program licensure requirements.
13. In no case may funds be used to pay any client bill that has gone to collections. Payments can be made on past due bills as long as the client is

eligible for services at the time of payment and the bill is less than 12 months old.

14. Ryan White Program funds may not be used to pay for off-premise social or recreational activities (i.e. movies, vacations, gym membership, parties, or retreats).
15. Every Ryan White Part B Program must be in compliance with the State requirements for a Release of Information (as required under ORS 192.518-192.524) in which a client authorizes in writing the disclosure of certain information about his/her case to another party (including family members).
16. All support service payments must be directly linked to documented need. Authorizing support service payments for one service to offset the client-identified need, which is either a disallowed service or for which the client has reached the service category cap, is not allowed. In other words, cost-shifting client expenses to offset a disallowed or "maxed" out service is not allowed.
17. Ryan White support services cannot be provided to persons incarcerated in a local, State or Federal correctional facility. Case management and/or care coordination for purposes of transition into the community is allowable.
18. Eligible clients can receive services regardless of immigration status.
19. Per HRSA policy, funds awarded under the Ryan White Part B Program may NOT be used for:
    - Inpatient Hospital Services: Funds may not be used to assist with inpatient care.
    - Clinical Trials: Funds may not be used to support the costs of operating clinical trials of investigational agents, treatments (to include administrative management or medical monitoring of patients) or the cost of transportation and travel for a client's participation.
    - Pre-Exposure Prophylaxis: Funds may not be used to purchase antiretroviral medication for HIV negative people.
    - Clothing: Purchase of clothing.
    - Detox: Inpatient detoxification in a hospital setting (Detoxification offered in a separate licensed residential setting is allowed, including a separately-licensed detoxification facility within the walls of a hospital, see Substance Abuse Services).
    - Funerals: Funeral, burial, cremation, or related expenses.
    - Household Appliances: Household appliances.
    - Mortgages: Payment of private mortgages.

- Medical Marijuana: For application fees, or any other cost associated with prescribed medical marijuana.
- Pets: Pet foods, products or veterinary visits. (Expenses for licensed guide dogs are allowable, see Medical Emergency Financial Assistance: Health Aids.)
- Taxes: Paying local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Vehicle Maintenance: Direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees.
- Water Filtration: Installation of permanent systems of filtration of all water entering a private residence. (Water filtration/purification devices (either portable filter/pitcher combinations or filters attached to a single water tap) are allowable under Psychosocial Emergency Financial Assistance: Supplemental Food Assistance, in communities/areas where recurrent problems with water purity exist and are documented. Such devices (including their replacement filter cartridges) purchased with Ryan White HIV/AIDS Program funds must meet National Sanitation Foundation standards for absolute cyst removal of particles less than one micron.)

CLIENT ELIGIBILITY

1. Client must have a verified HIV diagnosis.
2. Client must reside in the Ryan White Part B HIV case management service area where the client is seeking services, unless authorized by the HIV Community Services Program.
3. To qualify for Ryan White Program financial assistance, a client must be enrolled in HIV case management and their gross income must be verified at **or below 250% of Federal Poverty Level (FPL)**. Case Management (medical and non-medical) are exempted from this requirement.

At intake and annually thereafter, every client is required to complete a Client Eligibility Review form. Client eligibility must also be verified every six months through self-attestation and/or submission of appropriate documentation for information that has changed.

Verification of HIV Diagnosis

Proof of an HIV diagnosis is only required at the initial Intak**e**, and must be verified within 30 days of intake by a physician or lab result.

1. Documentation of HIV status must include at least one of the following:
    a. A current CAREAssist card or a copy of the CAREAssist Eligibility Report in the client file.
    b. Written verification of test results that confirm an HIV diagnosis sent directly from a lab or physician.
    c. Lab results at any time during the client's lifetime that show detectable HIV RNA sent directly from a lab or physician.
    d. Written verification from another HIV case manager who has one of the above documents in the client's file.
    e. Written verification of a test result that shows an unconfirmed preliminary positive HIV test result.
2. For clients with an unconfirmed preliminary diagnosis:
    a. HIV Case Management contractors should have a memorandum of understanding or agreement with key medical providers in their service area to facilitate the timely linkage of clients into HIV medical care. The receiving medical practice must be informed of the individual's unconfirmed preliminary positive HIV test and the urgent need for confirmation.

b. The client should be counseled about the likelihood of infection and real (though small) possibility of a false positive result.
c. Written verification of a confirmed HIV diagnosis must be included in the client file when obtained.

Verification of Identity

Identity may be verified for an individual by providing one of the following:

(a) Oregon Driver License;
(b) Tribal identification (ID);
(c) State of Oregon ID card;
(d) Military ID;
(e) Passport;
(f) Student ID;
(g) Social Security Card;
(h) Citizenship/Naturalization documents;
(i) Student visa;
(j) Oregon Learner's Permit or Temporary License;
(k) Birth certificate; or
(l) Other form of verification determined appropriate by the Ryan White Part B case management agency

Verification of Residence

Documents that verify that an individual resides in the HIV case management service area include but are not limited to documents with the client's full legal name and an address, within the service area, that matches the residential address provided during the intake. Residence may be verified by any of the following documents:

- Current CAREAssist Card or copy of the CAREAssist Eligibility Report
- Unexpired Oregon State driver license**,** Tribal ID or Oregon State ID
- Utility Bill (including cell phone)
- Lease, rental, mortgage or moorage agreement/document
- Current property tax document
- Current Oregon Voter Registration card
- Letter from lease holding roommate (must include the lease holder's name, address that matches the CAREAssist Application and/or HIV Community Services Intake Form, relationship to the client and the lease holder's phone number)
- Copy of public assistance/benefits letter/documentation (SSI, SSDI, TANF, etc.)
- Paystubs
- Court Corrections Proof of Identity
- Homeowner's association statement
- Military/Veteran's Affairs documents
- Oregon vehicle title or registration card
- Any document issued by a financial institution that includes residence address, such as, a bank statement, loan statement, student loan statement, dividend statement, credit card bill, mortgage document, closing paperwork, a statement for a retirement account, etc.;
- Approved letter from Oregon State Hospital, homeless shelter, transitional service provider or halfway house
- Letter on company letterhead from an employer certifying that the client lives at a non-business residence address owned by the business or corporation.

Verification of Insurance

Insurance may be verified for an individual by providing proof of coverage for:

- CAREAssist (CAREAssist Card and a copy of the CAREAssist Eligibility Report)
- Qualified Health Plan (QHP)
- Medicare
    - Part A
    - Part B
    - Part D
    - Low Income Subsidy
    - Qualified Medicare Beneficiary
- Oregon Health Plan (Medicaid)
- Private
    - Purchased outside Health Exchange
    - Group Policy (employer or spouse/parent's employer)
    - COBRA
    - Dental Insurance
- Other Public
    - VA Benefits[1]
    - Indian Health Services[2]
- No Insurance

Verification of Income

Although there is no income eligibility requirement In order to be eligible for case management/care coordination services, household income must be at or below 250% of the Federal Poverty Level to receive any other core medical or supportive services. An individual must submit appropriate income verification documentation for all family members and from all sources to determine total monthly income for a family.

There are 5 steps to determining income eligibility.

[1] Veterans are not required to seek medical services from these services under the Ryan White "funds of last resort" requirement and may receive eligible medical services through the Ryan White Program.
[2] Native Americans are not required to seek medical services from these services under the Ryan White "funds of last resort" requirement and may receive eligible medical services through the Ryan White Program.

Topic	Guidance
Step #1: Determine whether client is pre-qualified	If a client is active in CAREAssist, and CAREAssist has determined client's income is at or below 250% of the FPL, they are pre-qualified. To be pre-qualified, proof of current participation in the CAREAssist Program must be obtained during the original Intake and at every 6 month review.
Step #2: Determine family members	A family is defined as a group of two or more persons related by birth, marriage, adoption, or a legally defined dependent relationship (see "Dependent Status Policy" below). Life partner, significant other, legally registered Domestic Partner, or roommate (with no children in common) is not counted as family for purposes of income verification. Please note CAREWare uses the term "household" for the family definition described above. Also, the family/household definition described here is not the same as the definition of household used by the OHOP program.
Step #3: Determine allowable documentation	All income, produced by all dependents, must be declared as part of the household income. The following are the most commonly presented types of documentation: • Social Security award letter (current year) • Copy of Social Security check • Year-end 1099 form • W2 fax form from employer • Federal income tax return • Accounting paperwork (spread sheet, financial journal, account books, etc.) • Bank statements showing automatic deposits • Pay stubs (2 months current consecutive paystubs or earnings statements for ALL jobs) See "Allowable Income Documentation" below for complete list of allowed income and verification documents.
Step #4: Calculate Gross Income	In most circumstances, gross income is used to determine eligibility. Gross Income is total income BEFORE any taxes or other withholdings are deducted. Net Income is also known as "take home" income, or income AFTER taxes and withholdings are deducted. Net income may only be used when: (i) A self-employed individual or the individual's family member files an Internal Revenue Service, Form 1040, Schedule C in which case the agency will allow a 50 percent deduction from gross receipts or sales; or (ii) An individual or individual's family member has income from rental real estate and provides a copy of the most recent year's IRS Form 1040 (Schedule E). In this case the

	agency may use the total rental real estate income, as reported on the Schedule E. If the Schedule E shows a loss, the applicant or applicant's family member shall be considered to have no income from this source. Because annual income will vary based upon whether or not the client is paid hourly, weekly, bi-weekly, or twice a month, see "Gross Monthly Income Determination" below for instructions on annualize.
Step #5: Identify the Federal Poverty Level	Determine an applicant's income by adding together all sources of family income, and dividing that number by the applicable FPL. The resultant sum is the applicant's percentage of the FPL. To qualify for Ryan White Medical/Supportive services, a client's gross income can be no more than 250% of the FPL. All clients can receive case management/care coordination services regardless of income. *Please note: the CAREWare database will be updated after the poverty level changes take effect each year (March 1st); however, it can take some time to do so.*

Dependent Status Policy

Dependent family members are defined as those persons for whom the head of household has a legal responsibility to support.

- Dependent relationships include legal adoptions and guardianships.
- Dependent child status shall not extend beyond age 19, except when the dependent child is enrolled as a full-time student (min. 12 credit hours). In the case of student status, the age at which the dependent child status shall end is age 26. The client must attach documents to show that the child is enrolled in an educational institution and must be submitted with re-assessment.
- All claimed dependents, must appear on the client's Federal and State Income Tax Return for the most recent year.
- Clients may not claim dependent status for individuals who reside outside the United States, unless those persons are listed on his/her most recent Federal Tax Returns filed; and there is a judicial ruling in the United States that defines a legal relationship and dependent status.
- All persons 19 or older (who are not covered by the student status extension, and whom the head of household is claiming dependent status)

must be named specifically in a legally defined Guardianship Relationship approved by a U.S. Judicial proceeding. NO exceptions will be made to this requirement. Notarized copies of documents must be made available upon request to the program.

- Adults (i.e. elderly parents, disabled adult child, etc.) are approved dependents if the client has verifiable legal guardianship.
- In cases of joint custody, a child must live with the client 51% of the time in order to be included in the household.

Allowable Income Documentation

Income may be verified for an individual by providing any of the following applicable documents:

- Current CAREAssist Card or a copy of the CAREAssist Eligibility Report
- Work Income (Overtime pay, tips, bonuses, and commissions are all counted)
- Long Term Disability/all disability payments
- Self-employment income
- Pension / Retirement income
- Unemployment insurance income
- Child support
- Alimony
- Social Security Income (SSI)
- Social Security Disability Insurance (SSDI) (Income is "income **before"** the Medicare Part B is deducted)
- Income from interest paid by savings/checking accounts
- Survivor benefits
- Annuities
- Stocks, bonds, certificates and all other investments, if they pay dividends
- Rental properties (includes sublet of portions of the client's primary residence)
- Inheritance
- Life insurance payments
- Viatical payments
- Regular funds from friends and family.
- Scholarships/grants (Loans and Pell Grants excluded)

- Payments from a trust
- Affidavit of no income

Gross Monthly Income Determination

The following are program criteria for determining gross monthly income:

- **Employed clients:** Annual income, divided by 12 months, is used for clients who have been employed by the same employer for at least 12 months. If annual income doesn't reflect current and future earnings, average per pay period can be used. There are:
  - 2080 work hours in a year
  - 52 weeks in a year
  - 26 every-other-week pay periods
  - 24 twice-a-month pay periods

• If in the same job since the beginning of the year:	Refer to the year-to-date (YTD) total, then divide by the months, and percent of partial months, represented on the pay stub.	Example: Client X has a pay stub showing a pay date of June 15 and a YTD of $10,000. Divide the YTD amount by 5.5 months: *$10,000 divided by 5.5 months equals $1,818.18 per month.*
• If there is an hourly rate:	Calculate both the monthly income based on the YTD amount listed on their pay stub, described above, and annualize the hourly rate to find the monthly income to the client's best advantage.	Example: Client X makes $11 per hour. Calculate BOTH a YTD total AND multiply $11 x 2080 work hours per year which equals an annual income of $22,880. Then divide the annual income of $22,880 by 12 months which equals $1,906.67 per month.
• If the client has received a one-	This should be included in the ANNUAL salary (not YTD). To determine monthly income of total,	

time, annual bonus:	divide by 12 months. Proof of the one-time status of the bonus may be necessary.	
• If the client is paid twice-a-month OR every-other-week:	Carefully check the pay stub to determine which factor to calculate when determining annual income – 24 pay periods per year for twice-a-month and 26 pay periods per year for every-other-week.	
• If there is a discrepancy between the monthly rate based upon YTD and the monthly rate stated on the pay stub or by client:	The monthly rated based upon YTD is calculated by dividing the YTD amount on the pay stub by the number of months in the total pay period. If this monthly rate is different from the monthly rate stated on the pay stub or if the client stated a different pay rate, further investigation will be warranted. This usually indicates a change in client status. They may have experienced a reduction in hours, began working part-time or were laid off - if the YTD monthly is less than the stated monthly. They may have worked some extra overtime or had a special circumstance which is not going to continue - if the YTD monthly is more than the stated monthly.	

- **Seasonal work:** Annual income based on documented seasonal trending is used for clients who can prove seasonal employment. Seasonal employment often means income is generated during certain time periods, which may or may not be over the limit during that time period, but when annualized over 12 months is within limits. Again, the client's ability to document their earning "trend" is important and can be verified by looking at the client's previous year's federal income tax return.

- **Self-employed clients:** The client's ability to document their earning "trend" is important and can be verified by looking at the client's previous year's federal income tax return. A self-employed applicant or the

applicant's family member should provide a copy of the most recent year's IRS Form 1040 (Schedule C) in which case the Authority may allow a 50 percent deduction from gross receipts or sales.

- **Change in income or where there are no trends in income:** Annual income shouldn't be used for clients who experience frequent changes in income. Within reason, the program attempts to "look forward" in income assessment. The current monthly income should be used to determine eligibility.

- **Rental income** Net rental income will be used when the client submits the most recent year's Schedule E. If net income on the Schedule E is a negative amount, CAREAssist will consider this as zero income from this source. Without a Schedule E, gross rental income will be used.

Deductions

- Do not take into account garnished wages, liens, child support payments and the monies garnished from monthly SSDI awards, to include reimbursement of previous Social Security overpayments.

- Gross income includes the amount that is deducted from Social Security checks for Medicare Part B.

- Food stamps are not considered income.

SIX MONTH ELIGIBILITY DETERMINATION

Client eligibility must be verified every six months. If the client is a current CAREAssist client, the Six Month Self-Attestation Form and a copy of the CAREAssist Eligibility Report from within the past year (365 days) must be included in the client file

For clients who are not current CAREAssist clients at the six month review, clients may self-attest via telephone or in person and the Six Month Self-Attestation Form must be completed. For a telephone self-attestation, the person taking the information from the client signs the form. For in-person self-attestation, the client signs the form and a witness to the client's signature must sign the form.

- If there are no changes to residence, income or health insurance, nothing further is required.
- If there are changes to residence, income or health insurance, required documentation must be submitted and attached to self-attestation form.

Verification of Residence
If the client's address has changed, enter the new address and attach approved documentation.

Verification of Income
If the client's income has changed, enter the new income and attach approved documentation:

- 2 months current, consecutive paystubs or earnings statements for all jobs
- Most recent tax returns or 3 consecutive months business records
- Social Security letter
- Benefit award letter or annual benefit statement
- Other documentation

If the client now has no income (and that is a change), the client would complete the "No Income Affidavit" on Page 4 of OHA 8395.

Verification of Insurance
If the client's insurance has changed, check the appropriate box and attach allowable documentation:

SECTION 2: Locally Managed Services

MEDICAL CASE MANAGEMENT, INCLUDING TREATMENT ADHERENCE

Description:

Medical Case Management is the provision of activities focused on improving health outcomes in support of the HIV care continuum. Medical case management provides a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial supports, and other services. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. 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. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized care plan; (3) coordination of services required to implement the care plan; (4) continuous client monitoring to assess the efficacy of the plan and adaptation of the care plan, at least every 6 months, and as necessary during the enrollment of the client. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Program Guidance:

Case management activities under this category are provided by a licensed Registered Nurse or Nurse Practitioner. Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services. Telephone voicemail left for clients are not reportable as a Medical case management service visit. Staff should follow Agency policy regarding leaving a client voicemail.

Reporting Requirement:

Unit: 15 minutes
Report in CAREWare under Medical Case Management sub services.

Telephone voicemail are reported as: RN Attempt Clt. Contact.

MEDICAL NUTRITION THERAPY

Maximum Allowable (per Fiscal Year, July-June): $2500 per client per year total for all sub-services in this category.

Description:
Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

Program Guidance:
All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. When available, medical insurance should be billed prior to local services.

This service must be provided by a registered dietitian who is licensed to provide the service. The service should include: (a) an initial nutrition assessment, (b) development of a therapeutic diet based upon the client's needs and preferences, (c) development of a Medical Nutrition Plan, (d) the provision of Medical Nutrition Therapy (individual and/or group) and (e) a nutrition re-assessment to include an update of the Medical Nutrition Plan, as appropriate.

Food and nutritional supplements may be provided under this category if: (a) there is a written physician recommendation for food and/or nutritional supplements; (b) food and/or nutritional supplements are identified as needed in the Medical Nutrition Plan by the dietitian and (c) food and/or nutritional supplements are provided by the dietician as a part of the service plan.

A copy of the most current Medical Nutrition Plan, developed by the licensed registered dietitian, must be included in the client's chart and there

must be documentation of case conferencing between the Medical Case Manager and the licensed registered dietitian at a minimum of every 3 months during the time the client is receiving this service. If a client is receiving vouchers for food within this service, they should only be covered by Medical EFA: Nutrition Support.

See Appendix A: Ryan White Funded Food Services Quick Guide for more information.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Medical Nutrition Therapy"

MENTAL HEALTH SERVICES

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

Program Guidance:
This service is not available to "affected" family members. When available, medical insurance should be billed prior to local services.

Maximum Allowable (per Fiscal Year, July-June): $6500 per client per year.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Mental Health Services"

SUBSTANCE ABUSE OUTPATIENT SERVICES

Maximum Allowable (per Fiscal Year, July-June): $5000 per client per year for Substance Abuse Outpatient Services

Description:

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include screening and assessment, diagnosis, and/or treatment of substance use disorder, including pretreatment/recovery readiness programs, harm reduction, behavioral health counseling associated with substance use disorder, outpatient drug-free treatment and counseling, medication assisted therapy, neuro-psychiatric pharmaceuticals, and relapse prevention.

Program Guidance:

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program, it is included in a documented plan. When available, medical insurance should be billed prior to local services.

Reporting Requirement:

Unit: Payment
Report in CAREWare under "Substance Abuse Outpatient"

SUBSTANCE ABUSE SERVICES (RESIDENTIAL)

Maximum Allowable (per Fiscal Year, July-June): $5000 per client per year for Substance Abuse Services (Residential)

Description:

Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes: Pretreatment/recovery readiness programs, harm reduction, behavioral health counseling associated with substance use disorder, medication assisted therapy, neuro-psychiatric pharmaceuticals, relapse prevention, detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) are permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program. Acupuncture therapy may be allowable under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the RWHAP. RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license. This service is not available to "affected" family members. When available, medical insurance should be billed prior to local services.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Substance Abuse Residential"

HOME HEALTH CARE

Maximum Allowable (per Fiscal Year, July-June): $2000 per client per year <u>total</u> for both Professional/Specialized and Paraprofessional Home Health Care.

Description:
Home Health Care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include:
• Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
• Preventive and specialty care
• Wound care
• Routine diagnostics testing administered in the home
• Other medical therapies

Program Guidance:
This service is not available to "affected" family members. When available, medical insurance should be billed prior to local services.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Home Health Care"

NON-MEDICAL CASE MANAGEMENT

See Standards of Service document appropriate for the service area (county based or regional) for more information.

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

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

Program Guidance: Activities provided by someone who is recognized as a case manager/care coordinator but who does not meet "Nurse" definition includes any case management contact and/or activity with or on behalf of the client. This includes phone contacts with the client and/or his or her representatives and contact of any kind with social service providers on behalf of the client. Ancillary activities related to the case management performed for a client, include, but are not limited to visit preparation, chart notes, data entry, and written referrals, are reported here. Telephone

voicemail left for clients are not reportable as a non-medical case management service visit. Staff should follow Agency policy regarding leaving a client voicemail.

Reporting Requirement:
Unit: 15 minutes
Report in CAREWare under Non-medical Case Management sub-services. Telephone voicemail are reported as: Non-RN Attempt Clt. Contact.

MEDICAL EMERGENCY FINANCIAL ASSISTANCE

Maximum Allowable (per Fiscal Year, July-June): $1500 per client per year total for all sub-services in this category.

MEDICAL ACCESS

Description: The provision of temporary financial assistance to maintain access to necessary medical care for the treatment of HIV infection. Such care must ensure access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections. This service is only intended for short-term access to medications, medical insurance and medical services not otherwise covered by insurance.

Program Guidance:
Any service authorized under the category must coincide with an application/referral to CAREAssist. Prescription medications may not be purchased with support service funds unless documentation can be provided that the client is not eligible for CAREAssist/Bridge Program/UPP, or extenuating circumstances apply. It is recommended that the case manager pursue pharmaceutical company patient assistance programs as an alternative to paying for HIV specific prescription medications with local Ryan White funds. Documentation that the client is not eligible for CAREAssist must include, at a minimum: (1) a denial or restricted letter from CAREAssist or (2) notation of the reason(s) the client is not eligible for CAREAssist in the progress notes in the client's file.

Health Insurance premium payments are allowed only under the following circumstances.

- Documented emergency only
- Onetime payment only
- One payment per client per fiscal year (July-June)
- You must contact CAREAssist to find out about Health Insurance coverage options.

Reporting Requirements:
Unit: Payment
Report in CAREWare under "Medical Access"

EYE CARE

Description:
Services rendered by an Optometrist, Ophthalmologist or Optician.

Program Guidance:
This service category includes corrective prescription eyewear once every two (2) years. Contacts are not covered in this service category unless prescribed as medically necessary by a licensed professional. Insurance must be billed if applicable.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Eye Care"

HEALTH AID

Description:
An assisting device, which is beneficial to physical health. This may include adherence aids (including planners, pill reminders, pill splitters, alarms, and electronic reminders delivered by SMS, phone or email), and medical devices (such as crutches, slings, certified guide dog expenses, etc.) and hearing aids. Medical equipment (and supplies) may include diabetic supplies, respiratory equipment (CPAP, BiPAP), oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies. Notes: Denture replacement or realignment is covered under Oral Health Care.

Program Guidance:

Insurance must be billed if applicable.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Health Aid"

NON-PRESCRIPTION MEDICATIONS

Description:
Primary medical provider approved over-the-counter, non-prescription pharmaceuticals/ medications, including vitamins and supplements

Program Guidance:
Use of non-prescription medications must be recommended by the client's primary care provider or pharmacist.

Reporting Requirement:
Unit: Medication
Report in CAREWare under "Non-prescription medication - EFA"

NUTRITIONAL SUPPORT (RN AUTHORIZED)

Description:
A card/voucher that cannot be converted to cash, allowing a client to purchase food and/or supplemental products. The voucher should clearly state that purchase of alcohol and tobacco products are not allowed. *Note: A voucher can also be defined as payment to a store on behalf of a client.*

Program Guidance:
Food cards and vouchers under this category must be authorized by the RN case manager as a part of the client's nutritional assessment and be included as a part of the client's care plan. Documentation of a current (within the past 12 months) Nurse Assessment and identification of nutritional needs and goals must be included in the client's Care Plan. Food/supplements provided under this category should be provided to a client with specific instructions for maintaining nutrition/overall health based on the RN assessment of need (i.e. client needs high protein food, low sodium, high fat meals, etc.).

Please see "Supplemental Food Assistance" for information on how to assist clients who are not determined to have a nutritional need for specific food products but that still need supplemental food assistance. Clients who are receiving this service, should not simultaneously receive Supplemental Food Assistance. See Appendix A: Ryan White Funded Food Services Quick Guide for more information.

Reporting Requirement:
Unit: Card or Voucher
Report in CAREWare under "Nutritional Food Voucher"

PSYCHOSOCIAL EMERGENCY FINANCIAL ASSISTANCE

Maximum Allowable (per Fiscal Year, July-June): $1000 per client per year total for all sub-services in this category.

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

Program Guidance:
Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

SUPPLEMENTAL FOOD ASSISTANCE

Description:
A card/voucher that cannot be converted to cash, allowing a client to purchase food products and groceries (including hygiene products) necessary to maintain health.

Program Guidance:
Documentation that clients have exhausted other food services prior to authorization (i.e. food banks, food stamps) must be in the client's chart. The voucher should clearly state that purchase of alcohol and tobacco products are not allowed. A voucher can also be defined as a payment to a store on behalf of a client. For clients who have been assessed by a RN to have a nutritional need for food assistance please refer to Medical Nutritional Therapy or Nutrition Support under Medical EFA. See Appendix A: Ryan White Funded Food Services Quick Guide for more information.

Reporting Requirement:
Unit: Card or Voucher
Report in CAREWare under "Supplemental Food Assistance"

UTILITIES

Description:
A service provided as an essential service to the health and welfare of a client; to include: heat, water, electricity, internet, garbage collection and telephone service. Cable and satellite television service are excluded.

Program Guidance:
Ryan White Program, Part B funds may only be used to provide assistance for the portion of the client's utility not covered through a utility subsidy. Utility assistance is NOT allowed for any client who has received full utility assistance through any other program.

Clients receiving public or private assistance such as, but not limited to, OHOP (HOPWA), Low Income Home Energy Assistance Program (LIHEAP) assistance, or any other publicly funded assistance specifically for the purpose of subsidized utilities, may be eligible for Ryan White Program assistance if:

- They have been assessed as having an emergency need;
- They provide current detailed documentation substantiating the amount of the subsidy for the particular utility requested;
- The utility bill is current; and

- The client's Care Plan includes goals that specifically address activities to assist the client in meeting their utility costs without emergency assistance from Ryan White Program funds.

The OHOP program has access to HOPWA and other resources that can often meet the short-term utility assistance needs of clients. Consult with your regional OHOP Housing Coordinator to determine that Ryan White Program funds are the only resources available to meet a client's utility assistance needs before using Ryan White Program funds for utility assistance.

Pre-paid phone cards, low-cost phone plans, or internet may be purchased under this category for the purpose of connecting clients to HIV care and treatment services (including for the purpose of accessing OHA approved self-management trainings or education groups). This includes the need to provide ongoing communication between the client and the Oregon Housing Opportunities in Partnership (OHOP) Housing Coordinator. For landlines, special telephone service features that cost a fee in addition to basic service (e.g. call waiting, caller ID, etc.) are not allowed. Long distance telephone calls and toll calls may be allowed in special circumstances if pre-approved by the client's case manager.

Clients should provide evidence of application for reduced rate phone or internet services (such as Assurance Wireless or SafeLink Wireless) and the state energy assistance programs. Ryan White Program, Part B Case Managers must pre-authorize any payment for client services. In no case may program funds be used to pay client bills in arrears.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Utilities"

OTHER- EFA

Description:
The provision of short-term payments to assist with emergency expenses.

Program Guidance:
With the exception of payment of fees to access form of identification (such as an ID or birth certificate), no other services are allowed under this

category without prior authorization from the HIV Care and Treatment Program.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Other - EFA"

HOUSING SERVICES

Maximum Allowable (per Fiscal Year, July-June): $1,500 per client per year total for all sub-services in this category.

Housing services provide limited, short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation. For long-term permanent housing services, see Section 5: Oregon Housing Opportunities in Partnership (OHOP).

Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

Program Guidance:
Use of Ryan White Program funds for short-term or emergency housing must be linked to medical and/or health care services or be certified as essential to a client's

ability to gain or maintain access to HIV-related medical care or treatment. Client's care plan must document the necessity for this service and must be linked to the client's ability to stay in medical care.
Additionally, at least one housing-related goal must be included in the client's Care Plan.

Ryan White Program Housing funds may not be distributed as direct cash payments to recipients for services. In no case may Ryan White Program funds be used to pay client bills in arrears. Additionally, Housing funds may not pay for: mortgage payments, recreational vehicles (RV), or any item that would increase the property value of the home (hot water heater, centralized heating and air conditioning, roof, vinyl siding, renovations, etc.).

RENT ASSISTANCE

Description:
The full or partial monetary amount paid by a tenant or occupant of a dwelling to the owner/landlord for use of the dwelling in which the eligible client resides as their primary residence.

Program Guidance:
The OHOP program has access to HOPWA and other resources that may meet the rent assistance needs of clients. Assist clients in completing an OHOP referral packet and consult with your regional OHOP Housing Coordinator to determine that Ryan White Program funds are the only resources available to meet a client's rent assistance needs before using Ryan White Program funds for rent assistance. In extenuating circumstances and upon approval by HIV Community Services, rental assistance for those in subsidized units may be approved when an identified gap is identified that impacts immediate housing stability or health outcomes. However, under no circumstances can funds be used to pay any portion of the federally funded portion of rent.

In a shared living situation, Ryan White Program funds may only be used to support that portion assigned to a client, based on the pro-rated portion of the private space used by the client in the rental unit (e.g. If a client shares a three-bedroom unit with two roommates, and has exclusive use of one of the three bedrooms, housing assistance funds may be used to support one-third of the total rental cost of the unit).

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Rent Assistance"

HOUSING-RELATED DEPOSITS

Description:
Any monetary deposits required to secure and maintain housing for a client. This category could include application fees, security deposits, cleaning deposits, last month's rent and utilities deposits (including telephone).

Program Guidance:
This category can also include application fees if the client is participating in the Oregon Housing Opportunities in Partnership Program (OHOP) or requires assistance in accessing other subsidy housing programs (e.g. Section 8 housing).

All refundable deposits must be returned to the agency paying the deposit, NOT directly to the client/tenant.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Housing-Related Deposits

RESIDENTIAL FACILITY

Description:
Housing services that include some type of medical or supportive service, including residential foster care and assisted living residential services.

Program Guidance:
Note that the OHOP program has limited access to HOPWA and other resources that can sometimes meet the residential facility needs of clients. Assist clients in completing an OHOP referral packet and consult with your regional OHOP Housing Coordinator to determine that Ryan White Program funds are the only resources available to meet a client's residential facility needs before using Ryan White Program funds for residential facilities.

Reporting Requirement:

Unit: Day
Report in CAREWare under "Residential Facility"

TRANSITIONAL HOUSING

Description:
Transitional short-term emergency housing such as motels or hotels for purposes of moving or assisting an individual or family into a long-term stable living situation.

Program Guidance:
The OHOP program does not have direct access to HOPWA or other resources that can meet the transitional housing needs of clients, but transitional housing assistance should be closely coordinated with planned access to long-term housing assistance for clients. Assist clients in completing an OHOP referral packet and consult with your regional OHOP Housing Coordinator to closely coordinate use of Ryan White Program funds for client's transitional housing needs with planned access to long-term housing assistance through OHOP and other housing resources.

Reporting Requirement:
Unit: Day
Report in CAREWare under "Transitional Housing"

MEDICAL LODGING

Description:
Includes lodging necessary when traveling to receive medical care.

Program Guidance:
Medical Lodging must be pre-approved by the client's HIV case manager and documentation of the medical appointment requiring the travel must be in the client's file. Generally, clients traveling for 2 hours or more and/or 100 miles or more are eligible for this service. It is strongly recommended that if comparable medical services are available locally that case managers work with clients to transition to a local medical provider.

Reporting Requirement:
Unit: Day
Report in CAREWare under "Medical Lodging"

LINGUISTIC SERVICES

Maximum Allowable (per Fiscal Year, July-June): $250 per client per year.

Description:
Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.

Program Guidance:
Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).Includes Provision of interpretation and translation services to include ASL (American Sign Language). Ryan White Program, Part B funded providers should identify translation services which are available to clients for all commonly spoken languages.

Reporting Requirement:
Unit: 15 Minutes
Report in CAREWare under "Translation Services"

MEDICAL TRANSPORTATION SERVICES

Maximum Allowable (per Fiscal Year, July-June): $750 per client per year total for all sub-services in this category.

Description:
Medical transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services, including access to OHA approved self-management trainings or education groups or during a housing search period for permanent stable housing.

Program Guidance:

Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Voucher or token systems;
- Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed).

PUBLIC TRANSPORTATION-SINGLE TRIP

Description: See Above

Program Guidance: None

Reporting Requirement:
Unit: Trip
Report in CAREWare under "Public Transport-single trip"

PUBLIC TRANSPORTATION-MONTHLY PASS

Description: See Above

Program Guidance:
Bus passes should be purchased under the local transit system's disability rate wherever possible.

Reporting Requirement:
Unit: Month
Report in CAREWare under "Public Transportation-monthly pass"

GAS CARD

Description: See Above

Program Guidance:
Mileage may not be reimbursed directly to a client and should not exceed established rates for Federal programs. The amount of the gas voucher/card should be based upon (1) number of miles estimated for the trip, divided by the (2) client-reported miles per gallon for their vehicle (if client does not know, the average is 15 miles-per-gallon), and multiplied by the (3) current market value of gasoline. (For example, client needs to visit specialist and the round trip is 150 miles. Divide 150 miles by 15 miles-per-gallon to equal 10 gallons of gasoline required for the trip. If the current market value is $3.50 for regular gasoline. The gas voucher/card should be for $35.00).

Reporting Requirement:
Unit: Card or Voucher
Report in CAREWare under "Gas Card"

TAXI FARE

Description: See Above

Program Guidance: None

Reporting Requirement:
Unit: One-Way Trip
Report in CAREWare under "Taxi fare"

OTHER SPECIAL TRANSPORT SERVICES

Description:
Conveyance services provided directly to a client by licensed Medical Transportation provider so that the client may access health care or support services. Includes cost of a rental car.

Program Guidance: If service is providing a rental vehicle, vehicle must be insured.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Other special transportation svcs."

ORAL HEALTH CARE

Maximum Allowable (per Fiscal Year, July-June): $1000 per client per year total for all sub-services in this category.

Description:
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
This service does include medications dispensed or administered during the course of the service visit. Denture replacement or realignment is covered in this category. Cosmetic procedure and restorations are not allowable unless they are necessary to alter, restore or maintain occlusion (close mouth) or nutrition. Exceptions may be made with program authorization for infants, children and youth. This service is not available to "affected" family members.

When available, dental services provided through dental insurance, Part F funded dental clinics and SMS should be utilized prior to utilizing local funds.

Reporting Requirement:
Unit: Visit
Report in CAREWare under "Dental Services"

PSYCHOSOCIAL SUPPORT SERVICES

Maximum Allowable (per Fiscal Year, July-June): $500 per client per year total for all sub-services in this category.

Description: Caregiver support

Program Guidance:
Caregiver support includes transportation assistance for primary caregiver, such as a spouse or partner, to visit client when hospitalized or in long-term care facility.

Reporting Requirement:
Unit: Payment
Report in CAREWare under "Psychosocial Services"

EXCEEDING SERVICE CAPS

Service caps are provided as a means of equitably managing the amount of service an individual client receives in a year, and is not intended to create a barrier for clients with a documented need for service. CAREWare Custom Reports are available to help you determine when a client might be exceeding the cap. Exceptions to the "Maximum Allowable" service caps can be made for clients who meet the following eligibility requirements

- Client's Care Plan includes activities specific to the service that will help the client meet the service need, without utilizing Ryan White funds, on an ongoing basis.
- The client has been assessed Acuity level 3 or 4 in the acuity life area that corresponds to the intended need.

Required Documentation

To document delivery of a service that exceeds the maximum service cap, complete the CAREWare "Service Cap" case note template using the same date as the recorded CAREWare service.

ORAL HEALTH CARE

Description:

Diagnostic, preventative, and therapeutic services provided by a dental health care professional licensed to provide health care, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained dental assistants. This service also includes medications dispensed or administered during the course of the service visit (prescribed medications must be paid for by local funds and reported under "Drug Reimbursement"). Denture replacement or realignment is covered in this category.

Program Guidance:

These funds are intended to be used to cover costs not billable to insurance or another payer. When eligible, clients must apply to CAREAssist dental insurance, and the insurance should be used. Ryan White Part F funded dental clinics could also be used prior to SMS. LCC Dental Clinic (in Eugene) and Russell Street Dental Clinic (in Portland) provide HIV specific comprehensive dental services Dental care provided by LCC or Russell Street is very cost effective. Clients should be referred to LCC or Russell Street Dental Clinics unless extenuating circumstances apply. Extenuating circumstances may include, but are not limited to, illness, pain, disability, family/work responsibilities, travel distance/weather and must be documented in CAREWare Case Notes.

Cosmetic procedure and restorations are not allowable unless they are necessary to alter, restore or maintain occlusion (close mouth) or nutrition. Exceptions may be made with program authorization for infants, children and youth. No show appointment charges and contractual adjustment fees charged by the provider after primary insurance are not allowed. This service is not available to "affected" family members. Clients residing in the HIV Alliance service area do not qualify for SMS dental services through this process and must use the locally managed process for service authorization.

Maximum Allowable (per Fiscal Year, July-June): Maximum benefit based on local assessment of need. In order to guarantee equitable access, each case management contractor receives a Dental Services funding allocation annually. Case managers will be responsible for assessing client needs and prioritizing services based on the needs of the agency caseload. All requests will be drawn from the agency's Dental Services Funding Allocation; approving extensive services for one client will reduce the number of available funds for all clients served by the agency. SMS will pay up to the authorized funding amount for requested dental services that are not covered by insurance.

Reporting Requirement:
Paid by State program. Local jurisdictions will not report this service in CAREWare, however, you should enter the case management time to facilitate access to SMS in CAREWare.

Request Form
The Request Form is available at healthoregon.org/hiv.

Request Procedure:

1. A completed SMS Request Form must be submitted to request services for Phase 1. Phase 1 services provide coverage for an initial dental assessment.
2. A completed SMS Request Form must also be submitted to request services for Phase 2. Phase 2 services cover more extensive care, and requires submission of a dental treatment plan completed by the dentist that will be performing the services. In some situations it may be appropriate to only request Phase 2 services; however, a treatment plan must always be submitted to obtain a Phase 2 authorization. When eligible, a client must be enrolled and/or have applied to CAREAssist dental insurance at the time a Phase 2 request is submitted.
3. Within two days of receiving a completed Request Form, a Service Authorization letter will be sent indicating whether the requested service was accepted. All Service Authorizations are valid between July 1 and June 30, beginning with the authorization date, and ending when authorized funds are expended. All authorizations expire on June 30th of each year. Services provided before the funding approval date on the service authorization form will not be covered. If a request is

denied, a letter will be sent indicating reason for denial.

4. It is expected that SMS services will begin immediately after authorization is received. Invoices for service(s) must be received within 90 days from the date of authorization. If the invoice is not received within 90 days, the authorization may be cancelled and the case manager will be notified.
5. The dental provider will invoice OHA directly. The service provider must include their Federal Tax Identification Number on their invoice(s) unless VISA is accepted as a payment method. The program will reimburse at "usual and customary" rates as defined by the primary payer reimbursement schedule. If the primary insurance provider is billed first, the provider must submit an Explanation of Benefits (EOB)/Summary of Benefits (SOB)/Medicare Summary with the invoice(s).
6. All service providers must be authorized by the SMS Program. If more than one provider will be used for the same service, a new Request Form should be submitted to authorize the new provider. The services cap will be applied to the client and is not based on the number of authorized providers. The HIV case manager is responsible for assuring that the client and the service providers understand that they are sharing a single maximum service capped amount. The program will only pay up to the authorized amount on a "first-billed first-paid" basis, and will not pay invoices over the authorized maximum amount.
7. The case manager is expected to notify the SMS program, through submission of the SMS Request Form, when a client is no longer using the approved SMS services ((i.e. client moves, client does not want to continue services, client is not in case management). The program will close out the authorized client service file and remaining funds will be placed back into the agency's dental funding allocation for the year.
8. A client may only be approved for an SMS service once per year. However, previously closed Phase 1 or Phase 2 authorizations may be reactivated within the same program year. Changes in client income eligibility will not affect an authorized service period (unless the client is no longer engaged in case management services). If clients were eligible at the time the authorization was approved, the SMS Authorization will be in effect until the end of the authorized service date.

HIV HOME TEST KITS

Description: OraQuick In-Home HIV Test Kits may be distributed to non-Ryan White clients who may be at risk of HIV, but are unaware of their status.

Guidance: HIV Test Kits may be requested by any Ryan White Part B case manager. The intended recipient should be a sex or needle sharing partner of a Ryan White Part B client, or any other person identified to be at risk of HIV. The Request Form should be completed and submitted to HIV Community Services. HIV Test Kits may be shipped to the requesting agency or directly to a Ryan White client. Requesting agency should ensure documentation of distributed tests to include recipient name or alias, and date of distribution.

Reporting Requirement:
Paid by State program. Local jurisdictions will not report this service in CAREWare

SECTION 4: CAREAssist: Oregon's AIDS Drugs Assistance Program (ADAP)

Program Priorities

The mission of the CAREAssist program is to improve the health of HIV+ Oregon residents by paying for insurance premiums and co-payments on prescriptions and medical services. To that end, CAREAssist provides the following services:

1. Insurance premium payment on most insurance types, including employer based plans, Medicare, Oregon Health Plan, Qualified Health Plans purchased in or outside of the exchange, and in limited instances, COBRA policies.
2. Copayments, coinsurance and deductibles on medical services, including those not specific to HIV treatment. Payments will be made up to a maximum of $6,850 per client.
3. Copayments, coinsurance and deductibles on prescriptions, including those not specific to HIV treatment. There is no annual limit to prescription assistance. Use of an In-Network pharmacy is required except for 1) clients who are mandated to use a specific pharmacy per their insurance coverage or 2) medications for acute conditions can be accessed at an out of network pharmacy. For medications not covered by someone's insurance or uninsured clients, CAREAssist will pay for the medication as long as it isn't on the CAREAssist drug exclusion list and the client is using an in-network pharmacy.
4. Tobacco Cessation Supports. CAREAssist clients who are ready to quit tobacco can receive free Nicotine Replacement Therapy (patches, gum or lozenges), prescription based therapy, or referral to other supports such as the Oregon Quitline.
5. Medication Therapy management can be provided to eligible clients who are having difficulty adhering to medication regimens. MTM provides phone-based support to patients through direct adherence counseling with an HIV pharmacist who will work with the patient to fit their medication regimen into their life.

6. The Bridge program provides urgently needed HIV specific medical care and limited medications for persons who are in the process of applying for health insurance.
7. The Uninsured Persons program provides access to HIV specific medical care and medications to persons who are ineligible for health insurance until the next open enrollment period or they experience a qualifying life event, allowing them a Special Enrollment Period. See Appendix B for more information.
8. Dental Insurance: CAREAssist provides dental insurance through Delta Dental. Any CAREAssist client may enroll as long as their primary insurance is not the Oregon Health Plan. Dual-eligible clients with Medicare and Medicaid are eligible for this benefit. Only preventative care and examinations are covered within the first six months of enrollment. Restorative fillings are covered after six months and more comprehensive care like root canals, crowns, bridges etc. are allowed after 12 months. These waiting periods can be waived if a client had 12-months of other dental insurance. Other coverage must have been active within the last 90-days of application to Delta Dental to qualify. This includes OHP dental benefits.

Client Eligibility

In order to be eligible, a person must:

- Have a confirmed HIV status
- Reside in Oregon
- Have income at or below 500% of the Federal Poverty Level (FPL). CAREAssist includes almost all forms of income, including work income/wages/salaries, disability, self-employment income, pension/retirement income, child support and unemployment.

Coordination with CAREAssist

Part B Case Managers are expected to work in partnership with the CAREAssist program to ensure client's maintenance of health insurance and CAREAssist. Part B Case Managers are able to view current client eligibility review data online, including type of insurance and FPL through the Client Eligibility Report.

Program Requirements

1. All CAREAssist clients are required to recertify their eligibility for the program every 6 months through a process called the Client Eligibility Review (CER). CERs are mailed to clients every 6 months and they have a month to return.
2. Clients must immediately notify the program of changes to their monthly premium or eligibility for insurance. This includes notifying the program when a client becomes eligible for new insurance, like employer-sponsored coverage, even if the person is already insured.

Additional Resources

Please see the CAREAssist website for more information, including forms, applications, contact information, and additional ADAP related resources.

SECTION 5: OREGON HOUSING OPPORTUNITIES IN PARTNERSHIP PROGRAM

Program Overview

The Oregon Housing Opportunities in Partnership (OHOP) program is an important component of the HIV Care and Treatment Program. The goal of the program is to assist clients in achieving and maintaining housing stability so as to avoid homelessness and improve their access to, and engagement in, HIV care and treatment. The program provides tenant based rental assistance to low-income persons living with HIV/AIDS through rental subsidy payments, and is intended to act as a bridge to long-term assistance programs, such as Section 8. Additionally, the program assists clients in locating and/or securing suitable rental housing, identifying other related housing and community based resources that may be available to clients, and providing housing information and referral to those housing resources.

Client Eligibility

Clients accessing OHOP must be actively enrolled in Part B funded, HIV Case Management services, be homeless or at risk of homelessness, and have a total household income that is less than 80 percent of the median family income. OHOP maintains a wait list based on priority of need, so clients who have higher housing acuity are served first.

Coordination with OHOP

OHOP regional Housing Coordinators are an important resource to clients with housing needs. Housing Coordinators facilitate in-depth client housing needs assessments and access to housing services provided directly through the OHOP program or through referral to other community-based housing providers. The intent of the OHOP program is that HIV Case Managers, OHOP Coordinators and eligible clients will work together to develop and implement a client Housing Plan.

Referral Process

In order to assure that Ryan White housing assistance funds are used as the funds of last resort, Case Managers must submit an OHOP Client Referral Packet for the OHOP program whenever chronic client housing needs are identified. Case managers submit a referral form in order to initiate ongoing consultation among the client, the Case Manager, and the local OHOP Housing Coordinator. Referral to the OHOP program does not preclude the use of Ryan White housing assistance. When clients have emergency housing needs, HIV Case Managers may

assist clients with those housing needs immediately, while initiating contact with the local OHOP Housing Coordinator for longer term assistance

Additional Resources

More information about the OHOP program, including full policies, procedures and referral forms, can be found at: healthoregon.org/ohop

SECTION 6: Pharmacist-led Treatment Adherence Services

Program Overview

Pharmacist-led Treatment Adherence is the provision of mediation adherence counseling to ensure readiness for, and adherence to, complex HIV treatments. The goals for this service are to:

- Increase knowledge about the importance of adherence
- Identify strategies to overcome barriers to adherence and manage medications effectively
- Decrease negative drug interactions and side effects
- Improve medication adherence
- Maintain or improve health outcomes.

Although this service is provided by licensed pharmacists who are located at HIV Alliance in Eugene, consultation services are available to all Part B Case Managers and clients.

Client Eligibility

All Part B case management clients and case management providers are eligible for time-limited consultation services.

Referral Process

Staff employed by HIV Alliance should follow internal referral processes. All other case management providers are welcome to contact the clinical pharmacists at HIV Alliance directly. Consultation without an ROI is allowed as long as patient identifying information is not shared. If it is determined that direct consultation with the client would be beneficial, the client will need to sign a release of information prior to the service.

Services Provided

Consultations may occur face to face, over the phone, via email or secure videoconference. For all consultations, the clinical pharmacist will require at least the following information: patient's age, gender, history of present illness, past medical history, social history, family history (if possible), medication list (including supplements), and allergy list. Consultation may include counseling on new medications or changes in medications, medication adherence, drug-interaction analysis, HIV and comorbid disease state education, diet and lifestyle modification, and HIV/comorbid medication selection and recommendations.

Additional Resources

For more information, contact the Pharmacy Program at HIV Alliance, 541.342.5088.

SECTION 7: DENTAL CASE MANAGEMENT

Program Overview

Dental Case Management is available for all Part B clients to assist clients in accessing and retaining dental care through the Part F funded, LLC Dental Clinic (formally Clock Tower) located in Eugene. In addition to dental case management, supportive services are available for eligible clients who face additional barriers to accessing dental care.

Client Eligibility

All Part B Case Management clients in the 31 county Part B service area are eligible for dental case management offered by HIV Alliance. Clients eligible for locally funded support services may also eligible for dental transportation, lodging and food.

Referral Process

The Dental Case Manager is located at HIV Alliance. Staff located at HIV Alliance should follow internal referral and coordination processes. All other case management providers are welcome to refer a client directly to the Dental Case Manager at any time.

Coordination with Dental Case Management

While a client is being served by the Dental Case Manager, case conferences should occur regularly between the Dental Case Management program and the referring case manager to ensure coordination of services and support of the client as they complete their treatment.

Program Referral

To refer your clients please contact the Dental Case Manager at HIV Alliance for the appropriate referral form. Dental specific ROI and LCC no show policy (if applicable) are also needed to complete the referral process.

Additional Resources

Please contact the Dental Case Manager at HIV Alliance for more information, 541.342.5088

SECTION 8: EMPLOYMENT SERVICES

Program Overview

The HIV Community Services Program is committed to helping clients who are ready to improve their vocation and financial related circumstances, either through employment, education or other financial goals. To help case managers achieve this goal, the Vital Purpose program is available to the majority of Part B clients. Vital Purpose is an employment service program based out of HIV Alliance which aims to help PLWH improve their financial security. Services provided include:

- Comprehensive employment readiness assessment
- Individualized goal planning
- Resume development and interview practice
- Analyses of potential impact on benefits due to increased income.
- Specialized referral and information
- Financial support services for job-seeking related activities such as transportation assistance, vocational programs or classes, or other items necessary to ensure participation in employment.
- Ongoing coaching to help obtain and/or retain employment or application to educational programs.
- Counseling regarding HIV specific barriers to employment such as disclosure, illness or negotiating other HIV related needs in the workplace

Client Eligibility

Clients served by the following Part B Case Management agencies are eligible for the Vital Purpose program: HIV Alliance, or local health departments located in Polk, Tillamook, Linn/Benton, Hood River, Crook, Jefferson or Deschutes counties. Clients served by EOCIL are not eligible for participation in Vital Purpose.

Referral Process

Staff employed by HIV Alliance should follow internal referral processes. All other case management providers are welcome to refer a client directly to the Vital Purposes program at any time.

Coordination with Vital Purpose

While a client is being served by the Vital Purpose program, case conferences should occur regularly between Vital Purpose and the referring case manager to

ensure coordination of services and support of the client as they work to achieve their financial goals.

Services Provided

Employment services may occur face to face, over the phone, via email or secure videoconference. The amount of service provided is dependent on client interest and needs, and may range from a brief, single session phone call to extensive, ongoing support. You should consider offering a referral to any client who expresses interest in:

- Looking for work, education, GED or other training,
- Gaining work or volunteer experience
- Starting a business
- Seeking advice on a current work related situation
- Basic financial planning information or benefits counseling
- Financial support or special equipment required to maintain or seek current employment or education
- Obtaining a computer to look for work or attend school

Additional Resources

Please contact the Vital Purpose program at HIV Alliance, 541.342.5088.
Additional employment resources can also be found here.

SECTION 9: INSURANCE ASSISTER SERVICES

Program Overview

The Program provides HIV Insurance Assister Services in an effort to ensure all clients have medical services and medication coverage. Ryan White providers are required to "vigorously pursue" enrollment and insurance for eligible clients.

Client Eligibility

All CAREAssist clients enrolled in Part B Case Management are eligible for Insurance Assister Services offered at HIV Alliance and EOCIL. This includes assistance enrolling in Medicaid, Medicare, private policies sold on and off of the Federally Facilitated Marketplace (FFM) and Employer Sponsored Insurance. Case management clients NOT enrolled in CAREAssist or actively applying to CAREAssist are not eligible for this service.

Referral Process

You may refer a client directly to the Insurance Assister at either HIV Alliance or EOCIL.

Services Provided

1. Outreach to identified CAREAssist clients in need of insurance and application assistance.
2. Report of life changes to OHP, Qualified Health Plans within the Federal Marketplace and CAREAssist that would impact insurance eligibility or premium payment.
3. Refer clients to tax-filing resources
4. Assist clients with tax reconciliation when CAREAssist has overpaid or underpaid QHP premiums on their behalf.
5. Education on CAREAssist and insurance related policy and requirements.

Coordination with Insurance Services

An Insurance Assister may require the assistance of the case manager to obtain necessary documents for enrollment. Case conferences should occur regularly between the Insurance Assister and the referring provider to ensure successful enrollment in insurance and payment of insurance premium as needed.

Services Provided

Consultations may occur face to face, over the phone, via email or secure videoconference. The amount of service provided is dependent on client need, and

may range from a brief, single session phone call to an extended amount of time in order to help the client complete the enrollment and application process.

Additional Resources

Please contact the Insurance Assister at HIV Alliance, 541.342.5088 or at Eastern Oregon Center for Independent Living (EOCIL), 541-276-1037. If you are unsure which agency is responsible for providing these services for your county, please contact your supervisor or the Program.

SECTION 10: POSITIVE SELF-MANAGEMENT PROGRAM

Program Overview

The Positive Self-Management Program for HIV is an evidence-based workshop that assists participants in self-managing their disease while connecting with other people who are also living with HIV. The workshops are held for 2 ½ hours, once a week, for six consecutive weeks. The workshops are co-facilitated by an HIV positive peer and an AIDS Certified nurse.

Client Eligibility

All PLWH in the Part B service area are eligible to attend. Family members, friends and caregivers are also invited to attend in support.

Referral Process

A minimum of 8 registrants is needed for a workshop to be held in a given area. If you believe you have a number of people within your service area that would be interested in attending, please contact HIV Community Services.

Services Provided

Participants will learn about their medications and how to manage side effects, skills for coping with emotions such as isolation, fatigue, pain and fear, how to eat healthier and be more active, how to communicate effectively with family, friends and health care providers, and how to get a good night's sleep. Participants will receive healthy snacks, a free copy of the "Living a Healthy Life with HIV" book, a free relaxation CD, and $50 gift cards for attending 4 of the 6 sessions.

Gift cards of $50 can also be distributed to clients who attend any of the Living Well with Chronic Conditions classes that are held around the state. Contact HIV Community Services for more information.

Additional Resources

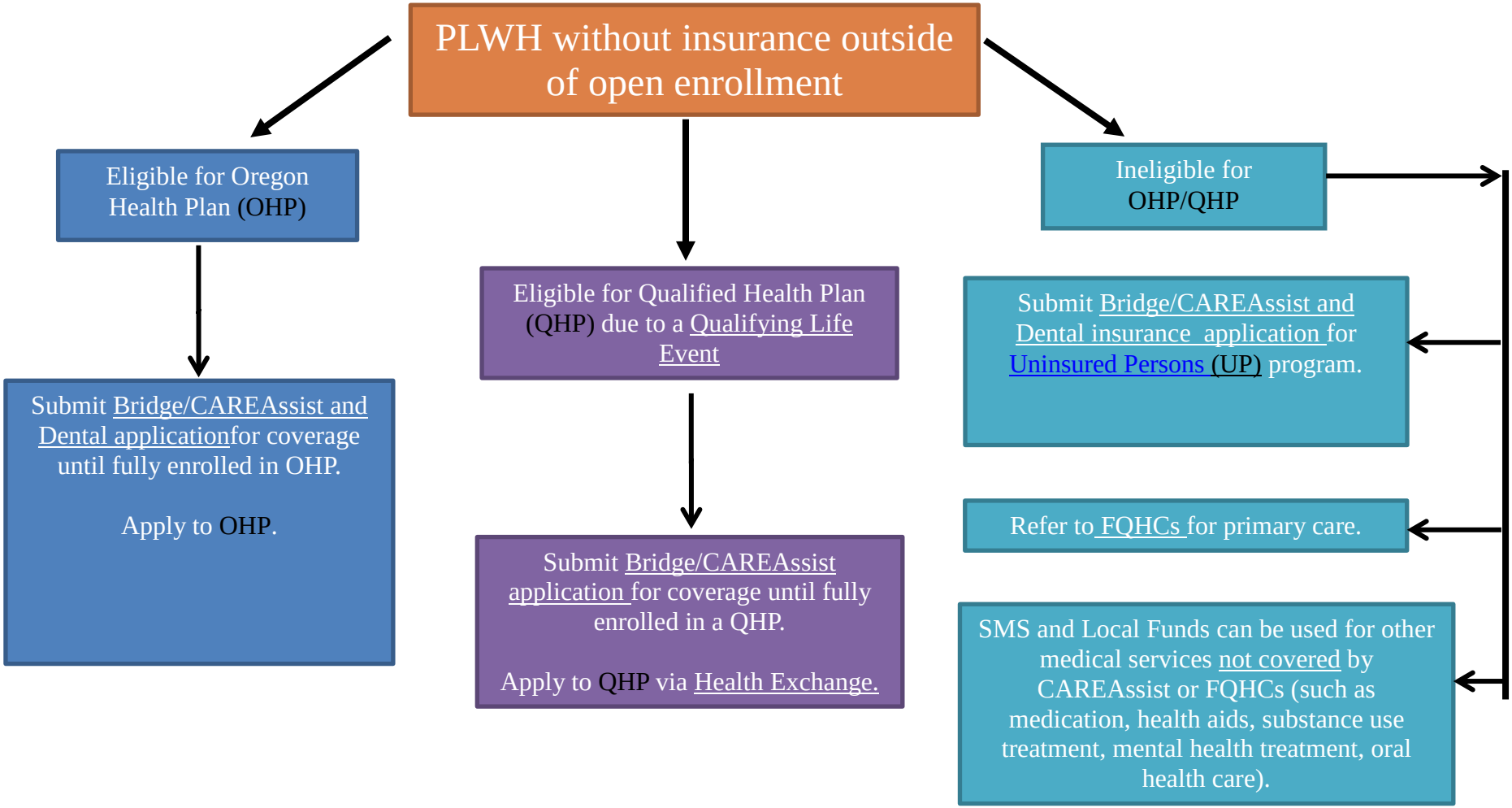
Please contact the HIV Services Coordinator if you are interested in bringing this workshop to your area.

APPENDIX A: RYAN WHITE FUNDED FOOD SERVICES QUICK GUIDE:

This guide is intended to clarify the use of food related assistance to ensure appropriate delivery and data entry of food services funded by Ryan White Program funds.

	EFA - Supplemental Food Assistance	**Medical EFA - Nutritional Support**	**Medical Nutritional Therapy**
Definition Summary	A card/voucher that allows a client to purchase food products and groceries (including hygiene products) necessary to maintain health.	A card/voucher that allows a client to purchase food products, groceries and supplements (i.e. Vitamins, Ensure) necessary to maintain health.	Includes nutrition assessment and screening, dietary/nutrition evaluation, food and/or nutrition supplements, nutrition education and counseling.
Service Cap	This service is one of four sub-services under Psychosocial Emergency Financial Assistance. The total services cap for Psychosocial EFA is $1000/per year, per client.	This service is one of seven sub-services under Medical Emergency Financial Assistance. The total services cap for Medical EFA is $1500/per year, per client.	$2500/per year, per client
Authorized By	Case Manager (RN or Psychosocial)	Medical Case Manager (RN)	Medical Provider
Provided By	Case Manager Or Medical Case Manager	Medical Case Manager	Licensed Dietician
Documentation Required from HIV Medical Provider	No	No	Yes- must be included in client chart prior to referral
Other Required Documentation	Documentation that client has exhausted other food services prior to authorization (i.e. food banks, food stamps) must be in the client's chart	Documentation of a current Nurse Assessment and identification of nutritional needs and goals in the client's care plan. Food/Supplements should be provided to a client with specific instructions for maintaining nutrition/overall health based on the Assessment.	A copy of the Medical Nutrition Plan, developed by the Dietician, must be included in the client's chart and there must be documentation of case conferencing between the Medical Case Manager & the Dietician at a minimum of every 3 months during the time the client is receiving this service.
Also Eligible For	No Other Food Service maybe provided.	Medical Nutritional Therapy	Medical EFA: Nutrition Support

APPENDIX B: ACCESSING MEDICAL SERVICES OUTSIDE OF OPEN ENROLLMENT



- A Bridge Application is preferred if there is a medically *urgent* need for client to access medication, or client is going to experience an interruption in ARV treatment.
- The Uninsured Persons program provides access to the CAREAssist formulary and a limited number of medical services necessary for HIV care, until full coverage can be obtained.
- Open Enrollment: QHP occurs throughout November. OHP enrollment can occur any time the client's income makes them eligible; Medicare has a separate open enrollment period if a client is past their original eligibility period.