Ryan White Part A:
Case Management Program Manual

Version: 2017.1

Manual developed by:

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR

COLUMBUS PUBLIC HEALTH

Purpose

The purpose of the Ryan White Part A: Case Management Program Manual (Manual) is to provide information and documentation protocols for Ryan White Part A medical case management and non-medical case management-support staff. It is intended to serve as a resource and to assist programs/staff with meeting grant compliance requirements, along with providing client-centered support and service. It is important to note that this Manual is a "living" document; as updates are made to forms and/or procedures, the Manual will be updated accordingly.

The Ryan White Part A: Case Management Program Manual could not have been developed without the invaluable expertise, time, and dedication of the Central Ohio Ryan White Network. Acknowledgement is given to AIDS Health Care Foundation, Columbus Public Health, Equitas Health, Nationwide Children's Hospital – FACES, Ohio Department of Health, and Southeast, Inc. Special thanks is given to those who served on the Project COCONUT steering committee and/or participated in Kazien events under the leadership of Caitlin Kapper, Public Health Quality Assurance Coordinator, Columbus Public Health and Laurie Rickert, LISW-S, HIV Care Services, Ohio Department of Health. Gratitude is also expressed to those who participated in focus groups and/or provided feedback. Finally, special appreciation is extended to Rachel Binting, Medical Case Manager Supervisor, Columbus Public Health and Katherine Kerr, Epidemiologist, Columbus Public Health for lending their knowledge, time, talent, and edits to the Manual.

- Stacy Herman, LSW
Program Manager, Columbus Public Health

Questions:

Manual:
Stacy Herman, LSW
Program Manager,
Columbus Public Health
614.645.1493
stherman@columbus.gov

Ryan White Part A Program:

Ryan White Part A Monitoring:
Caitlin Kapper, MPH
Public Health Quality Assurance Coordinator,
Columbus Public Health
614.645.2096
cckapper@columbus.gov

CAREWare:
Katherine Kerr, MPH
Epidemiologist,
Columbus Public Health
614.645.3267
KRKerr@columbus.gov

The following resources were used in the development of this manual:

1. AIDSinfo. *HIV/AIDS-Related Opportunistic Infections and Coinfections*. Accessed from: https://aidsinfo.nih.gov/education-materials/fact-sheets/26/86/what-is-an-opportunistic-infection.

2. Center for Financial Social Work. *Empower Your Clients to Achieve Financial Success with S.M.A.R.T. Goals*. Accessed from: https://www.financialsocialwork.com/blog/empower-clients-achieve-financial-success-s-m-r-t-goals.

3. Columbus Public Health. *Core Medical Services Eligibility for RWA Services Policy*.

4. Equitas Health. *Ohio's HIV Felonious Assault Law: What you Need to Know*.

5. Health Resources & Services Administration. *Ryan White Program Legislation*. Accessed from: http://hab.hrsa.gov/abouthab/legislation.html.

6. Nationwide Children's Hospital. *An Introduction to Advance Directives*.

7. Ohio Department of Health. *Drafted Standards of Care*.

8. Project Smart. *Stepping Up Smart Goals*. Accessed from: https://www.projectsmart.co.uk/stepping-up-smart-goals.php.

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Section I:
Ryan White Program

Background

The Ryan White HIV/AIDS Program is the largest federal program focused exclusively on providing HIV care and treatment services to people living with HIV. The program provides a comprehensive system of care for people living with HIV who are uninsured or underinsured.

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first authorized by the United States Congress in 1990 and then re-authorized in 1996, 2000, 2006 and 2009. The legislation provides federal funds for the treatment of HIV/AIDS in the medically uninsured or underinsured population. The legislation consists of five parts that serve different populations and regions based on HIV incidence rates.

Overview of Program Parts

Ryan White HIV/AIDS Program legislation is divided into five parts: A, B, C, D, and F. Dividing the legislation into parts provides a flexible structure to address HIV care needs on the basis of:

- different geographic areas;
- varying populations hardest hit by the HIV epidemic;
- types of HIV-related services; and
- service system needs.

Ryan White Part A

Ryan White Part A provides funding to locations that are most severely affected by the HIV/AIDS epidemic. These locations are called Eligible Metropolitan areas (EMAs) and Transitional Grant Areas (TGAs). Grants are awarded to the CEO of the city or county that provides health care services to the greatest number of people living with HIV/AIDS in the EMA or TGA.

Due to rising numbers of new infections, Columbus was identified in 2013 as an eligible recipient for Part A of the Ryan White Treatment Extension Act of 2009. Columbus Public Health is the recipient of Part A funding for the Columbus TGA, which includes Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union counties.

Ryan White Part B

Ryan White Part B provides funding to States and Territories to improve the quality, availability, and organization of HIV healthcare and support services. All 50 states, the District of Columbia, Puerto Rico, Guam, the US Virgin Islands, and the six US Pacific Territories/Associated Jurisdictions are eligible for Part B funding. In Ohio, the Ohio Department of Health is the recipient of Part B funding.

Ryan White Part C
Ryan White Part C provides funding to local community-based organizations to support outpatient HIV early intervention services and ambulatory care. In Central Ohio, for FY2017, Equitas Health and the Nationwide Children's Hospital FACES Program are the recipients of Part C funding.

Ryan White Part D
Ryan White Part D provides funding to local community-based organizations to support outpatient ambulatory and family-centered primary medical care for women, infants, children, and youth living with HIV. Part D funds both family-centered primary and specialty medical care and support services. In Central Ohio, there are currently no agencies funded under Part D.

Ryan White Part F
Ryan White Part F (Special Projects of National Significance Program) provides funding to public and private non-profit organizations that serve people living with HIV for the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by Ryan White HIV/AIDS Programs. In Central Ohio, the Midwestern Aids Education and Training Center (AETC), located at The Ohio State University Wexner Medical Center, Division of Infectious Diseases, utilizes Part F funding to deliver clinical education to providers and direct service professionals who serve individuals living with HIV/AIDS.

Payer of Last Resort
The Ryan White HIV/AIDS Program is the "payer of last resort". This means all funded service providers, regardless of which Part they are funded under, must make reasonable efforts to identify and secure other funding sources outside of Ryan White legislation funds, whenever possible. Funded service providers are responsible for verifying an individual's eligibility by investigating and eliminating other potential billing sources for each service, including public or private insurance programs.

Section II:
Ryan White Part A

Ryan White Part A

Ryan White Part A provides funding to locations (Eligible Metropolitan areas {EMAs} and Transitional Grant Areas {TGAs}) most severely affected by the HIV/AIDS epidemic. Grants are awarded to the Chief Executive Officer (CEO) of the city/county that provides health care services to the greatest number of people living with HIV/AIDS in the EMA or TGA. Funding for the Columbus TGA is awarded to the Mayor of Columbus, as the CEO of the city, who then directs Columbus Public Health to administer the grant.

Part A Eligibility Requirements
Ryan White Part A funded services are available to any individual who meets the following guidelines:

- diagnosis of HIV/AIDS;
- resides within the Columbus TGA (Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway or Union county); and
- low-income as defined as less than 300% of federal poverty level (FPL), (or with Columbus Public Health exception, less than 500% of FPL).

Eligible clients may have health insurance through public and private sources. Ryan White services are available to meet unmet medical and support service needs, as payer of last resort.

Part A Services
Part A services must be used to provide medical and support services to people living with HIV. Columbus Public Health funds the following Ryan White service categories:

- Core Medical Services:
  - *Outpatient/Ambulatory Medical Care*: provision of professional diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting.

  - *Early Intervention Services*: provision of a combination of service categories including:
    - referral services to improve HIV care and treatment services at key points of entry;
    - access and linkage to HIV care and treatment services such as HIV outpatient ambulatory health services, medical case management, and other support services;

  - *Mental Health Services*: provision of outpatient psychological and psychiatric treatment and counseling services offered to clients 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 of Ohio to render such services.

- *Medical Case Management, including treatment-adherence services*: provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

- Support Services:
  - *Case Management (Non-Medical - Housing):* provision of guidance and assistance to clients with securing and maintaining safe and appropriate housing with the ultimate goal of ensuring HIV infected persons are able to maintain stable housing arrangements and remain within the care system.

  - *Non-Medical Case Management–Support Services*: provision of guidance and assistance in accessing medical, social, community, legal, financial, and other needed services.

  - *Emergency Financial Assistance*: provision of limited one-time or short-term payments to assist clients with an emergent need for paying for essential utilities and housing.

  - *Housing Services*: provision of limited, short-term housing assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services.

  - *Medical Transportation Services*: provision of non-emergency transportation services that enables an eligible client to access or be retained in core medical and support services.

  - *Psychosocial Support Services:* provision of group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns.

Grievance Procedures

Part A:
All Ryan White Part A service providers must adhere to their established system for grievances about the operation of the service program. Complaints and grievances against the service provider related to Ryan White Part A grant supported services should be properly recorded and communicated to Columbus Public Health upon request. Additionally, case management service providers are required to inform clients that unresolved grievances related to Ryan White Part A grant-supported services can be directed to 614.645.2273 (CARE) for further instructions.

Part A Providers

Outpatient Ambulatory and Medical Case Management		
Provider Name	Address	Phone/Fax
AHF	815 West Broad Street; Columbus, OH 43222	614.223.1532 Fax: 614.223.1732
Equitas Health	4400 North High Street; Columbus, OH 43214	614.340.6745 Fax: 614.572.0859
Nationwide Children's Hospital	700 Children's Drive, Rm H138; Columbus, OH 43205	614.722.6061 Fax: 614.722.6770
OSU Infectious Disease	410 West 10th Avenue; Columbus, OH 43210	614.293.3004 Fax: 614.293.8102
Fairfield Healthcare Professionals	1253 East Main Street; Columbus, OH 43130	740.687.8854 Fax: 740.687.8803
Laboratories		
Fairfield Medical Center	401 North Ewing Street; Columbus, OH 43130	740.687.8235
James Cancer Hospital	300 West 10th Avenue; Columbus, OH 43210	614.293.2201
Laboratory Corporation of America	6370 Wilcox Road; Columbus, OH 43210	614.210.2862
OSU Hospital	410 West 10th Avenue; Columbus. OH 43210	614.293.2201
OSU Reference Lab	680 Ackerman Road, Bldg. 4, RM D405; Columbus, OH 43202	614.293.2201
Early Intervention Services (Linkage to Care)		
Columbus Public Health	240 Parsons Avenue; Columbus, OH 43215	614.340.6745
Mental Health		
AHF*		
Equitas Health	4400 North High Street; Columbus, OH 43214	614.340.6745
Nationwide Children's Hospital	700 Children's Drive, Rm H138; Columbus, OH 43205	614.722.6061
Medical Case Management/Non-Medical Case Management-Support		
AHF	815 West Broad Street; Columbus, OH 43222	614.223.1532
Columbus Public Health	240 Parsons Avenue; Columbus, OH 43215	614.724.2030
Equitas Health	4400 North High Street; Columbus, OH 43214	614.340.6745
Nationwide Children's Hospital	700 Children's Drive, Rm H138; Columbus, OH 43205	614.722.6061
Housing Services/Emergency Financial Assistance/Case Management (Non-Medical – Housing)		
Southeast, Inc. – Success In Housing	924 East Main Street; Columbus, OH 43205	614.360.0251 ext. 2119

* Address and phone number will be updated once the position is filled.

Section III:
Medical Case Management and Non-Medical Case Management-Support

Medical Case Management Service Definition

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

Key activities include initial assessment of service needs (Psychosocial Assessment); development of a comprehensive, individualized service plan; timely and coordinated access to medically appropriate levels of health and support services and continuity of care; continuous client monitoring to assess the efficacy of the plan; re-evaluation of the care plan at least every six months with adaptations as necessary; and ongoing assessment of the client's and other key family members' needs and personal support systems; treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; and client-specific advocacy and/or review of utilization of services.

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

Non-Medical Case Management–Support Service Definition

Non-medical case management–support (NMCM-Support) services provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. NMCM-Support 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, state pharmacy assistance programs, pharmaceutical manufacturer's patient assistance programs, other state or local health care and supportive services, or health insurance Marketplace plans. NMCM-Support includes several methods of communication including face-to-face, phone contact, and any other forms of communication.

Key activities include screening for MCM services, development of a comprehensive, individualized care plan, continuous client monitoring to assess the efficacy of the care plan, re-evaluation of the care plan at least every six months with adaptations as necessary, and on-going assessment of the client's and other key family members' needs and personal support systems.

Program Guidance

MCM services have as their objective "**improving health care outcomes"**. NMCM–Support have as their objective providing guidance and assistance in **"improving access to needed services"**.

Medical Case Management and Non-Medical Case Management–Support Service Unit

One unit of service is defined as fifteen (15) minutes, e.g. one hour of service equals four units. A service unit includes direct client or client-specific advocacy service either face-to-face or non-face-to-face.

Cultural Competency

MCMs and NMCM-Supports should be aware of and responsive to cultural and demographic diversity of the population and specific client profiles. It is the goal of the Ryan White Part A and Part B case management programs to provide culturally competent care, including interpretation services, with a corresponding policy and procedures.

Privacy and Confidentiality

Client confidentiality refers to the responsibility of MCMs and NMCM-Supports to protect information for and/or about their clients. Maintaining client confidentiality helps build trust between the client and professional.

Case management service providers must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations. Additionally, all federal and state laws concerning confidentiality of consumers' Personal Health Information (PHI) must also be adhered to when collecting client information.

Case management service providers are required to have a client release of information policy in place. MCMs and NMCM-Supports must review the limitations of the release of information prior to service delivery and have it completed and signed by the client or an authorized representative before information can be released/exchanged. MCMs and NMCM-Supports are responsible for following their agency's protocol on confidentiality and work with clients to complete any agency associated paperwork.

A completed Central Ohio HIV Case Management Network Release Form (see page 47 for additional information) is required for both Ryan White Parts A and B case management programs and allows information to be released/exchanged between central Ohio Ryan White funded agencies: AIDS Healthcare Foundation, Columbus

Public Health, Equitas Health, Nationwide Children's Hospital, Ohio Department of Health, Ohio State University Wexner Medical Center, and Southeast, Inc. Exchanging/ releasing information to a third party outside of these agencies requires the completion of a release of information form provided by the medical case management agency.

The following are best practices for maintaining privacy and confidentiality:

Clinical Records:

- ✓ Records must be kept in a locked, secure location.
- ✓ Records must be stored and accessible for seven years after closing of the case; after which, records can be destroyed in a way that will maintain confidentiality.
- ✓ All case management service provider employees and volunteers with access to client records are encouraged to sign a statement adhering to the practice of confidentiality set forth by the agency.

Electronic Records:

- ✓ Do not share your password with anyone.
- ✓ Exit or lock the computer system when you leave your workstation.

Telephone:

- ✓ Leave a voicemail greeting that does not identify you as an HIV MCM or NMCM-Support to help prevent others from obtaining knowledge of a client's status.
- ✓ When a message is left for a client (if the client permits you to do so), leave only the information the client permitted as indicated on their intake form.

Fax:

- ✓ If possible, the fax machine should be located in a locked, secure location, away from unauthorized personnel.
- ✓ Released confidential information should not be left unattended.

Supervision of Medical Case Management Personnel and Non-Medical Case Management–Support Personnel

Supervision provides assistance and support to MCMs and NMCM-Supports in the further development of their skills. As required by both Ryan White Part A and Part B programs, an LISW-S must provide two hours/week (on average) of supervision for each full-time equivalent MCM and NMCM-Support and one hour/week (on average) for each part-time equivalent MCM and NMCM-Support. A registered nurse may provide supervision to MCMs and NMCM-Supports in the absence of an LISW-S.

MCMs and NMCM-Supports along with their LISW-S supervisor are required to complete the Ryan White Case Management Supervision Log by documenting the date and time of each completed supervision meeting The completed Supervision Log should be submitted quarterly to Columbus Public Health (Ryan White Part A providers) or to the Ohio Department of Health (Ryan White Part B providers). Additionally, it is

recommended that items discussed in supervision along with the outcome be documented in case notes.

Definition of Social Work Supervision (*per the Ohio Revised Code, Chapter 4757-23-01*):
"Training supervision" means supervision for the purposes of obtaining a license and/or development of new areas of proficiency while providing services to clients. The training supervisor is responsible for providing direction to the supervisee, who applies social work theory, standardized knowledge, skills, competency, and applicable ethical content in the practice setting. The supervisor and the supervisee both share responsibility for carrying out their role in this collaborative process of professional growth and development. Training supervision may be individual supervision or group supervision.

(a) "Individual supervision" means face-to-face contact between a supervisor and an individual supervisee in a private session wherein the supervisor and supervisee deal with problems unique to the practice of that supervisee.

(b) "Group supervision" means face-to-face contact between a supervisor and a small group (not to exceed six supervisees) in a private session wherein practice problems are dealt with that are similar in nature and complexity to all supervisees in the group.

Orientation, Training, and Networking Opportunities

Each case management agency shall follow its own protocol for hiring and orienting new MCMs and NMCM-Supports to their organization and new position. In addition to the individual agency on-boarding process/training, it is recommended that new MCMs and NMCM-Supports do the following:

- Read and utilize the Ryan White Part A Case Management Program Manual to understand the Ryan White Program and the responsibilities of a MCM and NMCM-Support.
- Observe a MCM(s) and/or NMCM-Support(s) working with a client(s).
- Attend Ryan White Application Database training to increase awareness of Ryan White Part B systems and to learn how to utilize the Ryan White Part B client database. This training is provided by the Ohio Department of Health. Supervisors will provide their staff with the training schedule.

The roles of the MCM and NMCM-Support are expansive and broad, making it impossible to be expert in everything. Knowing how and where to seek guidance, assistance, and support is critical to MCM's and NMCM-Support's ability to provide the best care possible to clients. Each MCM and NMCM-Support is assigned to a supervisor who has credentials as an LISW-S. The supervisor is a valuable resource with expertise in clinical services and knowledge of the organization. When in doubt, MCMs and NMCM-Supports are always encouraged to seek guidance and direction from their supervisor. Additionally, colleagues from within each organization and the network bring knowledge, skill, and experience. MCMs and NMCM-Supports are

encouraged to share with each other community resources, strategies for engaging clients, and knowledge of how to complete tasks associated with the positions.

Through a partnership between the two case management funding sources for Part A (Columbus Public Health) and Part B (Ohio Department of Health), the Coordination, Resources, Updates, Networking, Consultation, Helping (CRUNCH) quarterly meetings were established. The purpose of CRUNCH meetings is to bring together MCMs and NMCM-Supports, supervisors, and funders for ongoing training, information exchange, networking, and support. Meetings are organized by Columbus Public Health and the Ohio Department of Health with agenda items selected by MCMs and NMCM-Supports, who also facilitate sections of each meeting. MCMs and NMCM-Supports are informed of upcoming CRUNCH meetings through an email invitation.

Section IV:
Intake and Client Case Assignment

The purpose of the intake process is to:

1. Screen the client to determine eligibility qualifications for Ryan White Parts A and B case management services and the need for an assessment;
2. Collect information from and about the client including contact, demographic, HIV/medical history, and need for services; and
3. Begin establishing rapport with the client and provide education on Ryan White Parts A and B case management services and intake/assessment timeline.

RYAN WHITE CLIENT INTAKE

Client Engagement

Each Ryan White Part A and Part B funded case management service provider will have on staff either a screener(s) or Linkage to Care coordinator(s) who is responsible for engaging and interviewing clients to complete the Ryan White Client Intake Form. These individuals serve as the first point of contact for entry into the Ryan White Program. Clients learn about the services available through the Ryan White Program primarily through word of mouth or referral from a medical professional. Contact with a screener or Linkage to Care coordinator may occur by client walk-in, phone calls, appointment, or in the community to the respective organization and/or by general referral from a professional in the community.

Form

A standardized Ryan White Client Intake Form has been developed for Ryan White Parts A and B case management programs. It is the responsibility of screeners and/or Linkage to Care coordinators to complete all sections of the Intake Form and submit it to the staff member in their organization who is responsible for case assignment. Each section of the form provides case assigners valuable information about the client and request for service.

Date of Intake:
This section contains the date the Client Intake Form was completed.

Client Acknowledgement of Understanding Confidentiality and HIPAA:
This section indicates confirmation of client understanding of the agency's confidentiality and HIPAA policies. Each case management service provider has its own established protocol on confidentiality and HIPAA. It is recommended that screeners/Linkage to Care coordinators provide a brief explanation of how information obtained through the intake process will be collected, utilized, and stored. Following this explanation, the screener/Linkage to Care coordinator should seek confirmation of understanding and initial this section accordingly.

Client Contact Information:
This section provides contacted information on the client and the client's emergency contact[1] along with contact information for the client's guardian/conservator, if applicable. Information from this section will be helpful to all professionals in knowing the best way to contact the client.

[1] The client's emergency contact may only be contacted if a valid release is on file, except in the event that a client experiences a true medical emergency. If this occurs, the emergency contact may be notified with or without a valid release.

Client Demographic Contact Information:
This section provides important information about the client's background. Data collected in this section includes identifying information such as client ID (the client ID should be based upon the screener's/Linkage to Care coordinator's agency' client identification system) and date of birth, along with sex and gender, race, and ethnicity, and preferred language information. This section will help inform all professionals working with the client and includes required data points for reporting purposes.

HIV/Medical Care History:
This section provides information on the client's HIV status, history of care and anti-retroviral therapy. Information collected in this section will be used in part to determine client eligibility for Ryan White services.

Basic Need Information - Green:
This section provides information on the basic needs a client might have in four sub-categories: support system, knowledge of HIV disease, sexual health/risk reduction, and legal. Information documented in this section will be used by the case assigner to determine acuity level.

Moderate Need Information - Yellow:
This section provides information on the moderate needs a client might have in six sub-categories: oral health, health insurance/medical care coverage, financial planning, transportation, language and literacy, and developmental disability/cognitive. Information documented in this section will be used by the case assigner to determine acuity level.

Intensive Need Information - Red:
This section provides information on the intensive needs a client might have in six sub-categories: basic needs, housing, medical needs, care and medication adherence, substance abuse, and mental health. Information documented in this section will be used by the case assigner to determine acuity level.

Intake Sign-Off:
This section provides general information about the individual who completed the Client Intake Form including their name, agency name, signature, and date of form submission for case assignment.

Case Assignment Use Only:
This section is to be completed by the case assigner following their review and assessment of information documented on the Client Intake Form. This section provides information on the date the intake form was received, determination of acuity level, name of the assigned medical case manager, date of case assignment, along with the name and signature of the case assigner.

Form Validity

The Client Intake Form is valid for the entire duration of time the client is engaged in care without a break in service. Any time a client falls out of care and is re-referred to case management, the Client Intake Form will need to be completed.

Accessing the Intake Form

The Client Intake Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Screeners/Linkage to Care coordinators are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Screener/Linkage to Care Intake Form Documentation and Submission Procedures

- The Client Intake Form may be completed by interviewing the client over the phone or meeting with them in person.

- Screeners/Linkage to Care coordinators are responsible for following their agency's protocol on confidentiality and HIPAA. It is recommended that screeners/Linkage to Care coordinators provide a brief explanation of how information obtained through the intake process will be collected, utilized, and stored. Documentation of client acknowledgement of understanding their rights as it pertains to confidentiality and HIPAA should be documented on the form.

- Screeners/Linkage to Care coordinators are responsible for completing all sections/questions on the Client Intake Form following their agency's protocol on the format in which the form should be documented, e.g. typed or handwritten.

- Client Intake Forms should be completed within the timeframe established by the screener/Linkage to Care coordinator's organization.

- If the client acknowledges having a court appointed guardian/conservator, the completion of the Client Intake Form may only be conducted if the guardian/conservator participates. This may require scheduling a time for both the client and their guardian/conservator to be present.

- Screeners/Linkage to Care coordinators must use address and HIV status information provided by the client to determine initial eligibility and inform the client accordingly.
    - Clients who live in the State of Ohio and have HIV should be determined eligible and should be informed that part of the assessment process will

include the collection of documents to verify information collected during the intake screening to fully determine eligibility.
    - Clients who live in the State of Ohio and do not have HIV should be informed that they are not eligible for Ryan White services.
    - Clients who have HIV and do not live in the State of Ohio should be informed that they are not eligible for Ryan White services in the State of Ohio and should be provided with a referral to a Ryan White program located within the state in which they reside.

- Screeners are NOT responsible for requesting and/or collecting any documentation from the client for the purpose of completing and submitting the Client Intake Form. However, Linkage to Care coordinators must also complete and submit eligibility documentation (see page 23 for additional information) with the Client Intake Form.

- Screeners/Linkage to Care coordinators must document an original signature on the Client Intake Form prior to submitting it to the case assigner within their organization.

- Incomplete Client Intake Forms may be returned to the individual who completed the form and could result in a delay in the provision of services to the client.

Best Practices – Screeners/Linkage to Care Coordinators

- ✓ It is recommended that screeners/Linkage to Care coordinators familiarize themselves with their agency's confidentiality and HIPAA protocols. Be prepared to inform clients of the purpose for collecting information that will be personal and explain how information will be utilized and stored.

- ✓ Provide open, clear communication. Inform the client of the following:
    - length of time for the intake call/meeting,
    - role of the screener/Linkage to Care Coordinator as it relates to intake,
    - determination of initial eligibility, and
    - next steps, including timeframe.

- ✓ Be sure to ask and obtain an answer for all questions on the Client Intake Form. Incomplete forms may result in a delay in service for the client.

- ✓ Prior to submitting the Client Intake Form to the case assigner, confirm accuracy of client contact information.

- ✓ If the client is ineligible for services due to living outside of Ohio, provide a referral to a Ryan White program within the state in which the client resides.

- ✓ If a client asks a question outside of the scope of responsibilities and/or knowledge of the screener/Linkage to Care coordinator, inform the client their question will be researched and an answer to the question will be provided in a timely manner. Be sure to check with a supervisor for information on how to respond to the client's question.

- ✓ Be sure to document on the Client Intake Form an original signature along with the date before submitting it to the case assigner.

Case Assignment Procedures

Each Ryan White Part A and Part B case management service provider will have a staff member(s) who is responsible for receiving completed Client Intake Forms, reviewing and assessing information contained on the completed forms, and assigning eligible clients to a medical case manager accordingly.

- Upon receipt of the completed Client Intake Form, the case assigner will:
  - Review the document to ensure all sections/questions on the Client Intake Form are complete. If anything is missing, contact the screener/Linkage to Care coordinator who completed the form and request missing information.
  - Document receipt information on the Client Intake Form under "case assignment use only" section.

- Utilizing the information documented on the Client Intake Form in the "basic, moderate, and intensive need" sections, assess the client's acuity based upon the information below and check the "green, yellow, or red" box in the "case assignment use only" section accordingly:
  - If the client responded "yes" to any of the questions listed under "intensive need" and/or indicated they are homeless, check the "RED" box, regardless of responses from the "moderate or basic needs" sections.
  - If the client responded "no" to all of the questions listed under "intensive need" and/or did not indicate they are homeless, consider the clients responses to the questions listed under "moderate need". If any responses indicate a need for service and/or assistance, check the "YELLOW" box, regardless of responses from the "basic needs" section.
  - If the client responded "no" to all of the questions listed under "intensive need" and/or did not indicate they are homeless and after consideration of responses under moderate need you determined there was NOT a need for service and/or assistance, check the "GREEN" box.

- Determine case assignment by utilizing the following criteria:
  - Medical case manager's current case load size.
  - Number of high, medium, and low acuity level (total acuity) clients on the medical case manager's case load.

- Document the name of the assigned medical case manager, date of case assignment, case assigner's name, and signature in the "case assignment use only" section.

- Provide the completed Client Intake Form to the assigned medical case manager within two business days of receiving the Client Intake Form.

Best Practices – Case Assigners

- ✓ Review all sections of the completed Client Intake Form to ensure completeness. If any information is missing, immediately reach out to the screener/Linkage to Care coordinator who completed the form and request missing information.

- ✓ Develop a tracking form to ensure equity in assigned caseloads to medical case managers. This may also be used as a quick reference tool.

- ✓ Use clinical judgement when assessing for the client's acuity level.

- ✓ Determine case assignment based on knowledge of the medical case manager's experience and skills in working with the client population. The recommended caseload acuity scores for various settings are:
    - Community-Based Medical Case Manager: 1500
    - Clinic-Based Medical Case Manager: 1500
    - Rural-Based Medical Case Manager: 990

Medical Case Manager Case Assignment Receipt Procedures

- Review all information documented on the Client Intake Form. Direct questions related to information contained on the form to the screener/Linkage to Care coordinator who completed the form.

- Upon receipt of case assignment, enter required information into the electronic system utilized by your organization.

- Contact the client within two business days to schedule an assessment appointment.

- Document a case note into the electronic system utilized by your organization on all interactions with and/or on behalf of the client.

- The Client Intake Form should be maintained in the client's file.

Best Practices – Medical Case Managers

- ✓ Provide open, clear communication. Inform the client of the following:
  - role of the medical case manager,
  - length of time for the assessment/enrollment meeting,
  - documentation to bring to assessment/enrollment meeting, and
  - next steps, including timeframe.

Section V:
Ryan White Part A - Eligibility

The purpose of the Ryan White Part A eligibility process is to:

1. Screen the client to determine that the individual is qualified to access services;
2. Collect documentation to verify eligibility including HIV status, residency, and income along with insurance information; and
3. Provide education on Ryan White Parts A and B case management services and assessment timeline.

Per HRSA requirements, to maintain eligibility for the Columbus TGA Ryan White Part A services, clients must be re-certified every six months. The primary purpose of the re-certification process is to ensure that an individual's residency, income, and insurance statuses continue to meet the Columbus TGA Ryan White Part A eligibility requirements.

RYAN WHITE PART A ELIGIBILITY FORM—INITIAL ASSESSMENT

Form

A standardized Ryan White Part A Eligibility Form—Initial Assessment has been developed for the Ryan White Part A Program. It is the responsibility of Linkage to Care coordinators, medical case managers, and/or non-medical case manager–supports[2] to complete all sections of this form. Required eligibility data should be entered into CAREWare following the protocol of the case management agency. Each section of the form helps determine/verify the individual's eligibility to receive Ryan White Part A services, including medical case management and/or non-medical case management–support.

Date of Initial Assessment:
This section contains the date the Ryan White Part A Eligibility Form—Initial Assessment is completed.

Client Information:
This section provides general information about the client, including their name, date of birth, sex at birth, and gender identity.

Client Demographics:
This section provides information about the client's race and ethnicity, which are required data used for reporting purposes.

HIV Status:
This section provides information on the client's HIV status, including the date they were determined HIV-positive. Documentation to verify HIV status is also required, including:

- Copy of a Counseling, Testing, and Referral (CTR) or other Clinical Laboratory Improvement Amendments (CLIA) certified laboratory report of an HIV-positive test result;
- Documentation confirming HIV-positive status in Ohio Disease Reporting System (ODRS);
- Official paperwork from a physician or advanced nurse practitioner confirming client's HIV-positive status;
- Proof of prescription for HIV medication(s); or
- Exception Form submitted to and approved by Columbus Public Health.

Residency Status:
This section indicates if the client lives in the Columbus TGA and collects zip code data. The Columbus TGA includes the following counties: Delaware, Fairfield, Franklin,

[2] In this section, when referring to all three professional positions - Linkage to Care coordinators, medical case managers, and non-medical case manager–supports, the term "professional or professionals" will be used.

Licking, Madison, Morrow, Pickaway, and Union. Documentation to verify residency within the Columbus TGA is also required, including:

- Copy of state issued identification card or driver's license;
- Copy of mail from a utility or service providing company that confirms client's residency;
- Copy of mail from a government agency that confirms client's residency;
- Copy of a lease or mortgage statement that lists the client;
- A professional's verification letter following a visit to the client's home;
- Signed attestation by client confirming residency (sample attestation is provided on page 35) (may be utilized only one time in a twelve month period); or
- Exception Form submitted to and approved by Columbus Public Health.

Income Status:

This section determines if the client meets the "low-income" requirement and collects information including annual income, household size, and Federal Poverty Level (FPL).

To be eligible for Ryan White Part A, clients must meet the "low-income" requirement, which is defined as less than 300% of FPL, using the Modified Adjusted Gross Income (MAGI) methodology (see page 36 for additional information). To determine annual income using the MAGI method, multiply the monthly MAGI amount by twelve and document this number on the form. Use the yearly FPL calculation to determine Ryan White Part A eligibility based on household size.

Documentation to verify income is also required, including:

- Copy of the most current IRS Tax Transcript (3 years of tax transcripts if self-employed);
- Completed MAGI Worksheet with a copy of four consecutive weeks of pay stubs;
- Completed MAGI Worksheet with letters from employer stating earnings;
- Completed MAGI Worksheet with copies of court orders for alimony or other court ordered payments, excluding child support;
- Completed MAGI Worksheet with copies of award letters for benefits from federal, state or county entitlement programs;
- A signed attestation (a sample attestation is provided on page 39) by the client stating their income, including if the client has no income (may be utilized only one time in a twelve month period); or
- Exception Form submitted to and approved by Columbus Public Health.

Additional Documentation: Insurance Status:

This section determines if the client has health insurance and the associated type. Clients must apply for health insurance programs for which they may be eligible, including Medicaid, Medicare, private employer-based insurance, and/or the Federal Marketplace. Documentation to verify insurance status is also required, including:

- Copy of current insurance card;
- Proof that the service is not covered by other third party insurance programs (Military Veterans with VA benefits are eligible for Ryan White Services);

- Signed attestation from a professional stating the client is not eligible for health insurance coverage.
- Copy of pending application, if potentially eligible;
- Signed attestation that the client was informed of health insurance coverage options and the benefits of applying for health insurance coverage, but opted not to apply (sample attestations are provided on pages 40 and 41). Ryan White services shall not be denied based upon the client's informed decision to abstain from health insurance;
- Exception Form submitted to and approved by Columbus Public Health.

Ryan White Part A Approval
This section serves as verification of client eligibility for Ryan White Part A services and requires the professional's name to be printed and signed, along with documentation of the date, name of the organization and the date of the next review.

Form Validity

The Ryan White Part A Eligibility Form—Initial Assessment is valid for six months from the date the form is completed and signed. To avoid disruption of care and services, a 30 day grace period is granted before and following the eligibility beginning and expiration dates in which the client may continue to receive services. Re-certification using the Ryan White Part A Eligibility Form—Six Month Review is required to be completed and documentation to be collected at a minimum of every six months (see page 27 for additional information). In the event eligibility paperwork is not certified by the end of the grace period, closure paperwork should be completed, if appropriate (see page 100 for additional information).

Accessing the Ryan White Part A Eligibility Form—Initial Assessment

The Ryan White Part A Eligibility Form—Initial Assessment is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Part A Eligibility Form—Initial Assessment Documentation and Submission Procedures

- The Ryan White Part A Eligibility Form—Initial Assessment is one of the first forms to be completed by professionals and should be done while meeting with the client in-person.

- Professionals are responsible for completing all sections/questions of the form following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

- Professionals must document an original signature on the Ryan White Part A Eligibility Form—Initial Assessment. An electronic signature on this form is not permissible.

- Professionals are responsible for collecting all required documentation to determine client eligibility for Ryan White Part A services.

- Within two business days of obtaining all of the required documentation, professionals must submit a copy of the Ryan White Part A Eligibility Form—Initial Assessment to Columbus Public Health via fax – 614.645.8873 or secure email – sexualhealth@columbus.gov.

- The original Ryan White Part A Eligibility Form—Initial Assessment along with required documentation should be maintained in the client's file.

Best Practices

- ✓ Be prepared for the initial meeting with the client by having:
  - all forms (completed intake form, client file (if returning client), along with blank medical case management and/or non-medical case management–support forms, and any agency-required forms);
  - access to a phone;
  - business cards; and
  - paper for documenting information to be included in case notes.

- ✓ Be sure to complete all sections of the form.

- ✓ Make sure forms are submitted to Columbus Public Health after all of the required documents have been collected.

- ✓ Ensure the form contains an original signature prior to submitting it to Columbus Public Health.

RYAN WHITE PART A ELIGIBILITY FORM—SIX MONTH REVIEW

Form

A standardized Ryan White Part A Eligibility Form—Six Month Review has been developed for the Ryan White Part A Program. This form is similar to the Ryan White Part A Eligibility Form—Initial Assessment. Per HRSA requirements, to maintain eligibility for Columbus TGA Ryan White Part A services, clients must be re-certified every six months. The primary purpose of the re-certification process is to ensure that an individual's residency, income, and insurance statuses continue to meet the Columbus TGA Ryan White Part A eligibility requirements. It is the responsibility of medical case managers (MCM) and/or non-medical case manager–supports (NMCM–Support) to complete all sections of this form and enter required data into CAREWare following the protocol of the case management agency. Each section of the form helps determine/verify the individual's eligibility to continue receiving Ryan White Part A services, including medical case management and/or non-medical case management-support.

Date of Review:
This section contains the date the Ryan White Part A Eligibility Form—Six Month Review is completed.

Date of Next Review:
This section contains the date of the next Ryan White Part A review, which should be approximately six months from the current date of review. The Ryan White Part A Eligibility Form—Six Month Review must be completed every six months.

Client Information:
This section provides general information about the client including their name, date of birth, and sex at birth.

Residency Status:

This section indicates if the client lives in the Columbus TGA and collects zip code data. The Columbus TGA includes the following counties: Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union. Documentation to verify residency within the Columbus TGA is also required. Acceptable forms of documentation are the same as those listed under "residency status" on the Ryan White Eligibility Form—Initial Assessment (see page 23 for additional information).

Income Status:
This section determines if the client meets the "low-income" requirement and collects information including annual income, household size, and Federal Poverty Level (FPL).

To be eligible, clients must meet the “low-income” requirement, which is defined as less than 300% of FPL, using the Modified Adjusted Gross Income (MAGI) methodology (see page 39 for additional information). To determine the annual income using the MAGI method, multiply the monthly MAGI amount by twelve and document this number on the form. Use the yearly FPL calculation to determine Ryan White Part A eligibility based on household size.

Documentation to verify income is also required. Acceptable forms of documentation are the same as those listed under “income status” on the Ryan White Eligibility Form—Initial Assessment (see page 24 for additional information).

Insurance Status:
This section determines if the client has health insurance and the associated type. Clients must apply for health insurance programs for which they may be eligible, including Medicaid, Medicare, private employer-based insurance, and/or the Federal Marketplace. Documentation to verify insurance status is also required. Acceptable forms of documentation are the same as those listed under “insurance status” on the Ryan White Eligibility Form—Initial Assessment (see page 24 for additional information).

Ryan White Part A Approval
This section serves as verification of client eligibility for Ryan White Part A services and requires the MCM or NMCM–Support name to be printed and signed along with documentation of the date and the name of the organization.

Form Validity

The Ryan White Part A Eligibility Form—Six Month Review is valid for six months from the date the form is completed and signed. To avoid disruption of care and services, a 30 day grace period is granted before and following the eligibility beginning and expiration dates in which the client may continue to receive services. Re-certification using this form is required to be completed and documentation to be collected at a minimum of every six months. In the event eligibility paperwork is not certified by the end of the grace period, closure paperwork should be completed, if appropriate (see page 100 for additional information).

Accessing the Ryan White Part A Eligibility Form—Six Month Review

The Ryan White Part A Eligibility Form—Six Month Review is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs and/or NMCM-Supports are responsible for following their agency’s protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Part A Eligibility Form—Six Month Review Documentation and Submission Procedures

- The Ryan White Part A Eligibility Form—Six Month Review should be completed to re-determine eligibility by MCMs and/or NMCM–Supports while meeting in person with the client.

- MCMs and/or NMCM-Supports are responsible for completing all sections/questions of the form following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

- MCMs and/or NMCM-Supports must document an original signature on the Ryan White Part A Eligibility Form—Six Month Review. An electronic signature on this form is not permissible.

- MCMs and/or NMCM-Supports are responsible for collecting all required documentation to re-determine client eligibility for Ryan White Part A services.

- Within two business days of obtaining all of the required documentation, MCMs and/or NMCM-Supports are responsible for submitting the Ryan White Part A Eligibility Form—Six Month Review to Columbus Public Health via fax – 614.645.8873 or secure email – sexualhealth@columbus.gov.

- The original Ryan White Part A Eligibility Form—Six Month Review along with required documentation should be maintained in the client's file.

Best Practices

- ✓ Be prepared for the initial meeting with the client by having:
  - all forms (completed intake form, client file (if returning client), along with blank medical case management forms and/or non-medical case management–support forms, and any agency-required forms);
  - access to a phone;
  - business cards; and
  - paper for documenting information to be included in case notes.

- ✓ Be sure to complete all sections of the form.

- ✓ Make sure forms are submitted to Columbus Public Health after all of the required documents have been collected.

- ✓ Ensure the form contains an original signature prior to submitting it to Columbus Public Health.

RYAN WHITE PART A ELIGIBILITY EXCEPTION FORM

Form

A standardized Ryan White Part A Eligibility Exception Form has been developed for the Ryan White Part A program. This form should be completed for clients who are/have:

- Over income (between 300% - 500% of the Federal Poverty Level (FPL));
- Significant safety or confidentiality concerns;
- Other documentation than what is listed in the policy to show eligibility; and
- Other – if a description of the other circumstance is documented.

It is the responsibility of medical case managers, non-medical case manager–supports, or other Ryan White Part A professionals[3] to complete all sections of the form and submit it along with the completed Ryan White Part A Eligibility Form to Columbus Public Health. Exception requests for clients who are over-income must also submit backup documentation, including a completed MAGI Worksheet (see page 36 for additional information) along with supporting documentation:

- copies of four consecutive weeks of pay stubs;
- letters from employer stating earnings;
- copies of court orders for alimony or other court ordered payments (except child support); OR
- copies of award letters for benefits from federal, state, or county entitlement programs.

Exceptions are made on a case-by-case basis and are determined by the identified cause for the request and availability of funding. Each section of the form provides Columbus Public Health valuable information about the client and reason for the requested exception.

Date of Request:
This section contains the date the form is completed.

Initial/Renewal Request:

- Initial: Indicates this is the first time a Ryan White Part A Eligibility Exception Form has been completed for the client.
- Renewal: Indicates a Ryan White Part A Eligibility Exception Form has been submitted for the client previously.

Client Information:
This section provides basic information on the client, including first and last name and date of birth.

[3] In this section, the term "professional or professionals" will be used to represent all professionals who have responsibilities associated with the Ryan White Part A Eligibility Exception Form.

Reason for Exception:
This section provides general information about the reason for the exception which will be used to help determine if the client will be approved to receive an exception.

Exception Request Description:
This section provides a detailed description of the client's situation that will help justify the need for an exception. Information from this section will be used to help determine if the client will be approved to receive an exception.

Exception Request Sign-Off:
This section provides information on the professional completing the form including name, email address, phone number, and signature.

CPH Office Use Only:
This section provides information on the approval status of the request, any additional information related to the approval process, and the date of decision notification. This section is to be completed by Columbus Public Health.

Form Validity

The approval of the Ryan White Part A Eligibility Exception Form is valid for six months. The client's need should be re-evaluated every six months at their re-certification review. If there continues to be a need for an exception, a subsequent request may be submitted to Columbus Public Health for review.

Accessing the Ryan White Part A Eligibility Exception Form

The Ryan White Part A Eligibility Exception Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Professionals – Ryan White Part A Eligibility Exception Form Documentation and Submission Procedures

Professionals are responsible for completing Eligibility Exception Forms on behalf of clients who do not meet the Ryan White Part A eligibility requirements and have circumstances that may require an exception to the policy.

- Eligibility exceptions are considered for clients who are/have:
    - Over income (between 300% - 500% of the FPL);
    - Significant safety or confidentiality concerns;
    - Other documentation than what is listed in the policy to show eligibility; and
    - Other – if a description of the other circumstance is documented.

- A detailed description justifying the need for the exception request should be documented on the form.

- Professionals are responsible for completing all sections/questions of the Ryan White Part A Eligibility Exception Form and following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

- Professionals must document an original signature on the Ryan White Part A Eligibility Exception Form. An electronic signature is not permissible.

- Ryan White Part A Eligibility Exception Forms along with the completed Ryan White Part A Eligibility Form should be faxed to Columbus Public Health at 614.645.0746.
    - Exception requests for clients who are over-income must also submit backup documentation, including a completed MAGI Worksheet and supporting documentation, e.g. pay stubs, award letters, etc.

- Incomplete Ryan White Part A Eligibility Exception Forms may be returned to the professional who submitted the form and will delay Columbus Public Health's ability to consider the exception request.

- Professionals are responsible for responding to requests for additional information from Columbus Public Health.

- A copy of the completed Eligibility Exception Form along with the written decision by Columbus Public Health should be maintained in the client's file.

Best Practices – Professionals

- ✓ Remember to check if the eligibility exception is an initial or renewal request
    - Eligibility exceptions are approved for a six month period of time. The client's need should be re-evaluated at their six month review. If there continues to be a need for an exception, the professional is responsible for submitting subsequent requests.

- ✓ Be sure to document an original signature on the Ryan White Part A Eligibility Exception Form before submitting it to Columbus Public Health.

- ✓ Exception Request Description: Clearly describe the client's circumstances and the reason for the request for an eligibility exception. It is recommended that the description demonstrates a correlation between the client's circumstance and the need for an exception. The following are a couple of examples:
    - Client's income is over 300% of FPL due to working overtime for the past two months. While this has resulted in increased income, the client is in great need of Ryan White Part A services.

- Client is currently living with their parents and is also on their insurance. Client is fearful that if the client's parents find out about their HIV status, they will be kicked out of their home.

Columbus Public Health Ryan White Part A Eligibility Exception Form Receipt Procedures

Columbus Public Health's medical case management program manager is responsible for receiving Ryan White Part A Eligibility Exception Forms, determining approval of requests, and communicating with professionals:

- Upon receipt of a completed Ryan White Part A Eligibility Exception Form, review the form to ensure all sections/questions are completed (for clients who are over-income, review the completed MAGI Worksheet and supporting documentation). If anything is missing, contact the professional who submitted the form and request missing information. If additional information is needed, also document a brief description of additional information needed under "CPH Office Use Only – Notes".

- Determine if the exception request is approved by considering the reason for the request and the availability of funding.

- Document the status of the request and any notes related to the exception under "CPH Office Use Only – Request Approved".

- Within two business days of receiving a completed Ryan White Part A Eligibility Exception Form, notify the professional who submitted the form of the outcome of the request. Document the date of the decision notification under "CPH Office Use Only – Date of Decision Notification".

- Provide a copy of the form to Columbus Public Health's Ryan White Part A epidemiologist.

SAMPLE DOCUMENTATION – PROFESSIONAL VERIFICATION OF CLIENT'S RESIDENCY

A signed attestation by the professional verifying the client's residency, following a visit to the client's home may be provided in the event that the client does not have and/or is unable to provide one of the following documents to verify residency:

- Copy of state issued identification card or driver's license;
- Copy of mail from a utility or service providing company that confirms client's residency;
- Copy of mail from a government agency that confirms client's residency;
- Copy of a lease or mortgage statement that lists the client; and/or
- Signed attestation by the client confirming residency (may be utilized only one time in a twelve-month period).

Sample Professional Verification Letter – Confirmation of Client's Residency

I _____ (print professional's name) visited _____ (print client's name) at their place of residence on _____ (insert date). This letter serves as verification that the client named above currently resides in the Columbus Public Health Ryan White Part A Program Transitional Grant Area. This area includes Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union counties.

_____ _____

Professional's Signature Date

SAMPLE DOCUMENTATION – CLIENT ATTESTATION OF RESIDENCY

A signed attestation by the client confirming residency (may be utilized one time in a twelve-month period) may be provided in the event that the client does not have and/or is unable to provide one of the following documents to verify residency:

- Copy of state issued identification card or driver's license;
- Copy of mail from a utility or service providing company that confirms client's residency;
- Copy of mail from a government agency that confirms client's residency; and/or
- Copy of a lease or mortgage statement that lists the client.

Sample Client Letter of Attestation – Confirmation of Residency

I _____ (print client's name) swear or affirm that I currently reside in the Columbus Public Health Ryan White Part A Program Transitional Grant Area. This area includes Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, and Union counties.

I am aware that providing false, incomplete or inaccurate information regarding my residency may result in my inability to receive further assistance from the Ryan White Part A Program.

_____ _____

Client's Signature Date

MAGI WORKSHEET

MAGI

Modified Adjusted Gross Income (MAGI) is used to determine eligibility for a variety of federal tax benefits, including eligibility for Ryan White Part A Program services. The client's household taxable income is considered for MAGI, e.g. all individual's claimed on the client's tax return including spouse and/or children. Taxable household members may or may not include all individuals who physically live in the household and may include individuals who do not physically reside in the household.

Form

A standardized MAGI Worksheet has been developed for the Ryan White Part A Program to be completed with clients who have not filed a tax return for the most recent tax year. It is the responsibility of Linkage to Care Coordinators, medical case managers, and/or non-medical case manager–supports[4] to complete all sections of the form to verify income and to collect the following documents from the client:

- copies of four consecutive weeks of pay stubs;
- letters from employer stating earnings;
- copies of court orders for alimony or other court ordered payments, excluding child support; OR
- copies of award letters for benefits from federal, state, or county entitlement programs.

Each section of the form provides financial information about the client that will be utilized to determine eligibility for Ryan White Part A program services.

Client Name and DOB:
This section provides the client's name and date of birth.

Income Sources:
This section provides the total monthly income for all taxable household members for each category listed in the table. Income categories listed in all capital letters are not calculated in MAGI, but are required fields, as applicable.

Non-MAGI:
This section includes the total monthly expenses for all taxable household members for each category listed in the table. Expense information collected in this table is not calculated for MAGI, but are required fields, as applicable.

[4] In this section, when referring to all three professional positions - Linkage to Care coordinators, medical case managers, and non-medical case manager–supports, the term "professional or professionals" will be used.

Modified Adjusted Gross Income (MAGI):
This section includes the total of the taxable household's income minus the taxable household's non-MAGI income.

Notes:
This section provides a place for professionals to document any information related to the client's income.

Client Signature and Date:
This section provides the client's signature and date.

Form Validity

The MAGI Worksheet is valid for six months from the date the form is completed and signed.

Accessing the MAGI Worksheet

The MAGI Worksheet is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

MAGI Worksheet Documentation Procedures

- Professionals are responsible for documenting all fields on the form. A zero (0) should be documented in any field that does not apply to the client.

- Income listed in all capital letters are required fields, as applicable, but are not calculated in MAGI.

- To calculate income using pay stubs:
    - obtain copies of four consecutive weeks of pay stubs;
    - determine gross pay (pay before taxes are taken out);
    - add together the four weeks of gross pay (per pay stub). This number represents one month of total gross pay; and
    - subtract any eligible MAGI deductions (this number represents MAGI).

- The following required documents should be collected from the client:
    - copies of four consecutive weeks of pay stubs;
    - letters from employer stating earnings;
    - copies of court orders for alimony or other court ordered payments (except child support); OR

- copies of award letters for benefits from federal, state or county entitlement programs.

- Professionals are responsible for ensuring the client's original signature is present on the form.

- Completed MAGI Worksheets, along with required supplemental documents, should be maintained in the client's file.

Best Practices

- ✓ Only complete the MAGI Worksheet and collect required documentation when the client has not provided a copy of their most current IRS tax transcript or signed an income attestation.

- ✓ Be sure to complete all sections of the form.

- ✓ If the client and the client's taxable household do not have an income, document zero (0) in associated categories listed in the "income sources" table.

- ✓ Make sure the client documents an original signature and date on the MAGI Worksheet.

- ✓ Collect copies of required documents.

- ✓ Maintain completed form and required documents in the client's file.

SAMPLE DOCUMENTATION – CLIENT ATTESTATION OF INCOME

A signed attestation by the client stating their income, including if the client has no income (may be utilized one time in a twelve-month period), can be provided in the event that the client does not have and/or is unable to provide one of the following documents to verify income:

- Copy of the most current IRS Tax Transcript (three years of tax transcripts if self-employed);
- Completed MAGI Worksheet with a copy of four consecutive weeks of pay stubs;
- Completed MAGI Worksheet with letters from employer stating earnings;
- Completed MAGI Worksheet with copies of court orders for alimony or other court ordered payments, excluding child support;
- Completed MAGI Worksheet with copies of award letters for benefits from federal, state, or county entitlement programs.

Sample Client Letter of Attestation – Confirmation of Income

I _____ (print client's name) swear or affirm that I currently receive $_____ in monthly income. I understand that income includes all money received from work, even that which is not reported for tax purposes. Income also includes, but is not limited to, money received from retirement, investments, unemployment compensation, and disability benefits. I am aware that I must also report any and all income earned by a spouse (if married) and legal guardian (if dependent).

I am aware that providing false, incomplete, or inaccurate information regarding income may result in my inability to receive further assistance from the Ryan White Part A Program.

_____ _____

Client's Signature Date

SAMPLE DOCUMENTATION – HEALTH INSURANCE ELIGIBILITY ATTESTATION

A signed attestation from a professional stating the client is not eligible for health insurance coverage may be provided in the event that the client does not have and/or is unable to provide one of the following documents to verify health insurance coverage:

- Copy of current insurance card;
- Evidence of denial from an insurance program;
- Copy of pending application (if potentially eligible);
- Signed attestation that the client was informed of health insurance coverage options, but did not apply; or
- Proof that the service is not covered by other third party insurance programs.

Sample Professional Letter of Attestation – Health Insurance Eligibility

I _____ (print professional's name) affirm that _____ (print client's name) is not eligible for health insurance coverage.

_____ _____

Professional's Signature Date

SAMPLE DOCUMENTATION – CLIENT ATTESTATION OF HEALTH INSURANCE

If a client is uninsured and unwilling to obtain health insurance coverage, a signed attestation by the client declaring they were informed of health insurance coverage options, may be provided.

Sample Client Letter of Attestation – Confirmation of Awareness and Denial of Health Insurance Options

I _____ (print client's name) was informed by _____ (print professional's name) that Ryan White is a payer of last resort program. I was informed that I should apply for a health insurance program that could pay for my HIV-related medical costs. I understand that applying for such a program could provide additional coverage for me, including comprehensive primary care and hospital associated costs. I am aware that the Ryan White Program cannot pay for these costs and I may be billed for them. With this information, I decline health insurance and choose to request that Ryan White pay for my care.

_____ _____

Client's Signature Date

_____ _____

Professional's Signature Date

Section VI:
Part A and B – Expectations of Care and Releases

The purpose of explaining expectations of care and obtaining releases is to:

1. Assure that clients of Ryan White Part A and Part B case management programs know the expectations, limits of service to be provided, and client responsibilities;
2. Allow for the exchange and/or release of information within the network and/or other providers; and
3. Enable client information to be maintained in electronic data systems.

RYAN WHITE CASE MANAGEMENT EXPECTATIONS OF CARE

Form

A standardized Ryan White Case Management Expectations of Care Form has been developed for Ryan White Parts A and B case management programs. It is the responsibility of medical case managers (MCM) or non-medical case manager-supports (NMCM–Support) to explain to clients all information contained on this form. Each section of the form provides the client with valuable information about the Ryan White case management programs.

As a Client, You Can Expect:
This section provides information on what will be provided to clients through the Ryan White case management programs, including frequency of interactions, advocacy information, referrals, communication, confidentiality, client rights and responsibilities, and grievance procedures.

We Cannot Commit To:
This section provides information on the limits of service that will be available/provided to clients through the Ryan White case management programs, including payment for services, transportation, and advice outside of the of scope of the program.

The Client Agrees To:
This section outlines the client's responsibilities as a participant in the program, such as providing required information, keeping appointments, and informing the MCM and/or NMCM-Support of any changes in information and/or needs.

Primary Contact for all Services:
This section contains the contact information for the case manager (either MCM or NMCM-Support), including name, phone number, and email address.

Case Manager/Client:
This section contains the case manager's (either MCM or NMCM-Support) and client's printed names, signatures, and date.

Form Validity

The Ryan White Case Management Expectations of Care Form is valid for the entire duration of time that the client is in the program. In the event the client's case is closed and re-opened at a later time, a new form would need to be completed.

Accessing the Ryan White Case Management Expectations of Care Form

The Ryan White Case Management Expectations of Care Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs and/or NMCM-Supports are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Case Management Expectations of Care Form Procedures

MCMs or NMCM-Supports are responsible for reading and explaining to the client all information contained in the Case Management Expectations of Care Form.

- The Ryan White Case Management Expectations of Care Form should be completed upon entry into case management or when returning to case management if the client's case has been closed.
    - Clients who begin receiving services through medical case management and complete the Ryan White Case Management Expectations of Care Form will not need to complete a new form if their case is transferred to non-medical case management–support.

- To confirm client understanding of the Case Management Expectations of Care Form, the client is responsible for documenting their initials next to each statement accordingly (1i, 1j, 1k, and 2c) and signing the form.
    - If the client is unable to initial the form, the MCM or NMCM-Support, with verbal permission from the client, may place an "x" next to each statement and should document a case note.
    - If the client is unwilling to initial any of the statements containing space for client initials, the MCM or NMCM-Support should offer to re-explain the section that is not understood. If the client remains unwilling to initial any of the statements, the MCM or NMCM-Support is responsible for contacting a supervisor and reaching out to the grantee for further instruction. Providing services without client initials/signature on all areas listed under client agreement creates risk for the client, the MCM and/or NMCM-Support, and the medical case management agency.

- The client and MCM or NMCM-Support are both responsible for documenting their signatures and date on the form. In the event that the client is unable or unwilling to sign the form, the MCM or NMCM-Support should still sign the form and document a case note with a description of the reason for the client's denial.

- Upon completion of the Case Management Expectations of Care Form, a copy should be provided/offered to the client and the original should be maintained in the client's file.

Best Practices

- ✓ Be prepared for the initial meeting with the client by having:
  - all forms (completed intake form, client file (if returning client), along with blank medical case management forms and/or non-medical case management–support forms, and any agency-required forms);
  - access to a phone;
  - business cards; and
  - paper for documenting information to be included in case notes.

- ✓ Take time to explain all aspects of the program to clarify expectations, limits of service to be provided, and client responsibilities. This should be completed in person with the client to help build rapport, reduce confusion, and increase participation and follow-through.

- ✓ It is strongly recommended this form be explained to the client in a conversational manner. In addition to reading all information contained on the form, take time to explain key sections:
  - 1) As a client you can expect:
    1a) Prompt, individualized, quality services by your case management team to improve your health outcomes – explain that there is a team approach to care and that they may be contacted by other agency personnel. Remind the client that their MCM or NMCM-Support is their primary point of contact.

    1f) A professional relationship – explain what professional boundaries mean by indicating that the following are not appropriate: dating the client, connections on social media (Facebook, Twitter, Instagram, etc.), performing personal errands for the client, attending social events with the client, personal home visits, acceptance of gifts (be sensitive to cultural considerations), and offering gifts to the client.

    1g) Guidance to obtaining self-sufficiency (graduating) – explain that the program has an end-goal. It is expected that each client, with support from their MCM and/or NMCM-Support, will be working to reach self-management and graduate from the program.

    1i) Confidentiality, with exception of mandated reporting requirements – explain what MCMs and NMCM-Supports are mandated to report (child abuse/neglect, elder abuse/neglect, harm to self or others, and subpoena) and that these supersede the confidentiality agreement.

  - 2) We cannot commit to:
    2a) Pay for services from a non-Ryan White approved provider – explain the importance of contacting the MCM or NMCM-Support to discuss in/out-of-network coverage prior to meeting with a provider and

that Ryan White funding is not able to pay for an in-patient stay or emergency department services.

2d) Provide advice outside of the scope of our practice – explain that MCMs and NMCM–Supports may only provide service within the range of the program's services and would not be able to provide any advice/guidance with legal matters, medical diagnosis, or information that requires licensing (other than social work, for MCMs and/or NMCM-Supports who have a license in social work).

- 3) The client agrees to:
  3c) Keep us updated on your change of phone number or address – explain that it is imperative they inform the MCM and/or NMCM-Support of any changes to their contact information in order to receive important information.

  3f) Provide advanced notice of your needs when possible to help us serve you better – explain that requesting assistance and/or informing the MCM and/or NMCM-Support of needs as early as possible will help assure that they receive the service sooner. For example, if the client is in need of a gas card, it is best to ask for this assistance in advance of the need, not the same day as the need, so that arrangements can be made to give the client the needed gas card.

✓ MCMs and/or NMCM-Supports are encouraged to annually review this form with the client (even though the signed form is valid for the entire duration the client is in the program). This will help clients to continue to be aware of valuable information on the Ryan White case management programs.

CENTRAL OHIO HIV CASE MANAGEMENT NETWORK RELEASE

Form

A standardized Central Ohio HIV Case Management Network Release Form has been developed for Ryan White Parts A and B programs. It is the responsibility of Linkage to Care coordinators, medical case managers, and/or non-medical case manager–supports[5] to explain to clients all information contained on this form. Completed/signed forms allow for client information to be maintained in electronic data systems, e.g. CAREWare/RWAD that are accessed by all agencies within the Central Ohio HIV network, as well as enabling the agencies in this network to release and/or share information related to the client's HIV status, physical, financial, chemical dependency, and/or mental health condition for the purpose of assisting the client to receive/gain access to services related to their needs.

Authorization of Appropriate Staff:
This section provides the client's legal name and date of birth.

Automatic Expiration:
In the last line of the second paragraph on the form, the client has the opportunity to indicate if they would like the authorization for the release of information to expire in less than 365 days. If the client indicates a desire to shorten the length of the authorization, a number of less than 365 should be documented in the space provided.

Date of Expiration:
This section provides the date the authorization will expire. The maximum amount of time the authorization may be valid is 365 days (one year from date of signature).

Reason and Date of Earlier Expiration:
The reason for and date of early expiration should be documented in this section, if the client has selected a date of less than 365 days for the authorization to expire.

Client's Signature and Date:
This section contains the client's signature and date.

Agency Representative's Signature and Date:
This section contains the professional's signature and date.

[5] In this section, when referring to all three professional positions - Linkage to Care coordinators, medical case managers, and non-medical case manager–supports, the term "professional or professionals" will be used.

Form Validity

The Central Ohio HIV Case Management Network Release Form is valid for one year from the date the form is signed, unless an earlier date is requested by the client and documented on the form. It is recommended that medical case managers and/or non-medical case manager–supports are proactive in obtaining the client's signature every six months when they complete eligibility renewal paperwork.

Accessing the Central Ohio HIV Case Management Network Release Form

The Central Ohio HIV Case Management Network Release Form is a PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible for completing this form with handwritten responses.

Central Ohio HIV Case Management Network Release Form Procedures

- Professionals are responsible for explaining to the client all information contained on this form, including the revocation process, prior to completing the form with the client.
    - Clients who transfer between Linkage to Care, medical case management, and/or non-medical case management–support will not need to complete a new Central Ohio HIV Case Management Network Release Form until it is time to complete their eligibility renewal paperwork

- The Central Ohio HIV Case Management Network Release may not be altered in any way. In the event that a client is unwilling to sign the form, a supervisor and Columbus Public Health, should be contacted. For example, if the client does not want to sign the form because they do not want a particular agency to view or access their information, the professional should contact their supervisor and the supervisor should contact Columbus Public Health.

- Professionals are responsible for ensuring the form is documented correctly and includes both the client's and professional's signatures.

- Upon completion of the Central Ohio HIV Case Management Network Release Form, a copy should be provided/offered to the client and the original should be maintained in the client's file.

- A brief description of the interaction with the client should be documented as a case note.

- Once the Central Ohio HIV Case Management Network Release Form is completed and signed, the professional may exchange or release information to

the appropriate staff and/or volunteers from the following Ryan White funded agencies: Equitas Health, Southeast, Inc., Columbus Public Health, Ohio Department of Health, Nationwide Children's Hospital, Ohio State University Wexner Medical Center, and AIDS Healthcare Foundation.

Best Practices

- ✓ Provide to the client an explanation of the purpose and contents of the form. This will help prevent confusion and protect the client, professional, medical case management agency, and the network agencies to whom information will be exchanged or released.

- ✓ Develop a tracking system of when this form will expire and be sure to renew this form with the client annually.

- ✓ It is recommended that medical case managers and/or non-medical case manager-supports are proactive in obtaining the client's signature prior to the form's expiration date, e.g. six months prior.

- ✓ Make sure that the Central Ohio HIV Case Management Network Release is not altered in any way. If the client opposes signing the form because they do not want a particular agency to view or access their information, the professional should contact their supervisor and the supervisor should contact Columbus Public Health.

RYAN WHITE PART A CASE MANAGEMENT AGENCY-SPECIFIC FORMS

Each Ryan White Part A-funded case management agency may have additional forms that medical case managers and/or non-medical case manager-supports are required to complete with clients in addition to the forms contained in this Manual. These forms may include:

- Agency-specific release of information,
- Confidentiality,
- Health Insurance Portability and Accountability Act (HIPAA), and/or
- Expectations of care (including grievance).

Medical case managers and non-medical case manager-supports are responsible for following their agency's protocol on completing agency-specific forms.

Section VII:
Part A and B – Client Information

The Client Information Form is a required form for medical case managers (MCM) and non-medical case manager-supports (NMCM–Support) to complete **IF** they maintain a paper file and an optional form if they maintain an electronic file. The purpose of the Client Information Form is to assure that MCMs and NMCM–Supports have current client, guardian/conservator (if applicable), and emergency contact information on file.

RYAN WHITE CLIENT INFORMATION

Form

A standardized Ryan White Client Information Form has been developed for Ryan White Parts A and B case management programs. It is the responsibility of medical case managers (MCM) and non-medical case manager-supports (NMCM–Support) who maintain a paper client file, and as needed by those who maintain an electronic client file, to complete all sections of the form. Each section of the form provides MCMs and NMCM–Supports with up-to-date client, guardian/conservator (if applicable), and emergency contact information.

Date:
This section contains the date the Client Information Form was completed.

No Changes/Date:
This section should be checked and a date should be documented if there were no changes in the client's address, phone number, and/or email address within the six month timeframe in which the form is valid.

Client Contact Information:
This section provides contact information on the client and the client's emergency contact, along with contact information for the client's guardian/conservator, if applicable. Information from this section will be helpful to the MCM and/or NMCM–Support in knowing the best way to contact the client.

Updated Client Contact Information:
In the event that the client has a change in address, phone number, and/or email within the six month timeframe in which the form is valid, this section should be completed, including the date of completion.

Form Validity

The Client Contact Information Form is valid for six months from the date the form is completed.

Accessing the Client Information Form

The Client Information Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs and NMCM–Supports are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Client Information Form Documentation Procedures

The Client Information Form is to be completed every six months by MCMs and NMCM–Supports who maintain a paper client file, and as needed by those who maintain an electronic client file. If at the conclusion of the six months there were no changes to the client's address, phone number, and/or email, a check mark may be placed in the "no changes" box along with the date the box was checked.

- The Client Information Form may be completed by meeting with the client in person, e.g. when completing eligibility paperwork, or interviewing the client over the phone.

- MCMs and NMCM–Supports are responsible for completing all sections/questions on the form following their agency's protocol on the format in which the form should be documented, e.g. typed or handwritten.

- If the client acknowledges having a court appointed guardian/conservator, the completion of any and all medical case management forms and/or non-medical case management–support forms may only be conducted if the guardian/conservator participates. This may require scheduling a time for both the client and their guardian/conservator to be present.

- MCMs and/or NMCM-Supports are responsible for explaining to clients the preferred method of contact section, checking the associated boxes for the method in which the client would like to be contacted, and obtaining the client's initials.

- In the event that the client has changes other than their address, phone number, and/or email address during the six month timeframe, a new Ryan White Client Information Form should be documented.

- Client Information Forms should be maintained in the client's file.

Best Practices

- ✓ Explain to the client the purpose of the form. For example, the purpose of the form is to maintain accurate contact information and preferred method and type of information to leave in messages.

- ✓ Be sure to ask and obtain an answer for all questions on the Client Information Form. Incomplete forms may result in an inability to communicate with the client, guardian/conservator (if applicable), and/or emergency contact.

- ✓ Confirm accuracy of all information documented on the form.

Section VIII:
Part A and B – Medical Case Management - Assessment

The purpose of the assessment process is to:

1. Interview clients to identify areas of need, which will ultimately be addressed through the Individualized Service Plan;
2. Evaluate and document client acuity in seventeen critical need areas; and
3. Determine if the client should remain in medical case management, transfer to non-medical case management–support, or graduate from the program.

RYAN WHITE MEDICAL CASE MANAGEMENT PYSCHOSOCIAL ASSESSMENT

Form

A standardized Ryan White Medical Case Management Psychosocial Assessment Form has been developed for the Ryan White Part A and Part B medical case management programs. It is the responsibility of medical case managers (MCM) to interview, assess, and evaluate clients in seventeen functional areas and document the information accordingly. MCMs' assessment of clients in each area of functioning will determine client acuity level and amount and/or type of care to be provided through Ryan White services.

Information from the Psychosocial Assessment will also be used to determine if the client will remain in medical case management or be transferred to non-medical case management–support:

- Clients with moderate or intensive needs in housing, medical needs, care and medication adherence, mental health, substance abuse, safety, or developmental disability shall remain in medical case management.
- Clients with needs only in basic needs, oral health, health insurance, financial planning, transportation, language and literacy, support system, sexual health/risk reduction, knowledge of HIV disease, or legal issues shall be transferred to non-medical case management–support.

MCMs will use clinical judgement to determine if the client should remain in medical case management or be transferred to non-medical case management-support for clients with:

- basic needs in housing, medical needs, care and medication adherence, mental health, substance abuse, safety, or developmental disability, and/or
- basic/moderate/intensive need in basic needs, oral health, health insurance, financial planning, transportation, language and literacy, support system, sexual health/risk reduction, knowledge of HIV disease, or legal issues.

Clients transferred to non-medical case management–support will not participate in further assessments with a MCM unless the client's need changes in the future, requiring a comprehensive assessment (see page 92 for additional information).

The Psychosocial Assessment also includes the Client Historical Assessment (see page 63 for additional information), Anxiety Screen – GAD-7 (see page 65 for additional information), Depression Screen – PHQ-9 (see page 67 for additional information), and Substance Abuse Screen – DAST-20 (see page 70 for additional information)[6].

[6] In this section, when referring to the Client Historical Assessment, Anxiety Screen (GAD-7), Depression Screen (PHQ-9), and/or Substance Abuse Screen (DAST-20), the term "screen" or "screens" will be used.

MCMs are responsible for meeting with clients every six months to assess and evaluate client acuity in all seventeen areas of functioning:

- Annually: Complete all questions and acuity tables to determine acuity in each area of functioning. Document notes and complete the screens as needed.
- Semi-Annually: Complete all questions and acuity tables to determine acuity in each area of functioning. Document notes and complete the screens as needed.

Assessment Sign-Off and Total Acuity Score:

This section contains information about the client, MCM, and acuity score, including client legal name, date of birth, case manager name, name of case management agency, date of assessment, and total acuity score. Shaded information should only be completed at the semi-annual review. MCMs are responsible for signing and dating the form after completing the annual and semi-annual assessments.

Seventeen Areas of Functioning:

Each area of functioning contains questions, notes and referrals, an acuity table, and an acuity score.

- Questions: MCMs are responsible for determining how they will obtain answers to all of the questions; MCMs have the option of reading the questions to the client from the form or asking open-ended questions. Questions on the Psychosocial Assessment are designed to assist MCMs with determining the client's acuity in each of area of functioning.
    - Annually: MCMs are required to document an answer to all questions on the Psychosocial Assessment.
    - Semi-Annually: MCMs may either document a response to each of the questions on the Psychosocial Assessment **OR** write a narrative summarizing their assessment of the client's acuity.

- Notes and Referrals: Notes may be documented every six months, along with any referrals that are needed and/or provided to the client. Notes may describe the client's presenting problem related to the functional area and could address the question, "what is the impact of the concern on the client's ability to meet their need in each area of functioning?".

- Acuity Table: Using information gathered, e.g. responses to questions during the assessment and/or information obtained through direct interaction with the client within the past 30 days, MCMs are responsible for evaluating client acuity by checking boxes within the acuity table that best correspond to the client's current state. For example, the client may have three intensive needs and one self-management need and all four boxes should be checked accordingly. At least one box should be checked in the acuity table for each functional area.

- Acuity Score: MCMs will determine the acuity score for each area of functioning by taking the highest level of need checked in the acuity table and documenting it next to annual or semi-annual review accordingly.

- If two or more levels of need are checked for any area of functioning, the client should be assigned the number corresponding to the highest level of need for that area of functioning. For example, if two boxes are checked for basic need (4) and one box is checked for moderate need (6), the level of need for the functional area would be moderate (6).
- The highest score a client may receive, per functional area, is 8. For example, if three boxes are checked for intensive need (8), the score would be 8, not 24.

The Psychosocial Assessment utilizes a weighted scoring system for each area of functioning. The functional areas are prioritized according to time to be spent by the MCM (and/or NMCM-Support, if the case is transferred) with the client and the degree of severity related to the client's HIV medical care:

- Low: the following areas of functioning are considered low and have a score of 0 – 4 points available in the acuity table: legal, knowledge of HIV disease, sexual health/risk reduction, and support system.
- Medium: the following areas of functioning are considered medium and have a score of 0 – 5 points available in the acuity table: safety, developmental disability, language and literacy, transportation, financial planning/counseling, health insurance, and oral health.
- High: the following areas of functioning are considered high and have a score of 0 to 8 points available in the acuity table: substance abuse, mental health, care and medication adherence, medical needs, housing, and basic needs.

Form Validity

The Ryan White Case Management Psychosocial Assessment is valid for six months from the date the form is signed. The form should be completed two times per 12-month period (with clients remaining in medical case management).

Accessing the Ryan White Medical Case Management Psychosocial Assessment

The Ryan White Medical Case Management Psychosocial Assessment is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Medical Case Management Psychosocial Assessment Procedures

- MCMs are responsible for contacting newly-assigned clients within two business days of assignment to schedule the initial Psychosocial Assessment.

- The initial Psychosocial Assessment must be completed by the MCM within two weeks of initial contact with the newly-assigned client.

- MCMs are responsible for meeting with clients every six months to assess and evaluate client acuity in seventeen areas of functioning.
  - Annually: MCMs are required to document an answer to <u>all</u> questions on the Psychosocial Assessment.
  - Semi-Annually: MCMs are responsible for fully assessing clients in all areas of functioning and may <u>either</u> document a response to each of the questions **<u>OR</u>** write a narrative summarizing their assessment of the client's acuity. This should be based upon knowledge gained through:
    - ❖ contact with the client within <u>30 days prior to the Psychosocial Assessment due date.</u> For example, if MCMs have contact with clients about a specific functional area(s), they will not need to interview the client in that specific area(s). However, they are required to document an answer to all questions in that area(s); <u>AND/OR</u>
    - ❖ interviewing the client, e.g. MCMs who have contact with the client within <u>30 days prior to the Psychosocial Assessment due date</u> about some, <u>but not all</u>, functional areas <u>and/or do not have any contact with the client within 30 days prior to the Psychosocial Assessment due date</u>, will need to interview the client about the areas they did not discuss with the client and document the Psychosocial Assessment accordingly.

- MCMs will evaluate client acuity and score the acuity table for each functional area by:
  - Utilizing information gathered on the Psychosocial Assessment and/or obtained through direct interaction with the client within the past 30 days.
  - Checking boxes in the acuity table for each functional area according to what best corresponds with the client's current state. For example, the client may have three intensive needs and one self-management need and all four boxes should be checked accordingly. At minimum, at least one box should be checked in the acuity table for each functional area.
  - Determining acuity level for each area of functioning by taking the highest level of need checked in the acuity table and documenting it next to annual or semi-annual review accordingly.
    - ❖ If two or more levels of need are checked within an area of functioning, the client should be assigned the number corresponding to the highest level of need. For example, if two boxes are checked for basic need (4) and one box is checked for moderate (6), the level of need for the functional area would be moderate (6).
    - ❖ The highest score the client may ever receive, per functional area, is 8. For example, if three boxes are checked for intensive need (8), the score would be 8, not 24.

- MCMs will determine the client's total annual/semi-annual acuity score by doing the following:
    - Total (add) the numbers of the annual or semi-annual score from each area of functioning and document this number in the "total annual acuity score" or "total semi-annual acuity score" accordingly.
    - Utilize the total acuity score result to determine the frequency of contact with the client. Clients with an acuity score of:
        - 45 - 99 are considered an "intensive effort case" and require contact with the client monthly at minimum and more frequently as needed.
        - 21 - 44 are considered a "moderate effort case" and require contact with the client every three months at minimum and more frequently as needed.
        - 2 - 20 are considered a "basic effort case" and require contact with the client every six months at minimum and more frequently as needed.

- Use clinical judgement and follow the prompts to determine if any of the screens should be completed.

- MCMs should follow their agency's protocol for ensuring acuity scores are entered into CAREWare by the 15th of the following month.

- When determining a client's acuity, MCMs should use their best clinical judgement. If uncertain, a supervisor should be consulted.

Best Practices

- ✓ MCMs are encouraged to obtain answers to all of the questions listed on the Psychosocial Assessment every six months.

- ✓ Use the tips/prompts provided on what to evaluate in each area of functioning.

- ✓ Be sure to use clinical judgement when determining acuity and/or whether or not to complete the various screens available within the Psychosocial Assessment.

- ✓ Utilize supervision to address questions, concerns, and uncertainty about how to interview, assess, and/or document the Psychosocial Assessment.

RYAN WHITE PSYCHOSOCIAL ASSESSMENT SUMMARY

Form

A standardized Ryan White Psychosocial Assessment Summary Form has been developed for the Ryan White Part A and Part B medical case management programs. This is an optional form that medical case managers (MCM) may complete to assist with determining if the client should remain in medical case management or be transferred to non-medical case management–support. MCMs may also complete this form to assist with the development of the Individualized Service Plan (see page 77 for additional information).

Date:
This section contains the date the Psychosocial Assessment Summary Form was completed.

Client Information:
This section provides important identifying information, including the client's legal name.

Psychosocial Assessment Summary Table:
This section contains a summary table that should be documented to correspond with the client's level of need as indicated in the acuity table of each area of functioning on the completed Psychosocial Assessment (see page 55 for additional information).

Questions:
This section contains questions with associated prompts to assist MCMs with making a determination on retaining the client in medical case management or transferring the client to non-medical case management–support.

Form Validity

The Ryan White Psychosocial Assessment Summary Form is an optional form that if completed, should correspond with the Psychosocial Assessment form validity period of six months.

Accessing the Ryan White Psychosocial Assessment Summary Form

The Ryan White Psychosocial Assessment Summary Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs are responsible for

following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Psychosocial Assessment Summary Form Procedures

The Psychosocial Assessment Summary Form should be completed as needed and be used to help determine if a client should remain in medical case management or be transferred to non-medical case management–support. Additionally, the form may be helpful to MCMs when completing the Individualized Service Plan.

- MCMs should document the Psychosocial Assessment Summary Form with, or immediately following, the completion of the Psychosocial Assessment in the format determined by each agency, e.g. typed or handwritten.

- Using information documented in the acuity table for each functional area of the Psychosocial Assessment, MCMs are responsible for placing a checkmark in the corresponding box in the "summary table" on the Psychosocial Assessment Summary Form.
    - As a reminder, if two or more levels of need are checked in an acuity table for any area of functioning on the Psychosocial Assessment, the client should be assigned the level corresponding to the highest level of need for that area of functioning. For example, if two boxes are checked for basic need and one box is checked for moderate, the level of need for the functional area would be moderate.

- MCMs should answer the questions on the form using information documented in the "summary table". The prompts provided should be utilized along with clinical judgement to assist with determining if the client should remain in medical case management or be transferred to non-medical case management–support. If in doubt, it is recommended the client be retained in medical case management.

- MCMs will do the following with <u>clients remaining in medical case management</u>:
    - complete the Ryan White Case Management Individualized Service Plan (see page 77 for additional information),
    - deliver services to clients according to the client's acuity level and activities outlined in the Individualized Service Plan,
    - document case notes, and
    - complete required paperwork/assessments semi-annually.

- MCMs will do the following with <u>clients who will be transferred to non-medical case management–support</u>[7]:
    - complete the Ryan White Case Management Individualized Service plan (see page 77 for additional information),

[7] Clients transferred to non-medical case management–support will only participate in further Psychosocial Assessments with a medical case manager if they transferred back to medical case management in the future.

- inform the client that they may be working with another professional on the activities outlined in the Individualized Service Plan,
- complete and submit the Ryan White Client Transfer and Case Conference Form (see page 92 for additional information). It will be to the discretion of the case assigner if the client's case will ultimately be transferred.
  - If the case assigner approves the transfer to non-medical case management-support:
    - participate in a case conference that only includes the professionals transferring and receiving the case (see page 96 for additional information).
  - If the case assigner determines the case will remain in medical case management, the MCM will need to:
    - communicate with the client that they will continue working together; and
    - discuss and document a medical goal on the Individualized Service Plan.

Best Practices

- ✓ Use prompts provided on the Psychosocial Assessment Summary Form to help inform the decision to retain or transfer the client. When in doubt, it is recommended the client be retained in medical case management services.

- ✓ Be sure to use supervision to discuss and explore the decision-making process for when to retain and when to transfer clients.

- ✓ Become familiar with the steps to follow if the client is to be transferred to non-medical case management–support and/or to be returned to medical case management.

RYAN WHITE MEDICAL CASE MANAGEMENT CLIENT HISTORICAL ASSESSMENT AND GLOSSARY OF OPPORTUNISTIC INFECTIONS

Form

A standardized Ryan White Medical Case Management Client Historical Assessment form has been developed for the Ryan White Part A and Part B medical case management programs. Also included is a glossary of opportunistic infections[8] that provides a brief description of the infections listed on the Client Historical Assessment Form. It is the responsibility of medical case managers (MCM) to complete this form in conjunction with completing the client's first ever Psychosocial Assessment. It is recommended that this form be completed before completing the "medical needs" area of functioning in the Psychosocial Assessment. Each section of the form provides MCMs and/or non-medical case manager-supports with information on the client's history with opportunistic infections and other illnesses/diseases.

Client Information:
This section contains information about the client and case manager, including client legal name, date of birth, case manager name, name of case management agency, client ID, and date of assessment.

Diagnosis of Opportunistic Infections:
This section contains a listing of the opportunistic infections along with a place to document "other" in the event the client indicates opportunistic infections that are not listed on the form.

Diagnosis of Other Illnesses/Diseases:
This section contains a listing of other illnesses and diseases, including sexually transmitted diseases, along with a place to document "other STDs" and "other conditions."

Form Validity

The Ryan White Medical Case Management Client Historical Assessment is valid for the entire duration of time the client is engaged in case management services.

[8] Opportunistic infections are infections that occur more often or are more severe in people with weakened immune systems, including people living with HIV, than in people with healthy immune systems.

Accessing the Ryan White Medical Case Management Client Historical Assessment

The Ryan White Medical Case Management Client Historical Assessment is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Medical Case Management Client Historical Assessment Procedures

The Ryan White Medical Case Management Client Historical Assessment should be completed with the client's first ever Psychosocial Assessment. The "medical needs" area of functioning on the Psychosocial Assessment contains a prompt to complete the Client Historical Assessment first before proceeding.

- MCMs are responsible for documenting all sections/questions on the form.
- MCMs may utilize and refer to the Glossary of Opportunistic Infections when completing the Client Historical Assessment.
- MCMs should explore with the client the client's history of having any opportunistic infections and other illnesses/diseases and document dates of any diagnoses on the form.
- The completed Ryan White Case Management Client Historical Assessment should be maintained in the client's file.

Best Practices

- ✓ MCMs are encouraged to familiarize themselves with the Glossary of Opportunistic Infections, which contains a brief description of the infections listed on the Client Historical Assessment Form.
- ✓ For the purpose of accuracy of information, it MCMs with access to medical records may cross-reference information from the medical record with information provided by the client through the Client Historical Assessment.

ANXIETY SCREEN (GAD-7)

Form

Ryan White Part A and Part B medical case management programs utilize a standardized anxiety screening tool, Generalized Anxiety Disorder 7 (GAD-7), to assess clients for anxiety. The mental health area of functioning in the Psychosocial Assessment contains a prompt to use clinical judgement to determine if the GAD-7 is needed. The GAD-7 is comprised of seven statements. Clients and/or the medical case manager (MCM), if the screen is to be read to the client, will record a number from zero through three (0 = not at all; 1 = several days; 2 = more than half the days; and 3 = nearly every day) to indicate the frequency of how the statement applied to the client over the past two weeks. A scoring guide is provided to assist MCMs with determining if a referral for mental health services is needed.

Identifier
This section contains the client's name.

Date:
This section contains the date the assessment is completed.

Seven Statements:
Seven statements are detailed on the form and the client should indicate (either in writing or verbally to the MCM) how much the statement applied to them over the past two weeks – not at all (0), several days (1), more than half the days (2), or nearly every day (3).

Form Validity

The Anxiety Screen (GAD-7) should be completed as needed and used to determine if a client should be referred for mental health services.

Accessing the Anxiety Screen

The Anxiety Screen (GAD-7) is a PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs are responsible for completing this form with handwritten responses.

Anxiety Screen (GAD-7) Procedures

The Anxiety Screen (GAD-7) should be completed as needed based upon the MCMs assessment of the client in the "mental health" area of functioning in the Psychosocial

Assessment. This functional area also contains a prompt to use clinical judgement to determine if the GAD-7 is needed.

- MCMs should use their best judgement to determine if the GAD-7 should be completed by the client independently or with assistance.
    - If the client is to complete the assessment independently, they should only be provided with page one.

- MCMs are responsible for ensuring all sections/questions on the GAD-7 are complete.
    - Regardless of how the GAD-7 is completed (independently by the client or with assistance from the MCM), MCMs are responsible for providing directions to the client on how to complete the form – "read (or listen to) each statement and record (state) a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past two weeks".
    - Remind the client to not spend too much time on any one statement.
    - Assure the client that there are no right or wrong answers.

- After the client has completed documenting/stating responses to each of the seven statements, MCMs should use page two of the GAD-7 to score and determine the results.
    - To score the assessment, total (add) the responses from each of the statements. The maximum score of the GAD-7 is 21. Higher scores are indicative of a potential need for services:
        - ❖ A score of 5 – 9 is indication of mild anxiety;
        - ❖ A score of 10 – 14 is indication of moderate anxiety; and
        - ❖ A score of 15 – 21 is indication of severe anxiety.

      Clients with a score of 10 or greater should be referred for further evaluation by a mental health provider.

- Be sure to explain to the client the results of the assessment and provide referrals accordingly.

- The completed GAD-7 should be maintained in the client's file.

DEPRESSION SCREEN (PHQ-9)

Form

Ryan White Part A and Part B medical case management programs utilize a standardized depression screening tool, Patient Health Questionnaire (PHQ-9), to assess clients for depression. The mental health area of functioning in the Psychosocial Assessment contains a prompt to use clinical judgement to determine if the PHQ-9 is needed. The PHQ-9 is comprised of nine statements and a follow-up question. Clients and/or the medical case manager (MCM), if the screen is to be read to the client, will place a checkmark to indicate the frequency (0 = not at all, 1 = several days, 2 = more than half the days, and 3 = nearly every day) of how the statement applied to the client over the past two weeks. A scoring guide is provided to assist MCMs with determining if a referral for mental health services is needed.

Name/Date:
This section contains the client's name and the date the assessment is completed.

Nine Statements:
Nine statements are detailed on the form and the client should indicate (either in writing or verbally to the MCM) how often over the past two weeks they have been bothered by the "problems" listed in each of the statements – not at all (0), several days (1), more than half the days (2), or nearly every day (3).

Form Validity

The Depression Screen (PHQ-9) should be completed as needed and used to determine if a client should be referred for mental health services.

Accessing the Depression Screen

The Depression Screen (PHQ-9) is a PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs are responsible for completing this form with handwritten responses.

Depression Screen (PHQ-9) Procedures

The Depression Screen (PHQ-9) should be completed as needed based upon the MCMs' assessment of the client in the "mental health" area of functioning in the Psychosocial Assessment. This area of functioning also contains a prompt to use clinical judgement to determine if the PHQ-9 is needed.

- MCMs should use their best judgement to determine if the PHQ-9 should be completed by the client independently or with assistance.
    - If the client is to complete the assessment independently, they should only be provided with page one.

- MCMs are responsible for ensuring all sections/questions on the PHQ-9 are complete. Remember to have the client respond to question ten.
    - Regardless of how the PHQ-9 will be completed (independently by the client or with assistance from the MCM), MCMs are responsible for providing directions to the client on how to complete the form – "read (or listen to) each statement and document (state) a checkmark that best describes how often you have been bothered by each statements over the past two weeks, not at all (0), several days (1), more than half the days (2), or nearly every day (3).
    - Assure the client that there are no right or wrong answers.

- After the client has completed documenting (stating) responses to each of the nine statements and question ten, use page two of the PHQ-9 to score and determine the results.
    - To score the assessment, total (add) the checkmarks by column and document the total score/column in the boxes provided at the bottom of the columns using the following scoring system:
        - ❖ 1 point/each: Checkmarks in the "several days" column;
        - ❖ 2 points/each: Checkmarks in the "more than half the days" column; and
        - ❖ 3 points/each: Checkmarks in the "nearly every day" column.
    - Total (add) the scores from each of the columns to determine the "total score" and document this number in the "total box":
        - ❖ A score of 5 – 9 is indication of mild depression;
        - ❖ A score of 10 – 14 is indication of moderate depression;
        - ❖ A score of 15 – 19 is indication of moderately severe depression; and
        - ❖ A score of 20 – 27 is indication of severe depression.

- Utilize the following guidance to determine if the client should be referred for further evaluation by a mental health provider:
    - If there are at least four checkmarks in the shaded section (including questions one and two), consider a depressive disorder. Add score to determine severity.
    - If there are at least five check marks in the shaded section (one of which corresponds to questions one or two) consider a major depressive disorder.
    - If there are two to four check marks in the shaded section (one of which corresponds to questions one or two), consider other depressive disorders.

- Be sure to explain to the client the results of the assessment and provide referrals accordingly.

- The completed PHQ-9 should be maintained in the client's file.

SUBSTANCE ABUSE SCREEN (DAST-20)

Form

Ryan White Part A and Part B medical case management programs utilize a standardized substance abuse screening tool, Drug Abuse Screening Test (DAST-20), to assess clients for drug use. The substance abuse area of functioning in the Psychosocial Assessment contains a prompt to complete the DAST-20 as needed with clients who indicate they have "used drugs other than for medical reasons". The DAST-20 is comprised of 20 questions. Clients and/or the medical case manager (MCM), if the screen is to be read to the client, will circle "yes" or "no" to indicate their participation in the activity in question in the past 12 months. A scoring guide is provided to assist MCMs with determining if a referral for substance abuse treatment is needed.

Client Information:
This section contains the client's name, case number, charges (please leave blank), test date (date of assessment), and score (of the DAST-20).

Twenty Questions:
Twenty questions are listed on the form and the client should indicate (either in writing (drawing a circle) or verbally to the MCM) "yes" or "no" according to whether they have participated in the activity in question during the past 12 months.

Form Validity

The Substance Abuse Screen (DAST-20) should be completed as needed and used to determine if a client should be linked to substance use treatment/recovery services.

Accessing the Substance Abuse Screen

The Substance Abuse Screen (DAST-20) is a PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs are responsible for completing this form with handwritten responses.

Substance Abuse Screen (DAST-20) Procedures

The Substance Abuse Screen (DAST-20) should be completed as needed with clients who indicate they have "used drugs other than for medical reasons" in the "substance abuse" area of functioning in the Psychosocial Assessment. This functional area also contains a prompt regarding when to complete the DAST-20.

- MCMs should use clinical judgement to determine if the DAST-20 should be completed by the client independently or with assistance.
    - If the client is to complete the assessment independently, they should only be provided with page one.

- MCMs are responsible for ensuring all sections/questions on the DAST-20 are complete.
    - Regardless of how the DAST-20 will be completed (independently by the client or with assistance from the MCM), MCMs are responsible for providing directions to the client on how to complete the form – "read (or listen to) each question and circle (state) "yes" or "no" according to whether you have participated in the activity in question during the past 12 months".
    - MCMs should explain to the client that the term "drug abuse" does not include alcohol, but refers to the client's use of prescribed or over the counter drugs in excess of the recommended dosage. The term "drug abuse" also includes any non-medical drug use, including illegal drugs.

- After the client has completed documenting (stating) responses to each of the 20 questions, MCMs should use page two of the DAST-20 to score and determine the results.
    - Score one point for each question answered with a "yes", except for questions four and five, for which an answer of "no" should receive a score of one point.
    - Total (add) the points to determine the client's score on the DAST-20 and document this number on the "score" line on page one of the DAST-20.

- Utilize the following guide to interpret the score and determine if a referral for substance use treatment/recovery services is needed:
    - A score of 1 – 5 is indication of low severity. It is recommended the client be linked to a brief intervention.
    - A score of 6 – 10 is indication of intermediate severity (likely meets DSM criteria). It is recommended the client be linked to outpatient (intensive) intervention.
    - A score of 11 – 15 is indication of substantial severity. It is recommended the client be linked to intensive intervention.
    - A score of 16 – 20 is indication of severe severity. It is recommended the client be linked to intensive intervention.

- Be sure to explain to the client the results of the assessment and provide referrals accordingly.

- The completed DAST-20 should be maintained in the client's file.

Section IX:
Part A and B – Screen for Medical Case Management Services

The purpose of the screening process is to:

1. Interview clients to identify potential need and/or changes in need; and
2. Determine if the client should remain in non-medical case management–support or be transferred to medical case management.

RYAN WHITE SCREENING (FOR MEDICAL CASE MANAGEMENT SERVICES)

Form

A standardized Ryan White Screening Form (for Medical Case Management Services) has been developed for the Ryan White Part A and Part B case management programs. It is the responsibility of non-medical case manager-supports (NMCM-Support) to meet with and interview clients in six areas of functioning and document responses accordingly. Client responses will determine if they will remain in non-medical case management–support or be transferred to medical case management for the completion of the Psychosocial Assessment and potential delivery of services.

Date of Screening:
This section contains the date the Screening Form was completed.

Client Information:
This section provides important identifying information, including the client's legal name.

Screening Information:
This section contains 15 questions designed to identify if the client may have a need for medical case management services. A response of "yes" to any of the questions would require a consultation between the NMCM-Support and their supervisor to determine if the client should be transferred to medical case management for the completion of a Psychosocial Assessment.

Screening Sign-Off
This section provides the NMCM-Support's printed name and signature, along with the date.

Form Validity

The Ryan White Screening Form is valid for six months from the date the form is signed. The form should be completed semi-annually.

Accessing the Ryan White Screening Form

The Ryan White Screening Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. NMCM-Supports are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Screening Procedures

- NMCM-Supports are responsible for interviewing clients semi-annually to complete the Screening Form.

- NMCM-Supports are responsible for following their agency's protocol on documenting a typed or handwritten response to all questions on the form.

- Clients who provide a response of "no" to ALL of the questions on the form will remain with non-medical case management–support and NMCM-Supports will do the following:
    - complete or update the Ryan White Individualized Service plan accordingly (see page 77 for additional information),
    - deliver services to clients accordingly,
    - document case notes, and
    - complete required paperwork/assessments semi-annually.

- Clients who provide a response of "yes" to ANY of the questions on the form requires a consultation between the NMCM-Support and their supervisor to determine if the client should be transferred to medical case management and NMCM-Supports will do the following:
    - complete the Ryan White Case Management Individualized Service Plan (see page 77 for additional information), including reviewing with the client and documenting progress towards meeting goals on the existing Ryan White Case Management Individualized Service plan,
    - inform the client that they may be working with another professional on the activities outlined in the Individualized Service Plan.

- Following the consultation between the NMCM-Support and a supervisor, if it is determined the client will be transferred to medical case management for a Psychosocial Assessment, complete and submit the Ryan White Client Transfer Form (see page 92 for additional information).
    - The case assigner will assign the case to a medical case manager to complete a Psychosocial Assessment to determine if a client transfer is necessary.
        - ❖ NMCM-Supports will participate in a case conference with the medical case manager (see page 96 for additional information).
        - ❖ Medical case managers will complete a Psychosocial Assessment and will use established criteria and clinical judgement to determine if the client should remain in medical case management or be transferred back to non-medical case management–support. If it is determined the client will return to non-medical case management-support, the NMCM-Support will need to:
            - communicate with the client that they will continue to work together;

- deliver services according to the Individualized Service Plan completed by the medical case manager,
- document case notes, and
- complete required paperwork/screening semi-annually.

Best Practices

- ✓ Be sure to ask and obtain answers to all of the questions listed on the Screening Form.

- ✓ While the form should be completed semi-annually, if a change in needs is noticed and/or the client indicates a change in needs prior to re-certification, complete the form as needed.

- ✓ Utilize supervision to address questions, concerns, and uncertainty about how to interview and/or document the form.

- ✓ Become familiar with the steps to follow if the client is to be transferred to medical case management and/or returned to non-medical case management-support.

Section X:
Part A and B –Individualized Service Plan

The purpose of the individualized service plan is to create goals, action steps, and timeframe for achievement. It is the responsibility of medical case managers and/or non-medical case managers–support and clients to work together to develop the plan and a review should occur at a minimum of every six months.

RYAN WHITE CASE MANANAGEMENT INDIVIDUALIZED SERVICE PLAN

Form

A standardized Ryan White Case Management Individualized Service Plan has been developed for Ryan White Parts A and B case management programs. The Individualized Service Plan is designed to provide specific activities towards obtaining needed services and support to meet client goals in associated areas of functioning.

While both medical case managers (MCM) and non-medical case manager–supports (MNCM–Support) will document the Ryan White Case Management Individualized Service Plan, there are slight differences in documentation requirements:

Medical Case Management:
MCMs are responsible for meeting with clients at least every six months to develop, revise, and/or update the Individualized Service Plan based upon the completed Psychosocial Assessment[9].

- *Clients transferring to NMCM–Support*: MCMs are responsible for documenting the non-shaded areas of the initial Individualized Service Plan. MCMs will consider specified functional areas from the Psychosocial Assessment (basic needs, oral health, health insurance, financial planning/counseling, transportation, language & literacy, support system, sexual health/risk reduction, knowledge of HIV disease, and/or legal issues) that are rated with moderate or intensive need and use clinical judgement to determine if the need should have an accompanying active or deferred goal. If the intensity of needs identified are only basic, the client must have at least one active goal in order to remain in the NMCM-Support program.

- *Clients remaining in MCM*: MCMs are responsible for documenting an accompanying active or deferred goal for all areas of functioning rated with moderate and intensive need on the completed Psychosocial Assessment. All clients must have at least one active medical goal documented annually and at the six-month review and update.
    - Annually: Develop with clients and document non-shaded areas of a new Individualized Service Plan based upon the completed annual Psychosocial Assessment.
    - Six-Month Review and Update: Review and update with clients and document shaded areas of the existing Individualized Service Plan based upon the completed semi-annual Psychosocial Assessment.

[9] Any time "Psychosocial Assessment" is referenced in the Individualized Service Plan section of the Manual, it is referring to the MCM's assessment and evaluation of client acuity in all seventeen (17) areas of functioning on the Psychosocial Assessment.

- ❖ If the client has developed new needs, complete all boxes in the shaded area except for the “summary of progress and goal attainment information” in the “active goals” section.
- ❖ If the client’s case is to be closed, review with the client and document progress towards meeting goals on the existing Individualized Service plan.

Non-Medical Case Management–Support:
NMCM–Support will meet with assigned clients to complete all other (annual and six-month review and updates) Individualized Service Plans. These plans should be documented based upon the most recent Psychosocial Assessment, the completed initial Individualized Service Plan, and the NMCM–Support’s knowledge of the client through interactions over the previous six months.

- Annually: Develop with clients and document non-shaded areas of the Individualized Service Plan.
- Six-Month Review and Update: Review and update with clients and document shaded areas of the existing Individualized Service Plan.
    - o For clients remaining in NMCM-Support, update the service plan according to the completed Psychosocial Assessment and the NMCM–Support’s knowledge of the client through interactions over the previous six months.
    - o If the client has developed new needs, complete all boxes in the shaded area except for the “summary of progress and goal attainment information” in the “active goals” section.
    - o If the case is to be closed, review with the client and document progress towards meeting goals on the existing Individualized Service Plan.

Client Information:
This section contains information about the client and MCM or NMCM–Support, including client legal name, date of birth, case manager name, case manager phone number, date of ISP development, and date of ISP review. Clients and MCMs or NMCM–Supports are responsible for documenting their signature and date after completing the annual and six-month review and update respectively.

Target Functional Areas:
This section contains a list of the areas of functioning from the Psychosocial Assessment.

- MCMs will use evaluation and acuity information from the annual and semi-annual Psychosocial Assessments to check all areas of functioning rated with moderate and intensive need.
- NMCM–Supports will use evaluation and acuity information from the most recent Psychosocial Assessment, along with their knowledge of the client gained through interactions over the previous six months, to check associated areas of need.

Client Agreement:
This section contains the client's signature and date, which confirms client understanding of, and agreement with, the information documented in the Individualized Service Plan.

Case Manager Verification:
This section serves as verification that the MCM or NMCM–Support has developed, explained, and reviewed the Individualized Service Plan with the client and contains the signature of the MCM or NMCM-Support and date.

Active Goals:

- Functional Area: This section contains the functional area identified as an area of need that will have an active goal for the six-month period (based upon the completed Psychosocial Assessment).
- Goal: This section contains the goal to be achieved that will address the functional area.
- Action Steps: This section contains the activities to be performed by the MCM OR NMCM–Support and/or the client towards meeting the goal to address the functional area.
- Timeframe: This section contains the "due date(s)" for completing each action step.
- Target Date: This section contains the anticipated date the goal will be achieved.
- Progress Summary: This section contains a brief description of progress towards meeting the goal during the previous six-month period (this section is only completed at the six-month review and update).
- Attainment: This section contains indication of whether or not the goal was achieved (this section is only completed at the six-month review and update).

Deferred Goals:

- Functional Area: This section contains any functional area identified as an area of need that will have a deferred goal for the six-month period (based upon the completed Psychosocial Assessment).
- Reason for Deferral: This section contains the reason the goal for the functional area is to be deferred, e.g. client refusal, lower priority, or other.
- Progress Summary: This section contains a brief description of progress towards moving the deferred goal to active status during the previous six-month period (this section is only completed at the six-month review and update).
- Status: This section contains the status of the functional area for the following six-month period, e.g. remain deferred, move to active goal, or NA.

Form Validity

The Ryan White Case Management Individualized Service Plan is valid for six months from the date the form is signed. The form should be completed two times per 12-month period.

Accessing the Ryan White Case Management Individualized Service Plan

The Ryan White Case Management Individualized Service plan is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs and NMCM–Supports are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Case Management Individualized Service Plan Documentation Procedures

Medical Case Managers:

- MCMs will use information from the Psychosocial Assessment to determine if the client will remain in medical case management or be transferred to non-medical case management–support (see page 60 for additional information on determining if the client should remain in MCM or be transferred to NMCM–Support).
    - MCMs are responsible for documenting the non-shaded areas of the initial Individualized Service Plan, considering specified functional areas from the Psychosocial Assessment that are rated with moderate or intensive need.
    - MCMs will use clinical judgement to determine if the need should have an accompanying active or deferred goal. If there are only basic needs identified, the client must have at least one active goal in order to remain in the case management program.

- For clients transferring to NMCM-Support, MCMs are responsible for informing them that they may be working with another professional on the activities outlined in the Individualized Service Plan.

- For clients remaining in MCM, MCMs are responsible for documenting an active or deferred goal for all areas of functioning rated with moderate and intensive need (based on the completed Psychosocial Assessment).
    - All clients must have at least one active medical goal documented annually and at the six-month review and update.

Non-Medical Case Manager-Supports:

- NMCM–Supports are responsible for ensuring all areas identified as a need have an accompanying active or deferred goal (based upon the initial Psychosocial Assessment, completed Individualized Service Plan, and knowledge of the client through interactions over the previous six months).

MCM and NMCM-Support Responsibilities:

- Document all sections/questions on the Individualized Service Plan and ensure original signatures are present on the completed form.

- Make sure that the functional areas checked under the section “target functional areas” match the functional areas documented as active or deferred goals.

- While it is highly likely the client and MCM or NMCM–Support will each have responsibility for completing action steps, it is possible that this responsibility could fall upon only the MCM or NMCM–Support OR the client.

- Be mindful when establishing timeframes and target dates. As a reminder, the target date should fall within, or by the end of, the six-month period.

- Only document the progress summary and attainment sections at the six-month review and update. If a new goal is to be documented at the six-month review and update, the progress summary and attainment for the new goal at the six-month review and update should be left blank.

- Six-Month Review and Update – Active Goals:
    - When reviewing existing goals at the six-month review and update, determine with the client if the goal for the functional area from the previous six-month period is still needed, will stay the same, or be updated and document accordingly. If the goal is to be updated, document the goal to be achieved over the next six months that will address the functional area.
    - Be sure to determine with the client if any deferred goals from the previous six-month period will move to become an active goal. If a goal is to be moved to active from deferred, document the goal to be achieved over the next six months that will address the functional area.
    - In the action steps section, if the goal is no longer needed, check NA. Otherwise, after the goal has been agreed upon, determine if the action steps will remain the same or be updated. It is only necessary to document action steps if they will be updated or if a new goal has been established.

- Six-Month Review and Update – Deferred Goals:
    - Be sure to document a brief description of progress towards moving the deferred goal to active status during the previous six-month period.

- Determine and document if the functional area is to “remain deferred, move to active goal, or NA” (no longer an area of need per the most current Psychosocial Assessment). If the functional area is to become an active goal, document the new goal in the shaded area under “active goals”.

- Upon completion of creating the plan, a copy should be provided/offered to the client and the original should be maintained in the client’s file.

- Follow up with the client during the six-month period regarding progress towards goal attainment.

- Case notes should be documented:
  - describing the interaction with the client to create the Individualized Service Plan along with any pertinent information;
  - in the event that the client is unable or unwilling to sign the form, with an explanation for the lack of client’ signature; and
  - to track and describe progress towards goal attainment.

Best Practices

- ✓ When documenting the Individualized Service Plan, remember that all sections should correlate with each other so that the goal addresses the need in the functional area, the activities connect to the goal, the timeframes are reasonable to complete the activities, and the goal attainment target date is appropriate.

- ✓ Consider using the “SMART” method for goal setting:
  - Specific: Identifies who/what the goal is about. Consider if another case manager would be able to execute the work if necessary.
  - Measurable: Identifies how progress and goal achievement will be determined.
  - Achievable: Identifies the action to be done. Consider if the goal can be accomplished at this time. If it is not likely and/or impractical, create a smaller, more manageable goal.
  - Realistic: Identifies the relevance of the goal to the functional area. Consider how the goal connects to the functional area and is practical and within the client’s capabilities to be reached.
  - Timely: Identifies the timeframe the goal is to be reached. Consider an appropriate deadline to achieve the goal. If it is unlikely the action steps can be achieved within six months, create a more reasonable activity.

- ✓ Discuss with the client the action steps to be taken and who should be responsible for each action step prior to documenting this section of the plan.

- ✓ Be sure to document clear, concise, reasonable action steps for both the client and the MCM or NMCM-Support.

- ✓ It is strongly recommended MCMs and NMCM–Supports periodically contact agencies/providers to ensure accuracy of information before providing a referral to a client. Whenever possible, find a point of contact within the agency, this may help with expediting assistance provided to clients.

- ✓ Be sure to offer/provide to the client a copy of the plan. Encourage them to keep it in a place they can easily reference, e.g. posted on their refrigerator.

- ✓ Follow-up with clients is critical to providing quality case management services and assisting clients with reaching their goals. Make sure to document in case notes any communication with and/or on behalf of clients.

- ✓ Consider using a paper or electronic calendar for reminders on when to follow-up with clients and/or communicate with referral sources.

Section XI:
Case Note Documentation

The purpose of case notes is to:

1. Be accountable for providing appropriate medical case management and non-medical case management–support services; and
2. Be legally responsible – client files may be subpoenaed by a court of law.
3. Provide the medical case manager or non-medical case manager–support, supervisor and/or outside reviewer the details of all activities performed with or on behalf of the client to assure highest quality in the continuity of care.

CASE NOTES

The following information is intended to be general guidance on the documentation of case notes. Each case management agency has protocols in place on case note documentation. Medical case managers (MCM) and non-medical case manager–supports (NMCM–Support) are responsible for following their agency's protocols.

Information to Include in Case Note Documentation

Case note documentation should include information:

- about services provided to clients;
- exchanged and/or released with a third party;
- provided by the MCM and/or NMCM–Support to the client;
- provided by the client to the MCM or NMCM-Support; and
- related to eligibility, care, and/or follow-up services

Elements of a Case Note:

All case notes should contain:

- date of the interaction;
- method of contact, e.g. face-to-face, phone, email, mail;
- description – including:
    - with whom the interaction occurred,
    - purpose of the interaction and role of the MCM and/or NMCM–Support,
    - details of the interaction along with the outcome, and
    - timeframe for follow-up;
- MCM's or NMCM–Support's name (signature, handwritten or electronic, if possible)

Best Practices:

- ✓ Case notes should be:
    - clear and concise;
    - accurate and complete;
    - objective/fact-based, include quotes from clients whenever possible; and
    - timely (documented within 48 hours of the interaction)

- ✓ Case notes should contain enough detail that an outside reviewer who is not familiar with the MCM, NMCM–Support, or the client could read, understand the situation, and provide the follow-up service, if necessary.

- ✓ Remember, if it is not written, it does not exist!

Section XII:
Part A and B Request for Non-Medical Case Management-Support

In addition to their caseload, non-medical case manager–supports may also provide assistance to medical case management clients at the request of medical case managers and/or a supervisor. Assistance may include:

- Transportation of clients for services;
- Delivery of goods;
- Completion of an application/paperwork; and/or
- Research and/or documentation of community resources.

RYAN WHITE REQUEST FOR NON-MEDICAL CASE MANAGEMENT–SUPPORT

Form

A standardized Ryan White Request for Non-Medical Case Management–Support Form has been developed for Ryan White Parts A and B case management programs. Medical case managers (MCM) may complete this form to request assistance of non-medical case management–support (NMCM–Support) with the provision of select services to clients. Each section of the form provides important information about the reason and request for assistance.

Date:
This section contains the date the form was completed.

Client Contact Information:
This section provides contact information on the client. Information from this section will be helpful to the NMCM–Support in knowing the best way to contact the client.

Service Requested:
This section contains a list of possible support services that may be provided to MCM clients by NMCM–Support.

Additional Information:
This section provides space for MCMs to document any pertinent information regarding the client and/or the request, e.g. timeframe for completing the request.

Medical Case Manager Information:
This section contains information about the MCM completing the form including name, signature, and date.

Supervisor Approval:
This section indicates the MCM's supervisor approval and includes the supervisor's name, signature, and date.

Support Staff Assignment Use Only:
This section is to be completed by the support assignment staff (supervisor) following their review of the completed Request for Non-Medical Case Management–Support Form. This section provides information on the date the form was received, name of the assigned NMCM–Support, date of assignment, and the name and signature of the support assignment staff (supervisor).

Form Validity

The Ryan White Request for Non-Medical Case Management–Support Form is valid for the entire duration of time that the service request is provided to the client by NMCM–Support. Any time a new service is needed by NMCM–Support, a new form will need to be completed.

Accessing the Ryan White Request for Non-Medical Case Management–Support Form

The Ryan White Non-Medical Case Management–Support Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Client Request for Non-Medical Case Management–Support Form Medical Case Manager Documentation and Submission Procedures

- MCMs are responsible for completing the Request for Non-Medical Case Management–Support Form to request assistance of NMCM–Support with the provision of select services to clients, e.g. transportation of clients for services, delivery of goods, completion of an application/paperwork, research and/or documentation of community resources, etc.

- MCMs are responsible for completing all sections/questions on the form following their agency's protocol on the format in which the form should be documented, e.g. typed or handwritten.

- In the "Service(s) Requested" section, MCMs should check and document accordingly all of the services requested for an NMCM–Support to provide to a MCM client.

- MCMs should clearly document the timeframe the request should be completed in the additional information section.

- MCMs are responsible for following their agency's protocol on obtaining a supervisor's approval.
    - If supervisor approval is required, be sure to obtain authorization prior to submitting the request to a NMCM–Support.
    - If supervisor approval is optional/not needed, requests may be submitted directly to a NMCM–Support.

Best Practices

- ✓ Be sure to consider client need when determining if it is appropriate to request assistance of NMCM–Support with the provision of select services.

- ✓ If the request is approved, make sure to communicate with the client the name of the NMCM–Support who will assist and a description of the assistance to be provided.

- ✓ Be mindful in providing any additional information to the NMCM–Support regarding the client so they are best prepared to provide the requested service.

- ✓ Make sure a timeframe for completing the requested task is clearly documented in the additional information section.

Support Staff (Supervisor) Assignment Procedures

Most Ryan White Part A and Part B medical case management service providers will have a staff member(s) who is responsible for receiving completed Request for Non-Medical Case Management–Support Forms, reviewing information contained on the completed forms, and assigning the request to a NMCM–Support accordingly.

- Upon receipt of the completed Request for Non-Medical Case Management–Support Form, the support staff assigner (supervisor) will review the document to ensure all sections/questions on the Form are complete. If anything is missing, contact the MCM and request missing information.

- Determine service request assignment by utilizing the following criteria:
  - Appropriateness of the request.
  - NMCM–Support's case load size.

- Document the date the form was received, name of the assigned NMCM–Support, date of case assignment, case assigner's name and signature in the "support staff assignment use only" section.

- Provide the completed Request for Non-Medical Case Management–Support Form to the assigned NMCM–Support within two business days of receiving the completed Form.

Best Practices – Support Staff (Supervisors)

- ✓ Review all sections of the Request for Non-Medical Case Management–Support Form to ensure completeness. If any information is missing, immediately reach out to the MCM and request missing information.

- ✓ Develop a tracking form or utilize reporting systems such as CAREWare or ETO to ensure equity in assigned caseloads to NMCM–Support. This may also be used as a quick reference tool.

Non-Medical Case Manager-Support Receipt Procedures

- Review all information documented on the Request for Non-Medical Case Management–Support Form. Direct questions related to information contained on the form to the MCM.
- Complete the requested service in the timeframe documented on the form and/or within two business days.
- Document a case note into the electronic system utilized by your organization on all interactions with and/or on behalf of the client.
- The Request for Non-Medical Case Management–Support Form should be maintained in the client's file.

Best Practices – Non-Medical Case Managers-Support

- ✓ Be sure to obtain any pertinent information regarding the client and/or service request by asking follow-up questions to the MCM.
- ✓ Be sure to document a case note describing all interactions with and/or on behalf of the client. This will help the requesting MCM know the status and the outcome of the request and any other pertinent information regarding interactions between the NMCM–Support and the client.

Section XIII:
Part A and B – Client Transfer and Case Conference

The purpose of the client transfer and case conference process is to:

1. Assure contents of client files to be transferred stay intact;
2. Provide the professional receiving the transferred client all historical information on file, including eligibility documentation, assessments, and any additional information relevant to or about the client; and
3. Assist the client in receiving seamless services without interruption in care.

RYAN WHITE CLIENT TRANSFER AND CASE CONFERENCE

Form

A standardized Ryan White Client Transfer and Case Conference Form has been developed for Ryan White Parts A and B case management programs. It is the responsibility of Linkage to Care coordinators, medical case managers, and/or non-medical case manager-supports[10] to complete the Client Transfer and Case Conference Form any time a client is to be moved from their caseload to another professional, e.g. a medical case manager leaving their position, transfer from Linkage to Care services to medical case management services, transfer from medical case management services to non-medical case management–support services, request from the client, etc.

- The professional transferring the case is responsible for documenting page one of the form;
- The professional receiving the case is responsible for documenting page two of the form.

Each section of the form provides the staff member receiving the client's case important information about the client and the documents included in the transfer.

Transfer Date/Client Legal Name/Date of Birth:
This section provides important identifying information, including the date of transfer, the client's name and date of birth, and information on the client's guardian/conservator, if applicable.

Transfer Information:
This section provides information about the transfer, including where the case is being transferred from and where the case is being transferred to, contact information, and the reason for the transfer.

Client Information:
This section provides information about the client's status in the Ryan White Program, including eligibility expiration date(s), acuity score (if applicable), and the name of the client's HIV doctor.

Materials to be Transferred:
This section indicates the eligibility and assessment documents to be transferred.

Supervisor Approval:
This section indicates supervisor approval and includes the supervisor's name, signature, and date. Clients may not be transferred without the approval of the transferring agency's supervisor.

[10] In this section, when referring to all three professional positions - Linkage to Care coordinators, medical case managers, and non-medical case manager–supports, the term "professional or professionals" will be used.

Case Assignment Use Only:
This section is to be completed by the case assigner following their review of information documented in the client file. This section provides information on the date the Client Transfer and Case Conference Form and materials were received, name of the assigned case manager, date of case assignment, and the name and signature of the case assigner.

Case Conference Participation:
This section contains the date of the case conference meeting, the type of meeting (face-to-face or over the phone), and information on each professional who participated in the case conference meeting.

Case Conference Discussion:
This section contains a list of possible information to be discussed between the professionals transferring/receiving the case to ensure that the professional receiving the case has the maximum amount of information available about the client. It is expected that this layer of communication will help create a smooth transition for the client.

Sign-Off:
This section contains the name and signature of the professional receiving the case, along with the date.

Form Validity

The Ryan White Client Transfer and Case Conference Form is valid for the entire duration of time that the client is transferred from one professional to another. Any time a client is to be transferred, a Client Transfer and Case Conference Form will need to be completed.

Accessing the Ryan White Client Transfer and Case Conference Form

The Ryan White Client Transfer and Case Conference Form is a PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible for completing this form with handwritten responses.

Ryan White Client Transfer and Case Conference Form
Documentation and Submission Procedures

Professionals Transferring the Client's Case (Page One – Client Transfer)

- The Client Transfer and Case Conference Form, transfer of associated documents, and notification to clients should be completed using the following timeframe:
    - Professional leaving their position: Client transfers should be completed by the last day in their position for all clients on their caseload.
        - ❖ If this is not feasible, the professional's supervisor is responsible for completing this task within ten business days from the date the professional leaves their position.
    - Client Request: Client transfers should be completed in a timely manner.

- Document a response to all sections/questions on page one of the Client Transfer and Case Conference Form. Consult a supervisor if uncertain of what to document in the "transfer information section – transfer to (agency name)".

- Documentation of the reason for the transfer should include as much detail as possible.

- Make sure that the case file includes all materials to be transferred, including eligibility documents, assessments, releases, etc.

- Prior to the actual transfer of the client to another professional/agency, the professional transferring the case must first obtain written approval from their supervisor in the "supervisor approval" section of the form.

- Clients should be provided with clear communication about the transfer, including the professional's last day, who to contact, and dates of expiration for Part A and Part B services (see page 98 for a sample transfer letter/email/phone script).

- Page one of the Ryan White Client Transfer and Case Conference Form, along with documents from the client file, should be sent via secure email/fax to the case assigner located at the associated case management agency.
    - Consult a supervisor for the case assigner's name and email address/fax number for which the client file will be transferred.

- Be prepared to participate in a case conference meeting (either in-person or over the phone) with the professional receiving the client's case.

Best Practices – Professionals Transferring the Client's Case

- ✓ Prior to transferring a case file, confirm accuracy of information documented on page one of the Client Transfer and Case Conference Form and assure all documents to be transferred are present in the client's file.

- ✓ Be sure to clearly explain the purpose of the transfer. If the purpose is related to the professional leaving their position, indicate the supervisor's name in the "reason for the transfer" as someone to contact with any questions.

- ✓ Provide clear, open communication with the client regarding the transfer, including who to contact and dates of expiration for Part A and Part B services.

- ✓ Be prepared to respond to questions and/or provide information to the professional receiving the client's case via a case conference meeting.

Case Assignment Procedures

Each Ryan White Part A and Part B case management service provider will have a staff member(s) who is responsible for receiving completed and approved Client Transfer and Case Conference Forms, reviewing information contained on the completed form and case file, and assigning clients accordingly.

- Upon receipt of page one of the Client Transfer and Case Conference Form, the case assigner will:
  - Review the document to ensure all sections/questions on the form are complete and match the information in the client's case file. If anything is missing, the case assigner will contact the professional who transferred the case and request missing information.
  - Document receipt information in the "case assignment use only" section.

- Determine case assignment based upon:
  - Medical case manager's current caseload size, along with the number of high, medium, and low acuity level clients in the case load (if the case is to be transferred to a medical case manager).
  - Non-medical case manager–support's current case load size (if the case is to be transferred to a non-medical case manager–support).

- Document in the "case assignment use only" section the name of the assigned case manager, date of case assignment, and case assigner's name and signature.

- Provide the completed Client Transfer and Case Conference Form and client file to the assigned case manager within two business days of receiving the transfer.

Best Practices – Case Assigners

- ✓ Review all sections of the completed Client Transfer and Case Conference Form and match it to the documents contained in the client's file to ensure completeness. If any information is missing, immediately reach out to the professional who transferred the case to request missing information.

- ✓ Determine case assignment based on knowledge of the case manager's experience and skills in working with the client population.

Ryan White Client Transfer and Case Conference Form Documentation and Submission Procedures

Professionals Receiving the Client's Case (Page Two – Case Conference)

- Review all information documented on page one of the Client Transfer and Case Conference Form, along with documents in the client file.

- Enter required information into the electronic system utilized by the case management agency, if applicable.

- Schedule a case conference meeting (to be conducted in-person or over the phone) with the professional who transferred the case[11] and document all sections/questions on page two of the Client Transfer and Case Conference Form.
    - Be sure the case conference meeting occurs prior to contacting the client (as a reminder, clients should be contacted within five business days of receiving the Client Transfer and Case Conference Form).

- Facilitate the meeting with the professional who transferred the case and obtain all needed information to allow for a smooth transition for the client. For example, confirm if additional eligibility documents need to be collected, communication patterns with the client, next steps in assisting the client with goals on the Individualized Service Plan, etc.

- Check all items discussed during the case conference meeting under the "case conference discussion" section.

- Document the name and signature of the professional receiving the case along with the date. This documentation indicates the case conference meeting occurred and requested information (as checked in the "case conference discussion" section) was obtained from the professional transferring the case.

[11] In the event that the professional's supervisor documented page one of the Client Transfer and Case Conference Form, a case conference meeting is not required. In this instance, the professional receiving the case should review page one of the Client Transfer and Case Conference Form, along with the documents in the client's file, and contact the supervisor with questions, if necessary.

- Contact the client within five business days (the case conference meeting with the professional who transferred the case should occur prior to contacting the client) to build rapport and review the next steps in working with the client. For example, review with the client upcoming appointments, renewal of eligibility, etc.

- The Client Transfer and Case Conference Form should be maintained in the client's file.

Best Practices – Professionals Receiving the Client's Case

- ✓ Prior to participating in the case conference meeting, review the materials transferred and identify questions and/or additional information needed to begin working with the client.

- ✓ Be sure to ask open-ended questions to allow for the professional transferring the case to provide as much information as possible regarding their work with the client.

- ✓ Take notes on information provided by the professional transferring the case to ensure that no information is lost/forgotten.

- ✓ Be sure to schedule the case conference meeting prior to contacting the client (clients should be contacted within five business days of receiving the transferred case).

- ✓ When contacting the client, be sure to provide open, clear communication. Inform the client of the following:
    - explain the professional's role,
    - length of time for the introductory appointment, if applicable
    - documentation to bring to the enrollment meeting, if applicable, and
    - next steps, including timeframe.

SAMPLE DOCUMENTATION – TRANSFER LETTER/EMAIL/PHONE SCRIPT TO CLIENT

In the event that a client is to be moved from one professional's caseload to another professional's caseload, the client must be notified. Ideally, this would be done by the professional currently working with the client, however, if this is not possible, it should be done by the supervisor. The following is a sample letter/email/phone script that may be used to inform the client that they will be transferred to another professional.

Sample Letter/Email/Phone Script to Client

I _____ (print professional's name) will no longer be your _____ _____ (Linkage to Care coordinator, medical case manager, or non-medical case manager–support) effective _____ (insert date). I have _____ (insert reason for the transfer, e.g. left my position, left my agency, arranged this transfer due to your request, etc.). The continuity of your care is very important. Please contact _____ (insert name of professional to contact in the absence of the professional) at _____ (insert phone number/email address) with any questions and/or concerns. As a reminder, your Ryan White Part A Eligibility Expiration Date is _____ (insert date) and your Ryan White Part B Eligibility Expiration Date is _____ (insert date).

A professional will be in contact with you very soon to continue the provision of Ryan White services. Thank you for the opportunity to work together.

_____ _____

Professional's Signature Date

Section XIV:
Part A and B Case Closure

Medical case managers (MCM) and non-medical case manager–supports (NMCM–Support) are responsible for closing a case from the medical case management program or non-medical case management program–support due to any of the following circumstances:

- Client moves outside of the service area;
- Client is/will be incarcerated for more than six months;
- Client request;
- Client has zero or low acuity score;
- Client is lost to care when certification is 30 days past due and does not reply after a combination of three attempts, and/or
- Client death.

The purpose of the case closure process is to:

1. Close (exit) clients who meet any of the circumstances listed above;
2. Provide appropriate continuity of care referrals to clients; and
3. Assure required closure documentation is completed.

Client self-sufficiency is a primary goal of the medical case management and non-medical case management–support programs. While all clients may not reach self-sufficiency, it is important to identify and recognize those who do. MCMs and NMCM–Supports are responsible for determining client graduation from the medical case management or non-medical case management–support programs based upon:

- Acuity score of zero (0); or
- Acuity score of fifteen (15) or lower, when the client's needs may be met in the community through community resources, based upon professional judgement.

Clients who meet either one of these criterion should be closed within six months, with supervisor approval.

RYAN WHITE CLIENT CASE CLOSURE

Form

A standardized Ryan White Client Case Closure Form has been developed for Ryan White Parts A and B case management programs. It is the responsibility of medical case managers (MCM) or non-medical case manager–supports (NMCM–Support) to complete the Ryan White Client Case Closure Form when a client meets any of the following circumstances:

- Client moves outside of the service area;
- Client is/will be incarcerated for more than six months;
- Client request;
- Client has zero or low acuity score;
- Client is lost to care when certification is 30 days past due and client does not reply after a combination of three attempts, e.g. phone, email, mail, home visit, and/or
- Client death

Each section of the form provides important information about the reason for case closure and activities performed to close the case.

Client Information:
This section provides important identifying information, including the date of the case closure, the date the client's Network Release Form will expire (see page 47 for additional information), the client's name, and the client's date of birth.

Reason for Case Closure:
This section provides information about the circumstance that led to the case being closed.

Case Closure Activities:
This section provides information on the status of the client's knowledge that their case has been closed along with when and how the client was notified of case closure. Additionally, details on referrals provided to the client, if applicable, are provided.

Additional Information:
This section provides space for MCMs or NMCM–Supports to document any pertinent information regarding the client and/or their work with the client, progress towards achieving goals, and/or any other information that will be helpful in the event the case is re-opened.

Case Closure Sign-Off:
This section contains the MCM's or NMCM–Support's name, signature, and date along with the name and signature of the supervisor and date.

Form Validity

The Ryan White Client Case Closure Form is valid for the entire duration of time that the client is closed from medical case management or non-medical case management–support until they return. Any time a client's case is to be closed, a Ryan White Client Case Closure Form will need to be completed.

Accessing the Ryan White Client Case Closure Form

The Ryan White Client Case Closure Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. MCMs and NMCM–Supports are responsible for following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Client Case Closure Form Procedures

- MCMs and NMCM–Supports are responsible for closing a client's case from the medical case management or non-medical case management-support programs due to any of the following circumstances:
    - Client moves outside of the service area;
    - Client is/will be incarcerated for more than six months;
    - Client request;
    - Client has zero or low acuity score;
    - Client is lost to care when certification is 30 days past due and does not reply after a combination of three attempts (for example phone, email, mail, home visit); and/or
    - Client death.

- In the event that a client's case is at risk of being closed due to loss to follow-up, it is recommended a letter be sent to the client as a "last attempt" to re-engage them in care, if a letter is an acceptable form of contact (see page 103 for a sample "last attempt letter to client").

- Prior to closing a client's case, MCMs or NMCM–Supports must put forth three attempts to reach clients who cannot be contacted 30 days following their eligibility renewal date. Ideally, the three attempts will be a combination, based upon the client's preferred method(s) of contact), e.g. phone, email, mail, home visit. If none of these attempts are successful, a closure letter should be mailed (see page 104 for a sample closure letter), if mail is an acceptable form of contact allowed by the client.

- Prior to closing a client's case, MCMs and NMCM–Supports, are responsible for providing to clients referrals for needed/ongoing services through the community and the phone number to call if needs change in the future.

- MCMs and NMCM–Supports are responsible for completing the Ryan White Client Case Closure Form in its entirety within five business days of case closure.

- In addition to completing the Ryan White Client Case Closure Form,
    - case notes should be documented describing all interactions with or on behalf of the client related to case closure. For example, the case note may include an account of all efforts made to contact the client along with a description of the meeting/conversation with the client regarding case closure,
    - copy of the letter sent to the client (see page 104 for a sample closure letter) along with a list of any referrals provided to the client, etc.
        - ❖ If a valid release of information is on file, a copy of the closure letter should also be sent to all of the client's Ryan White providers.

- MCMs and NMCM–Supports are responsible for following their agency's protocol on closing a client's case in the electronic system, if applicable.

- The Ryan White Case Closure Form, along with copies last attempt letters and/or closure letters, should be retained in the client's file.

Best Practices

- ✓ Be sure to put forth three attempts to reach clients who cannot be contacted 30 days following their eligibility renewal date.

- ✓ Provide open, clear communication with the client regarding the case closure, including reason for the case closure, who to contact if needs arise in the future, referrals, if applicable, etc.

- ✓ Be sure to complete all sections of the form, as applicable, e.g. if referrals are not provided to the client, check "NA" and/or if there is no additional information to be documented, document "NA".

- ✓ If referrals are provided, be sure to list the agency name(s), purpose(s) of referral(s), and contact information in the referral table on the form.

- ✓ Use the additional information section to document any information that may be helpful in the event the case is re-opened in the future.

SAMPLE DOCUMENTATION – LAST ATTEMPT LETTER TO CLIENT

In the event that a client's case is at risk of being closed due to loss to follow-up, it is recommended a letter be sent to the client as a "last attempt" to re-engage them in care, if a letter is an acceptable form of contact allowed by the client.

Sample Last Attempt Letter to Client

I, _____, (print name of medical case manager or non-medical case manager–support) tried to contact you on _____ to inform you that it is time to renew your eligibility with the Ryan White program. Your Ryan White Part A eligibility will expire on _____ and/or your Ryan White Part B eligibility will expire on _____. In order to ensure the continuity of your care, please contact me by _____ or your case with Ryan White _____ (medical case management or non-medical case management–support) will be closed on _____ (insert date) due to _____ _____ (insert reason for case closure).

The continuity of your care is very important and I look forward to working with you to renew your eligibility.

_____ _____

Case Manager Date

SAMPLE DOCUMENTATION – CASE CLOSURE LETTER TO CLIENT AND RYAN WHITE PROVIDERS

In the event that a client's case is to be closed, it is recommended an in-person meeting occurs between the medical case manager or non-medical case manager–support and the client, when possible, to discuss the reason for case closure, referrals, and a phone number to contact in the event circumstances change in the future. Additionally, a case closure letter must also be provided to the client and any Ryan White providers if the client has indicated that they can receive mail.

Sample Case Closure Letter to Client and Ryan White Providers

I, _____, (print name of medical case manager or non-medical case manager-support) tried to contact you on _____ to inform you that your case with Ryan White _____ (medical case management or non-medical case management–support) has been or will be closed on _____ (insert date) due to _____ _____ (insert reason for case closure). The continuity of your care is very important and I am providing the following referrals to community agencies:

Agency Name	Purpose of Referral	Agency Contact Information

Additionally, should your needs change in the future, please contact _____ (insert phone number of who to call to re-engage in case management).

Thank you for the opportunity to work together.

_____ _____

Case Manager Date

cc: (insert names of Ryan White Providers to receive a copy of the letter).

Section XV:
Accessing Part A Services

Medical case managers, non-medical case manager–supports, and Linkage to Care coordinators play a vital role in linking clients to Ryan White Part A services, including:

- outpatient/ambulatory medical care,
- mental health,
- housing, and
- medical transportation.

Clients who are transferred from Linkage to Care services to medical case management and/or non-medical case management–support may already be linked to some or all of the services listed above. Through documentation on the Client Transfer and Case Conference Form, Linkage to Care coordinators will provide information on any Ryan White Part A services for which they have connected clients.

Section XVA:
Ryan White Part A Outpatient/Ambulatory Medical Care

Outpatient/ambulatory medical care services include diagnostic laboratory testing (including all medical diagnostic testing considered integral to the treatment of HIV and related complications, e.g. viral load, CD4 counts and genotype assays), preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to sub-specialty care.

Pre-authorization is not necessary for Ryan White Part A clients to access outpatient/ambulatory medical care services. However, clients must see a Ryan White Part A service provider in order for the service to be covered (see page 7 for a list of Part A service providers).

RYAN WHITE PART A PATIENT APPROVAL

Form

A standardized Ryan White Part A Patient Approval Form has been developed for the Ryan White Part A program. It is the responsibility of Linkage to Care coordinators, medical case managers, and/or the non-medical case manager–supports[12] (as needed) to complete this form any time a referral is needed by a client for Ryan White Part A outpatient/ambulatory medical care services. Ryan White Part A outpatient/ambulatory medical care services will cover outpatient medical services related to the client's HIV care. Each section of the form provides outpatient/ambulatory service providers with approval for the client to receive medical services through Ryan White Part A.

Date:
This section contains the date the form is completed.

Client Information:
This section provides the first and last name of the client, the client's date of birth, and the client's Ryan White number (if applicable) and/or ETO number (if applicable).

Approval Date:
This section contains the date the client's eligibility documentation was reviewed and the client was approved to receive Ryan White Part A services.

Expiration:
This section contains the expiration date of the client's Ryan White Part A eligibility.

Ryan White Part A Approval:
This section contains the professional's name, title, organization name, phone number, signature, and date.

Form Validity

The Ryan White Part A Patient Approval Form is valid for the entire period of time between the eligibility approval date and expiration date that are documented on the form (six month maximum).

[12] In this section, when referring to all three professional positions - Linkage to Care coordinators, medical case managers, and non-medical case manager–supports, the term "professional or professionals" will be used.

Accessing the Ryan White Part A Patient Approval Form

The Ryan White Part A Patient Approval Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible following their agency's protocol on the format in which this form should be documented, e.g. typed or handwritten.

Ryan White Part A Patient Approval Form Procedures

- Professionals are responsible for providing clients with options for Ryan White Part A outpatient/ambulatory medical care providers so they may determine their provider (see page 7 for a list of Part A service providers).

- Professionals are responsible for completing the Ryan White Part A Patient Approval Form in its entirety, once the client has selected a Ryan White Part A outpatient/ambulatory medical care provider.

- A copy of the completed Ryan White Part A Patient Approval Form should be faxed to the Ryan White Part A outpatient/ambulatory medical care provider.

- The client may contact the Ryan White Part A outpatient/ambulatory medical care provider to schedule an appointment. If the client needs assistance with scheduling this appointment, the professional may contact the provider with, or on behalf of, the client.

- A copy of the completed Ryan White Part A Patient Approval Form should be maintained in the client's file.

Best Practices

- ✓ Be sure the client is eligible to receive Ryan White Part A services prior to completing the Ryan White Part A Patient Approval Form and/or referring a client to a Ryan White Part A provider.

- ✓ Provide the client with options for Ryan White outpatient/ambulatory medical care providers. Make clients aware that they must see an approved provider in order for the service to be approved/covered.

- ✓ Make sure all sections of the Ryan White Part A Patient Approval Form are completed prior to faxing the form to a provider.

- ✓ Retain, in the client file, a receipt of sending the fax. If the provider's office indicates they did not receive the form, this receipt will serve as validation.

Section XVB:
Ryan White Part A Mental Health Services

Ryan White Part A mental health services include the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services. Services are based upon a treatment plan and conducted in an outpatient group or individual session.

Clients may be referred to a Ryan White Part A mental health service provider (see page 7 for a list of Part A service providers) based upon:

- the outcome of the anxiety screen (GAD-7), depression screen (PHQ-9), and/or substance abuse screen (DAST-20) conducted during the psychosocial assessment (see pages 65-71 for additional information),
- client request, and/or
- medical case manager's clinical judgement.

RYAN WHITE PART A REFERRAL FOR MENTAL HEALTH SERVICES

Form

A standardized Ryan White Part A Referral for Mental Health Services Form has been developed for the Ryan White Part A program. It is the responsibility of Linkage to Care coordinators, medical case managers, and/or non-medical case manager–supports[13] (as needed) to complete this form any time a referral is needed by a client for Ryan White Part A mental health services. Ryan White Part A mental health services include the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services. Services are based upon a treatment plan and conducted in an outpatient group or individual session. Each section of the form provides mental health service providers with valuable information about the client and request for service.

Date:
This section contains the date the form is completed.

Client Information:
This section provides contact information for the client, Ryan White Part A eligibility information, client insurance status, as well as preferred method of contact and determination if a confidential message may be left on voicemail. Approval date refers to the date the client was verified as eligible and was approved to receive Ryan White Part A services. Expiration date refers to the end date of the client's Ryan White Part A eligibility.

Referral Information:
This section provides a detailed description of the client's situation that has resulted in a request for mental health services. Additionally, identification of completed assessments to be attached to the referral is included.

Ryan White Part A Approval:
This section contains the professional's name, title, organization name, phone number, signature, and date.

Form Validity

The Ryan White Part A Referral for Mental Health Services Form is valid for the entire period of time the client receives services from the mental health provider

[13] In this section, when referring to all three professional positions - Linkage to Care coordinators, medical case managers, and non-medical case manager–supports, the term "professional or professionals" will be used.

Accessing the Ryan White Part A Referral for Mental Health Services Form

The Ryan White Part A Patient Approval Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible for following their agency's protocol on completing this form with typed or handwritten responses.

Ryan White Part A Referral for Mental Health Services Form Procedures

- Professionals are responsible for referring clients for mental health services based upon:
    - the outcome of the anxiety screen (GAD-7), depression screen (PHQ-9), and/or substance abuse screen (DAST-20) conducted during the psychosocial assessment,
    - client request, and/or
    - the medical case manager's clinical judgement.

- Clients should be provided with options for Ryan White Part A mental health service providers so they may select their provider (see page 7 for a list of Part A service providers).

- Professionals are responsible for completing the Ryan White Part A Referral for Mental Health Services Form in its entirety, once the client has selected a Ryan White Part A mental health service provider.

- A detailed description indicating the presenting factors for the need for mental health services should be documented in the "referral information" section.

- A copy of the completed Ryan White Part A Referral for Mental Health Services Form, along with completed assessments (if applicable), e.g. GAD-7, PHQ-9, or DAST-20, should be faxed to the Ryan White Part A mental health provider,.

- The client may contact the Ryan White Part A mental health service provider to schedule an appointment. If the client needs assistance with scheduling this appointment, the professional may contact the provider with, or on behalf of, the client.

- A copy of the completed Ryan White Part A Referral for Mental Health Services Form should be maintained in the client's file.

Best Practices

- ✓ Be sure the client is eligible to receive Ryan White Part A services prior to completing the Ryan White Part A Referral for Mental Health Services Form and/or referring a client to a Ryan White Part A provider.

- ✓ Provide the client with options for mental health service providers. Be sure to make them aware that they must see an approved provider in order for the service to be approved/covered (see page 7 for a list of Part A service providers).

- ✓ Make sure all sections of the Ryan White Part A Referral for Mental Health Services Form are completed prior to faxing the form to a provider.

- ✓ Retain, in the client file, a receipt of sending the fax. If the provider's office indicates they did not receive the form and assessments, this receipt will serve as validation.

Section XVC:
Ryan White Part A Housing

Ryan White Part A funds the following housing service categories:

Housing Services: provides short-term and/or emergency housing that may include rental, hotel, or shelter assistance and/or other means deemed appropriate. Any household with short-term and/or emergency housing exceeding 24 months (over a lifetime) should have a specific and documented justification, which shall be reviewed at least every six months.

Housing Non-Medical Case Management: provides assistance with locating, securing, and/or maintaining decent and appropriate housing, with the ultimate goal of ensuring clients are able to maintain stable housing arrangements and remain within the care system.

Emergency Financial Assistance: provides payment assistance with utility bills and/or moving expenses.

RYAN WHITE PART A HOUSING REFERRAL

Form

A standardized Ryan White Part A Housing Referral Form has been developed for the Ryan White Part A program. It is the responsibility of Linkage to Care coordinators, medical case managers, and/or non-medical case manager–supports[14] to complete all sections of the Housing Referral Form and submit it, along with a copy of the most current Ryan White Part A Eligibility Form, to the Success In Housing Program (the Ryan White Part A housing services provider). Each section of the form provides valuable information about the client and request for service.

Communication between the Success In Housing Program/housing case managers and referring professionals is vital to meeting the needs of clients. The Housing Referral Form is the first step in the communication process. A timeline and flow for communication has been developed to reduce misunderstanding and better assure client needs are met (please see page 118 for more information).

Date:
This section contains the date the Housing Referral Form was completed.

Referral Source Information:
This section provides contact information on the referral source including the name of the referring professional, agency name, phone number and email address. This section also serves as verification of client eligibility for Ryan White Part A services and requires a handwritten signature of the referring professional along with the client's Ryan White Part A eligibility expiration date.

Client Contact Information:
This section provides contact information for the client, including preferred method of contact and determination if a confidential message may be left on voicemail.

Client Housing Information:
This section provides important information about the client's housing situation including income, size and composition of the household, Veteran status, active subsidies and financial assistance such as HEAP/PIPP, and risk factors including eviction and/or utility disconnection.

Request Information:
This section provides information on the request for assistance, including the type of request: housing case management (including services requested, e.g. budgeting, obtaining housing, etc.) and/or financial assistance (including the type, e.g. rent and/or

[14] In this section, when referring to all three professional positions - Linkage to Care coordinators, medical case managers, and non-medical case manager–supports, the term "professional or professionals" will be used.

utility etc. and the amount of financial assistance requested) and a detailed description of the client's situation that has resulted in a request for assistance. Additionally, this section also provides indication if the client has independently, and/or with the aid of a professional, attempted to access assistance from the community to address the need and a description of the outcome of the effort, if applicable.

Additional Information:
This section provides information about the client including primary language spoken and literacy concerns, need for transportation, mental health, substance use, and memory/organization/confusion concerns, along with any additional information that would be helpful to providing housing assistance.

Success In Housing Office Use Only:
This section is to be completed by Success In Housing and provides information on the referral received, communication with the referral source, and information on the assigned housing case manager.

Form Validity

The Ryan White Part A Housing Referral Form is valid from the date the form is completed until the Success In Housing Program closes the client's case. Typically, cases are closed within six months.

- If the client has additional housing needs while their case is open with Success In Housing, it will not be necessary for a new Housing Referral Form to be completed (an email request should be sent to the assigned housing case manager).
- If the client has additional housing needs and the case has been closed by Success In Housing, a new Housing Referral Form should be completed.

Accessing the Ryan White Part A Housing Referral Form

The Ryan White Part A Housing Referral Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible for completing this form with typed responses.

Housing Referral Form Documentation and Submission Procedures

- Professionals are responsible for responding to all questions/sections on the Housing Referral Form with typed responses.

- Referral Source Information:
    - Consider if the client would benefit from having the referring professional participate in the intake meeting (for support, for assistance with responding to the questions during the intake meeting, etc.).
    - Document any concerns about the housing case manager meeting one-on-one with the client so that the Success In Housing Program can arrange in advance for multiple professionals to be present, if necessary.

- Client Housing Information:
    - If the client does not have any income and a plan to gain income is not identified, likely Success In Housing will not be able to provide financial assistance. In this instance, Success In Housing would offer housing case management, which may include budgeting, benefits assistance, linkage to employment services, referral to the shelter system, etc.
    - Clients who receive certain housing subsidies, e.g. HOPWA TBRA, may not be eligible for rent or utility assistance through Success In Housing.
    - Success In Housing strives to provide the requested assistance in a timely manner. Sometimes, the short-term solution to the client's situation is entering the shelter system. This could be due to the client's need to secure housing in a shorter timeframe than can reasonably be met, the client's housing history, etc.

- Request Information
    - If financial assistance is needed, be sure to document the type AND amount of assistance requested. In the event that the financial request is greater than the client's income, it is likely Success In Housing will not be able to provide the financial assistance requested. In this instance, housing case management would be offered, which may include a referral to mediation services to end the lease early.
    - Be sure to describe the situation that led to the need for assistance. This information will assist the Success In Housing Program with determining if they are the best program to meet the client's need.
    - It is not required that the client seek, and/or the professional assist the client with seeking, community resources prior to being referred to Success In Housing. However, as a payer of last resort, the <u>Success In Housing Program is responsible for determining if community resources have been exhausted prior to providing financial assistance to the client</u>.
        - ❖ If it is indicated the professional assisted the client with seeking community resources to assist with a financial request, Success In Housing will use this documentation as payer of last resort. Assistance from the professional is defined as the professional leading/participating in a phone call and/or meeting with a community resource to address the financial request. If the professional strictly provided the client contact information for a community resource, this would <u>not</u> be considered assisting the client with seeking community resources.

        - ❖ If it is indicated the client independently attempted to access community resources to assist with a financial request, Success In Housing will explore with the client what this entailed to determine if a referral and/or assistance with seeking community resources is necessary to comply with payer of last resort requirements.
    - In order to provide financial assistance for rent or utilities, Success In Housing must verify the client resides in the unit. Clients are required to provide a copy of the lease and/or utility bill featuring their name.
    - For clients who are approved to receive financial assistance for rent, Success In Housing will pay the client's portion. For example, if the client resides with one other person, Success In Housing will pay the client's portion of up to 50% of the total rent.

- Additional Information:
    - Be sure to indicate if an interpreter is needed. If indicated, Success In Housing will arrange for translation services for housing services.
    - If it is indicated that the client needs transportation for housing services, Success In Housing is responsible for either providing the client with bus passes/gas cards and/or arranging to meet the client at an agreed upon location convenient for the client, e.g. the client's home, library, etc.
    - Make sure to indicate if Success In Housing should assist with linking the client to mental health and/or treatment services. If it is indicated that this assistance is needed, Success In Housing will strive to link the client to these services through their agency, Southeast, Inc.
    - Be sure to document any additional information relevant to working with and reaching the client and/or the situation along with the best method and time to reach the referring professional.

- Prior to submitting the form to Success In Housing, professionals must document an original signature on the form.

- Housing Referral Forms, along with a copy of the Ryan White Part A Eligibility Form, should be faxed to Success In Housing at 614.291.0682.

- Incomplete Housing Referral Forms will be returned to the referring professional. Missing Ryan White Part A Eligibility Forms will delay the start of services.

- Communication: While communication should occur following the timeframe outlined in the table below, be aware that the timeframe is directly impacted by factors including completeness of the Housing Referral Form/submission of a copy of the Ryan White Part A Eligibility Form, Success In Housing's ability to reach the client, the client's availability to participate in an intake appointment and/or follow-up calls/meetings, etc.

  In the event that timely communication is not provided, referring professionals are responsible for contacting the assigned housing case manager to try to

resolve the issue. If the issue is not resolved satisfactorily, consult your supervisor to determine if the concern should be escalated to the Success In Housing program coordinator (willisk@southeastinc.com) or program director (caffeya@southeastinc.com or 614.360.0251, ext. 2105).

The table below outlines the timeline and flow of required communication:

Professional Responsible for Initiating Communication	**Professional/Client Responsible for Receiving Communication**	**Purpose of Communication**	**Timeframe**
Success In Housing	Referring Professional	To request missing and/or additional information regarding the Housing Referral Form and/or to inform referring professional the client is ineligible due to reaching the service unit limit.	Within two business of receiving the Housing Referral Form.
Success In Housing Program Coordinator	Housing Case Manager	To assign a case.	Within two business days of receiving a complete Housing Referral Form and Ryan White Part A Eligibility Form.
Housing Case Manager	Referring Professional	To provide name and contact information of the assigned housing case manager.	Within two business days of receiving a case assignment.
Housing Case Manager	Client	To schedule and provide information about the intake appointment.	Within two business days of receiving case assignment.
Housing Case Manager	Referring Professional	To inform referring professional of any challenges with contacting the client to schedule an intake appointment, if applicable.	Following three attempts to reach the client using methods documented on the Housing Referral Form.
Housing Case Manager	Referring Professional	To provide an overview of key information exchanged during the intake appointment and provide a copy of the housing plan.	Within two business days of documenting the housing plan.
Referring Professional	Housing Case Manager	To ask questions and/or seek clarification on information exchanged during the intake appointment and/or the housing plan	Within two business days of receiving the housing plan.
Housing Case Manager	Referring Professional	To provide an update on progress towards meeting goals documented in the housing plan.	Every two weeks until the case is closed.
Referring Professional	Housing Case Manager	To inform housing case manager of any updates/changes to the client's situation, relevant to housing.	Within two business days of becoming aware of changes.
Referring Professional	Housing Case Manager	To ask questions and/or seek clarification on progress towards meeting goals documented in the housing plan.	Within two business days of receiving an update from the housing case manager.

Best Practices

- ✓ Be sure to document an original signature on the Housing Referral Form before submitting it to the Success In Housing Program.

- ✓ Prior to submitting the Housing Referral Form, confirm accuracy of client contact information.

- ✓ It is recommended that the description for the client's circumstances and the reason for the request:
  - illustrates a demonstrated need for housing to gain or maintain access to HIV-related medical care, stay adherent to treatment regimes, prevent loss of housing, or alleviate homelessness; and
  - indicates the precipitating factors leading to the need for housing assistance.

- ✓ Be sure to indicate if the client independently, or with the aid of a professional, attempted to access assistance to address their need. If it is indicated the professional assisted the client with seeking community resources to assist with a financial request, Success In Housing will use this documentation as payer of last resort. Assistance from the professional is defined as the professional leading/participating in a phone call and/or meeting with a community resource to address the financial request.

- ✓ If the client either did not attempt or independently attempted to access community resources, Success In Housing will explore with the client what this entailed to determine if a referral and/or assistance with seeking community resources is necessary to comply with payer of last resort requirements. If so determined, this could be the first goal on the housing plan before financial assistance will be provided.

- ✓ Referral sources are encouraged to provide to housing case managers any updates to the client's situation pertaining to housing.

- ✓ In the event that timely communication is not provided by Success In Housing, referring professionals should contact the assigned housing case manager as soon as possible to try to resolve the issue. If the issue is not resolved satisfactorily, consult a supervisor to determine if the concern should be escalated to the Success In Housing program coordinator or program director.

RYAN WHITE PART A HOUSING SERVICE LIMIT EXCEPTION

Form

A standardized Ryan White Part A Housing Service Limit Exception Form has been developed for the Ryan White Part A program. It is the responsibility of Linkage to Care coordinators, medical case managers, and/or non-medical case manager–supports[15] to complete all sections of the form and submit it to the Success In Housing Program. This form is to be completed when clients have received financial assistance three times in a calendar year and have circumstances that may require an exception to the service limit policy.

Due to funding constraints, there is a limit on the amount of times financial assistance for rent, utilities, application fees, and/or moving expenses may be provided to a client. Clients may receive financial assistance a maximum of three times per calendar year. Additionally, there is a 24-month maximum lifetime limit. Exceptions to this service limit are made on a case-by-case basis and are determined by the identified cause for the request and availability of funding. All determinations are final. The Success In Housing Program/housing case manager will provide referral sources with notification of the decision within two business days of receiving a completed Housing Service Limit Exception Form. Each section on the form provides valuable information about the client and reason for the requested exception.

Date of Request:
This section contains the date the Housing Service Limit Exception Form is completed.

Client Information:
This section provides contact information on the client including the client's name, date of birth, address, phone number, and email address.

Request Information:
This section provides information on the request, including the type and amount of financial assistance requested.

Reason for Exception:
This section provides general information about the reason for the exception. Information from this section will be used to help determine approval for an exception.

[15] In this section, when referring to all three professional positions - Linkage to Care coordinators, medical case managers, and non-medical case manager–supports, the term "professional or professionals" will be used.

Exception Request Description:
This section provides a detailed description of the client's situation that has resulted in a request for additional emergency financial assistance. Information from this section will be used to help determine approval for an exception.

Referral Source Information:
This section provides contact information on the referring professional including the name, title, phone number, email address, and signature of the professional along with the name of the professional's agency.

Success In Housing Use Only:
This section is to be completed by Success In Housing and provides information on the approval status of the request, any additional information related to the approval process, and the date the referring professional was notified of the decision.

Accessing the Housing Service Limit Exception Form

The Housing Service Limit Exception Form is a fillable PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible for completing this form with typed responses.

Housing Service Limit Exception Documentation and Submission Procedures

Professionals are responsible for completing Service Limit Exception Forms on behalf of clients who have received financial assistance three times in a calendar year and have circumstances that may require an exception to the service limit policy.

- Success In Housing service limit exceptions are considered for clients with a:
  - Severe medical condition;
  - Major delay in service delivery;
  - Significant safety concern; and
  - Other – if a description of the other circumstance is documented.

- Professionals are responsible for providing a typed response to all sections/questions of the form

- A detailed description justifying the need for the exception request should be documented on the form.

- Professionals must sign the Housing Service Limit Exception Form prior to submitting it to the Success In Housing Program.

- Housing Service Limit Exception Forms should be faxed to 614.291.0682.

- Incomplete Service Limit Exception Forms will be returned to the referring professional and will delay the Success In Housing Program's ability to consider the request.

- Professionals are responsible for responding to requests for additional information and/or consultation.

Best Practices

- ✓ Be sure to sign the Housing Service Limit Exception Form before submitting it to the Success In Housing Program.

- ✓ Prior to submitting the Housing Service Limit Exception Form, confirm accuracy of client contact information.

- ✓ Clearly describe the client's circumstances and the reason for the request for additional emergency financial assistance. It is recommended that the description:
  - indicates the precipitating factors leading to the need for additional financial assistance;
  - illustrates a demonstrated need for housing to gain or maintain access to HIV-related medical care, stay adherent to treatment regimes, prevent loss of housing, or alleviate homelessness; and
  - includes information on how much additional financial assistance is needed, e.g. $100 for gas bills for two months while the client is awaiting receipt of benefits.

- ✓ Communication: Communication between the Success In Housing Program and referral sources is vital to meeting the needs of clients. Referral sources are responsible for responding to requests for additional information and/or consultation from the Success In Housing Program and are encouraged to provide to Success In Housing any updates on the client's situation pertaining to housing. In the event referral sources do not receive notification of the decision on the exception within two business days, they should contact the Success In Housing program coordinator at 614.800.8646.

Section XVD:
Ryan White Part A
Medical Transportation Services

Ryan White Part A funds may be used to provide transportation for eligible Ryan White program clients to access core medical and support services. This includes travel between the funded providers for services, as well as transportation assistance to government agencies or medical facilities required by any of the service's eligibility requirements, e.g. local job and family service agency for medical assistance. Covered medical transportation services must be HIV-related and the Ryan White Part A program must be the payer of last resort.

Each case management agency has its own transportation policy. Information outlined in this section pertains to the distribution and use of bus passes and gas cards accessed through Columbus Public Health.

RYAN WHITE PART A
BUS PASS/GAS CARD REQUEST

Form

A standardized Ryan White Part A Bus Pass/Gas Card Request Form has been developed for the Ryan White Part A program. Ryan White Part A medical transportation services are available for eligible clients to access core medical and support services, including travel between funded providers and transportation assistance to government agencies/medical facilities required by any of the service's eligibility requirements. A representative from a Ryan White Part A service provider must complete the Ryan White Part A Bus Pass/Gas Card Request Form to obtain bus passes and gas cards to distribute to eligible clients. Each section of the form provides Columbus Public Health with confirmation of the agency's agreement to abide by the transportation policy and verification of the bus passes/gas cards to be distributed.

Date:
This section contains the date the form is completed.

Narrative Section:
The narrative section provides information about the request and agreement to abide by the Ryan White Part A Medical Transportation Policy. This section contains the name of the requesting agency and the number of bus passes and gas cards being requested.

Requestor Information:
This section contains the name, signature, and title of the requestor, along with the requested date to pick-up the bus passes and gas cards.

Columbus Public Health Information:
This section contains the signature of the representative from Columbus Public Health, the date the bus passes/gas cards were obtained by the requesting agency, and the bus pass numbers and/or gas card numbers distributed.

Form Validity

The Ryan White Part A Bus Pass/Gas Card Request Form is valid for the entire period of time the agency distributes to clients the specific bus passes/gas cards provided through the request.

Accessing the Ryan White Part A Bus Pass/Gas Card Request Form

The Ryan White Part A Bus Pass/Gas Card Request Form is a PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Agency representatives are responsible for completing this form with handwritten responses.

Case Management Agency Bus Pass/Gas Card Request Form Procedures

- Ryan White Part A case management agencies may request bus passes/gas cards by completing the Ryan White Part A Bus Pass/Gas Card Request Form.
- Ryan White Part A case management agencies must abide by the policies and procedures outlined on the form and in the Ryan White Part A Medical Transportation Policy.
- Case management agencies are responsible for documenting the date of the request, the agency name, the amount of bus passes and/or gas cards requested, and requested date to pick-up the bus passes/gas cards, along with the requestor's name, signature, and title.
- Completed Ryan White Part A Bus Pass/Gas Card Request Forms should be emailed to IMDavolio@columbus.gov.
- A copy of the completed Ryan White Part A Bus Pass/Gas Card Request Form should be retained by the requesting case management agency.

Case Management Agency Best Practices

- ✓ Be sure to complete the form in its entirety.
- ✓ It is recommended requests be submitted to Columbus Public Health two weeks prior to the date the bus passes/gas cards are needed.

Columbus Public Health Bus Pass/Gas Card Request Form Procedures

- A staff member from Columbus Public Health's Ryan White Part A Program is responsible for receiving completed Ryan White Part A Bus Pass/Gas Card Request Forms, distributing bus passes/gas cards accordingly, and maintaining completed request forms.
- Upon receipt of a Bus Pass/Gas Card Request Form, respond by email to the requestor and arrange for a date, time, and location for the pick-up/delivery of bus passes/gas cards.

- At pick/up/delivery, be sure to sign and date the completed Ryan White Part A Bus Pass/Gas Card Request Form and document the bus pass numbers and gas cards numbers provided to the requestor.

- Retain the original completed form.

RYAN WHITE PART A TRANSPORTATION ASSISTANCE

Form

A standardized Ryan White Part A Transportation Assistance Form has been developed for the Ryan White Part A program. Ryan White Part A medical transportation services are available for eligible clients to access core medical and support services, including travel between the funded providers, as well as transportation assistance to government agencies or medical facilities required by any of the service's eligibility requirements. It is the responsibility of Linkage to Care coordinators, medical case managers, and/or non-medical case manager-supports[16] to complete this form each time bus passes or gas cards are distributed to clients. Each section of the form provides Columbus Public Health with verification of transportation assistance.

Date:
This section contains the date the form was completed.

Client Information:
This section contains identifying information, including the client's name and date of birth.

Appointment Information:
This section indicates the type of appointment(s) the client will attend through Ryan White Part A transportation assistance, date(s) of appointment(s), and provider name(s). The origination and destination addresses should also be documented for clients who receive gas cards.

Transportation Assistance:
This section provides guidelines for distribution of bus passes and gas cards, along with indication of the type of assistance provided - gas card(s) or bus pass(es), and the corresponding voucher number.

Client Agreement:
This section contains the client's signature and date, which confirms client understanding that transportation is provided for them to access medical appointments and/or support services. The professional's signature and date are also contained in this section.

[16] In this section, when referring to all three professional positions - Linkage to Care coordinators, medical case managers, and non-medical case manager–supports, the term "professional or professionals" will be used.

Form Validity

The Ryan White Part A Transportation Assistance Form is valid through the appointment date(s) documented on the form.

Accessing the Ryan White Part A Transportation Assistance Form

The Ryan White Part A Transportation Assistance Form is a PDF document that may be accessed through this link: https://sites.google.com/site/ryanwhitepartacolumbustga/. Professionals are responsible for completing this form with handwritten responses.

Ryan White Part A Transportation Assistance Form Documentation Procedures

- Professionals must verify that a client is eligible to receive transportation assistance through Ryan White Part A. Eligible clients are those currently enrolled in the Columbus TGA Ryan White Part A program and have a Ryan White Part A Eligibility Form on file at Columbus Public Health (see page 22 for additional information).

- Professionals are responsible for documenting handwritten responses to all sections/questions of the Ryan White Part A Transportation Assistance Form.

- Be sure to identify the appointment type and check the associated box(es) accordingly. Be sure to include details about the appointment(s) including date(s) and provider name(s).
    - For clients who receive gas cards, documentation must also include the originating and destination addresses.

- Determine the type of transportation assistance to be provided, e.g. gas card or bus pass, and check the type of assistance accordingly. The voucher number(s) should also be documented.
    - COTA Mainstream bus passes are available on a case-by-case basis, approved by Columbus Public Health.

- Multiple appointments may be documented on the form, however, details for each appointment must be listed to justify the amount of assistance.

- Ensure the client's original signature is present on the form.

- A case note should be documented that demonstrates an assessment of need and effort to access community resources for transportation services.

- Maintain the completed Ryan White Part A Transportation Assistance Form in the client's file.

Best Practices

- ✓ Be sure to complete all sections/questions on the form.
- ✓ Make sure to obtain the client's signature and explain to the client the purpose of the form and reason for their signature.
- ✓ Retain the original, completed Ryan White Part A Transportation Assistance Form in the client's file.

Appendix A:
Psychosocial Assessment Supplemental Materials

This section contains the following documents:

- Sample Budget Template: This tool may be used to assist clients with understanding their income and expenses, reducing out-of-pocket expenses, and/or planning for the future.

- Ohio's HIV Felonious Assault Law: What you Need to Know: This handout may be reproduced and provided to clients to increase their knowledge and understanding of the law.

- Advance Directives Presentation: This presentation was provided by Nationwide Children's Hospital and provides information about the types of advance directives, the importance of advance care planning, legal forms and alternative options, and information on how to best support individuals in completing the documents.

Monthly Household Budget

Client Name: _____

Monthly Income: $_____

	Current Budget	New Budget
Rent/Mortgage	$_____	$_____
Home/Rental Insurance	$_____	$_____
Storage	$_____	$_____
Electricity	$_____	$_____
Gas	$_____	$_____
Phone	$_____	$_____
Water/Sewer/Trash	$_____	$_____
Cable/Internet	$_____	$_____
Medical Insurance	$_____	$_____
Medical or Rx Copays	$_____	$_____
Public Transportation	$_____	$_____
Car Payment	$_____	$_____
Car Insurance	$_____	$_____
Auto Fuel/Maintenance	$_____	$_____
Food	$_____	$_____
Personal Care/Toiletries	$_____	$_____
Laundry/Laundromat	$_____	$_____
Cigarettes	$_____	$_____
Pet Care	$_____	$_____
Clothing	$_____	$_____
Credit Card/Debt Payments	$_____	$_____
Child Care	$_____	$_____
Child Support	$_____	$_____
Tuition	$_____	$_____
Court Fines/Fees	$_____	$_____
Other: _____	$_____	$_____
TOTAL:	$_____	$_____

NEW:

Total Household Income: $_____ - Total Expenses $_____ = $_____

If income is insufficient, how will the household be maintained?_____

Ohio's HIV Felonious Assault Law: What you Need to Know

Are you a person living with HIV/AIDS? Are you sexually active? If so, there is an important law in Ohio that you must know about. It is the HIV Felonious Assault Law (often referred to as House Bill 100). This law makes it a crime, or felony, for anyone diagnosed with HIV or AIDS to have sex without letting their sex partner know about this HIV/AIDS before having sex. This has been the law since March of 2000.

You must tell anyone you have sex with you are HIV+ before any sex act. If you participate in any sex act, no matter how major or minor – you must tell your partner you are HIV+ before having sex – even if you are practicing safer sex!

What does "*any sex act"* mean?

This law covers at least all these sex acts:

1. Vaginal or anal intercourse
2. Any and all kinds of penetration – even with toys or dildos
3. Fellatio
4. Cunnilingus
5. "Going down" on someone
6. Giving or getting head or a blow job
7. Using your fist, dildos, or toys

What if a sex partner accuses me of having sex and not telling before the sex act?

1. You will lose all your rights to your privacy.
2. Your HIV status and sex life become a matter of public record.
3. You will need a lawyer to defend you. This can cost a lot of money.
4. Legal costs can mean you lose ownership of anything you have that has value, even your home.

What if I am found guilty (convicted) of having sex and not telling?

1. You can be sent to prison for 2 – 8 years.
2. You can be put on probation or fined up to $15,000.

How can I keep myself from being accused if I follow the law and tell my sex partners I am HIV+?

1. Ask you sex partner(s) to sign a paper saying you told them you are HIV+.
2. Have someone you know and trust listen to you tell your sex partner that you are HIV+. That person can be your witness that you tell.

What kind of crime is felonious assault?

1. An assault is an unlawful attempt to do bodily injury to another person. Felony, or felonious, means a bad crime such as murder, rape, or burglary. Felonies carry a harder sentence than lesser crimes.
2. An HIV+ person who has sex without telling his or her partner about the HIV commits a second degree felony. This means that if the person is convicted the sentence will be less than it would be for a first degree felony like murder.

Are there any other parts to the law that I should know about?

1. If you are HIV+, it is a felony for you to have sex with anyone under the age of 18, even if you tell the person you are HIV+ before you have sex. If you are married to someone under the age of 18, this part of the law does not apply.
2. If you are HIV+, it is a felony for you to have sex with anyone who can't mentally understand the risks of HIV, even if you tell the person you are HIV+ before you have sex.
3. If you are HIV+, it is a felony for you to solicit another person to engage in sexual activity for hire, or prostitution.
4. If you are HIV+, it is a felony to sell or donate your blood, plasma, or blood product if you know that the fluid is being accepted for the purpose of transfusion.
5. If you are HIV+, it is a felony to share needles with someone without informing them that you are HIV+ first.

An Introduction to Advance Directives

Karen Rediger, MSSA, LISW-S
Nicole Parente, LSW

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.™

Objectives

- Learn about the types of advance directives
- Discuss the importance of advance care planning
- Identify the legal forms and alternative options
- Increase understanding of how to best support individuals in completing the documents

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.™

What are Advance Directives?

- A tool to help you think through and communicate your choices
- Outline your choices for health care
- Name someone to make choices when you become unable to make decisions
- Applies to individuals ages 18 and up

What is Included?

- Healthcare Power of Attorney (HPOA)
- Living Will

Important note: If you have both a living will and power of attorney, the physician must comply with the wishes you state in your living will.

Why are They Important?

- They help you express your wishes
- Allow an opportunity to have an open discussion with loved ones
- Decrease stress for families during a difficult time

Health Care Power of Attorney

- Identifies who you want to make health care decisions on your behalf
- Goes into effect when your doctor says you are unable to make your own medical decisions (temporarily or permanently)
- Includes decisions about the end-of-life and other medical situations
- It is **not** the same as a power of attorney for financial matters

Health Care Power of Attorney

Who should you consider?

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.™

Health Care Power of Attorney

Who **cannot** be your POA?

- Your health care provider
- An employee of your health care provider
  - Unless related to you by blood, marriage, adoption
- Anyone under the age of 18

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.™

Health Care Power of Attorney

Who makes decisions if you do not designate a HPOA?

In the following order:

- Court appointed guardian (with court approval)
- Spouse
- Adult child or, if more than one, the majority of my children
- Parent or parents
- Adult brother or sister

Health Care Power of Attorney

- Agent can, if indicated, have immediate access to protected health information
- Allows you to nominate of a guardian (other than designated agent)
  - Person: day-to-day decisions of a personal nature (food, clothing, living arrangements)
  - Estate: financial decisions
    - *Appointment of a guardian still will need to go through court proceedings.*
- There are limitations outlined in the document

Living Will

- Allows you to establish the medical care you would and would not want to receive if you were to become **permanently** unconscious or terminally ill, and unable speak for yourself
- Two physicians must decide that you have no reasonable possibility of regaining consciousness
- Specifically addresses treatments that extend life – procedures that support the body and keep a person alive when the body is not able to function on its own

Living Will

- A living will gives your physician the authority to withhold life-sustaining treatment and permit you to die naturally and take no actions to postpone your death
- This includes “comfort care” including removing nutrition and hydration.
  - nutrition and hydration are considered “life prolonging” if they are given through a tube.
  - food and water will be offered, but will not be given through a tube if death is imminent and you have signed a general living will.

Living Will

- Administer no life-sustaining treatment, including CPR
- Withdraw such treatment, including CPR, if such treatment has started
- Issue a Do Not Resuscitate Order (DNR) order
- Permit me to die naturally while still providing care necessary to make you comfortable and relieve my pain

Living Will

Things to consider:

- Feed, bathe, or take care of myself
- Be free from pain
- Live without being hooked up to machines
- My life is always worth living no matter how sick I am
- Where you want to die

Advance Directives Ohio

- Each state requires its own forms for advance directives
- The document must be notarized or witnessed by two people who are not the attending physician or related by blood, marriage, or adoption.
- Provide patient with the original and multiple copies for their records.

Alternative Documents

- Five Wishes
  - Addresses medical, personal, emotional, and spiritual needs
- Voicing My Choices
  - Based on the Five Wishes
  - designed for adolescents and young adults
- The Conversation Starter Kit
  - A document created by The Conversation Project to help people start conversations with their loved ones about end-of-life care
  - Both pediatric and adult kits available for free
  - www.theconversationproject.org/starter-kit/intro

** Not legal documents in Ohio*

How Can You Help?

- It is important to have a discussion with the patient to ensure that they are prepared to complete the documents. They may not always be ready at that time.
- This can be a difficult transition for patients, so it is important to work with them to increase their comfort level.
- It can be an ongoing process and does not have to be completed in one meeting.
- The process includes educating about the benefits, helping patients complete the documents, and communicating with family/friends.

How Can You Help?

- Some patients may be more comfortable focusing on designating a healthcare power of attorney first and then completing the living will.
- This can be, but does not have to be an “end-of-life” discussion.
- Upon completion, ensure that the patient is aware they can change or revoke their advance directives at any point.
- Focus on empowering them to make their own medical decisions and ensure that their wishes are known.

Important Notes

- Having advance directives does not mean a physician will not treat you. It means that the physician will treat you the way you want to be treated.
- You will not lose your ability to make your own medical decisions once you designate an HPOA. As long as you retain decision making ability, you will maintain control over all decisions.
- Even with advance directives in place, there will be difficult decisions to make. You should have ongoing conversations with family/friends to ensure they understand what you do and do not want/when “enough is enough”.

Appendix B:
Ryan White Part A Forms

This section contains the following Ryan White Part A Forms:

1. Ryan White Part A Eligibility Form-Initial Assessment
2. Ryan White Part A Eligibility Form-Six Month Review
3. Ryan White Part A Eligibility Exception Form
4. MAGI Worksheet
5. Ryan White Part A Patient Approval Form
6. Ryan White Part A Referral for Mental Health Services Form
7. Ryan White Part A Housing Referral Form
8. Ryan White Part A Housing Service Limit Exception Form
9. Ryan White Part A Bus Pass/Gas Card Request Form
10. Ryan White Part A Transportation Assistance Form

THE CITY OF COLUMBUS
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COLUMBUS PUBLIC HEALTH

Ryan White Part A Eligibility Form
INITIAL ASSESSMENT

Date of Initial Assessment: _____/_____/_____

1. Client Information

First Name: _____ **Middle Name:** _____

Last Name: _____ **Date of Birth:** _____/_____/_____

Sex at Birth: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ Transgender (MTF) ☐ Transgender (FTM)

2. Client Demographics

Race: *(Check all that apply)*
☐ White
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Asian

If Asian, please specify: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other

☐ Native Hawaiian or Pacific Islander

If Native Hawaiian or Pacific Islander, please specify: ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other

Ethnicity:
☐ Not Hispanic/Latino(a)
☐ Hispanic/Latino(a)

If Hispanic/Latino(a), please specify: ☐ Mexican, Mexican American, Chicano(a) ☐ Puerto Rican ☐ Another Hispanic, Latino(a) or Spanish Origin ☐ Cuban

3. HIV Status

HIV Status: ☐ HIV-positive, not AIDS ☐ HIV-positive, AIDS status unknown ☐ CDC-defined AIDS

HIV-positive Date: _____/_____/_____

Documentation:
☐ Copy of a CTR or other CLIA certified laboratory report of an HIV-positive test result
☐ Documentation confirming HIV-positive status in Ohio Disease Reporting System (ODRS)
☐ Official paperwork from a physician or advanced nurse practitioner confirming client's HIV-positive status
☐ Proof of prescription for HIV medication
☐ Exception Form submitted to and approved by Columbus Public Health

4. Residency Status

Does the client live in the Columbus TGA? ☐ Yes ☐ No

Zip Code: _____

Documentation:
☐ Copy of state issued identification card or driver's license
☐ Copy of mail from a utility or service providing company that confirms client's residency
☐ Copy of mail from a government agency that confirms client's residency
☐ Copy of a lease or mortgage statement that lists the client
☐ A professional's verification letter following a visit to the client's home
☐ Signed attestation by the client confirming residency (*may be utilized only one time in a twelve-month period*)
☐ Exception Form submitted to and approved by Columbus Public Health

5. Income Status

Does the client meet the "low-income" requirement? ☐ Yes ☐ No

Low-income is defined as less than 300% FPL using the MAGI methodology. Or, with grantee exception, low income may be defined as 500% FPL using the MAGI methodology.

Annual Income: $_____ **Household Size:** _____ **Federal Poverty Level:** _____

Documentation:

☐ Copy of most current IRS Tax Transcript (three (3) years of tax transcripts if self-employed)
☐ Completed MAGI Worksheet with a copy of four (4) consecutive weeks of pay stubs
☐ Completed MAGI Worksheet with letter from employer stating earnings
☐ Completed MAGI Worksheet with copies of court orders for alimony or other court-ordered payments, excluding child support
☐ Completed MAGI Worksheet with copies of award letters for benefits from federal, state or county entitlement programs
☐ Signed attestation by the client stating their income, including if the client has no income (*may be utilized only one time in a twelve-month period*)
☐ Exception Form submitted to and approved by Columbus Public Health

6. Insurance Status

Does the client have health insurance? ☐ Yes ☐ No

If "YES", indicate primary insurance type:

☐ Private—Employer
☐ Private—Individual
☐ Medicare
☐ Medicaid, CHIP or other public plan
☐ Veterans Health Administration (VA), military health care (TRICARE), or other military health care
☐ Indian Health Service
☐ Other *(not listed above)*

Documentation:

☐ Copy of current insurance card
☐ Proof that the service is not covered by other third party insurance programs (*Military Veterans with VA benefits are eligible for Ryan White services*)
☐ Signed attestation from a professional stating the client is not eligible for health insurance coverage
☐ Copy of pending application, if potentially eligible
☐ Signed attestation that the client was informed of health insurance coverage options and the benefits of applying for health insurance coverage, but opted not to apply (*Ryan White services shall not be denied based upon client's informed decision to abstain from health insurance*)
☐ Exception Form submitted to and approved by Columbus Public Health

7. Ryan White Part A Approval

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

_____ _____
Printed Name *Organization*

_____ _____/_____/_____
Signature *Date*

Date of next review:	_____/_____/_____

THE CITY OF COLUMBUS
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COLUMBUS PUBLIC HEALTH

Ryan White Part A Eligibility Form
SIX MONTH REVIEW

Date of Review: _____/_____/_____ | **Date of next review:** _____/_____/_____

1. Client Information

First Name: _____ **Last Name:** _____

Date of Birth: _____/_____/_____

Sex at Birth: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ Transgender (MTF) ☐ Transgender (FTM)

2. Residency Status

Does the client live in the Columbus TGA? ☐ Yes ☐ No **Zip Code:** _____

Documentation:

☐ Copy of state issued identification card or driver's license
☐ Copy of mail from a utility or service providing company that confirms client's residency
☐ Copy of mail from a government agency that confirms client's residency
☐ Copy of a lease or mortgage statement that lists the client
☐ A professional's verification letter following a visit to the client's home
☐ Signed attestation by the client confirming residency (*may be utilized only one time in a twelve-month period*)
☐ Exception Form submitted to and approved by Columbus Public Health

3. Income Status

Does the client meet the "low-income" requirement? ☐ Yes ☐ No

Low-income is defined as less than 300% FPL using the MAGI methodology. Or, with grantee exception, low income may be defined as 500% FPL using the MAGI methodology.

Annual Income: $_____ **Household Size:** _____ **Federal Poverty Level:** _____

Documentation:

☐ Copy of most current IRS Tax Transcript (three (3) years of tax transcripts if self-employed)
☐ Completed MAGI Worksheet with a copy of four (4) consecutive weeks of pay stubs
☐ Completed MAGI Worksheet with letter from employer stating earnings
☐ Completed MAGI Worksheet with copies of court orders for alimony or other court-ordered payments, excluding child support
☐ Completed MAGI Worksheet with copies of award letters for benefits from federal, state or county entitlement programs
☐ Signed attestation by the client stating their income, including if the client has no income (*may be utilized only one time in a twelve-month period*)
☐ Exception Form submitted to and approved by Columbus Public Health

4. Insurance Status

Does the client have health insurance? ☐ Yes ☐ No

If "YES", indicate primary insurance type:

☐ Private—Employer
☐ Private—Individual
☐ Medicare
☐ Medicaid, CHIP or other public plan
☐ Veterans Health Administration (VA), military health care (TRICARE), or other military health care
☐ Indian Health Service
☐ Other *(not listed above)*

Documentation:

☐ Copy of current insurance card
☐ Proof that the service is not covered by other third party insurance programs (*Military Veterans with VA benefits are eligible for Ryan White services*)
☐ Signed attestation from a professional stating the client is not eligible for health insurance coverage
☐ Copy of pending application, if potentially eligible
☐ Signed attestation that the client was informed of health insurance coverage options and the benefits of applying for health insurance coverage, but opted not to apply (*Ryan White services shall not be denied based upon client's informed decision to abstain from health insurance*)
☐ Exception Form submitted to and approved by Columbus Public Health

5. Ryan White Part A Approval

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

_____ _____
Printed Name *Organization*

_____ _____/_____/_____
Signature *Date*

THE CITY OF COLUMBUS
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COLUMBUS PUBLIC HEALTH

Ryan White Part A
ELIGIBILITY EXCEPTION FORM

Please fax to Columbus Public Health at (614)-645-0746
Attention: Ryan White Part A Eligibility Exception

Date of Request: _____/_____/_____

☐ **Initial Request**

☐ **Request Renewal**

1. Client Information

First Name: _____ **Last Name:** _____

Date of Birth: _____/_____/_____

2. Reason for Exception *(Check all that apply)*

☐ Over income (Between 300%-500% of the FPL)

☐ Significant safety or confidentiality concern

☐ Other documentation to be used to show eligibility than what is listed in the policy

☐ Other (Please List) _____

3. Exception Request Description *(Please provide additional information that will help justify the need for an exception)*

_____

_____

_____

_____

_____

_____

4. Exception Request Sign-Off

Name of Professional: _____

Email Address: _____

Phone Number: _____

Signature of Professional: _____

CPH Office Use Only:

Request Approved: ☐ Yes ☐ No ☐ More information needed

Notes:

_____

_____

_____

_____

Date of Decision Notification: _____/_____/_____

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MAGI Worksheet

Only for use with applicants who have not filed a Tax Return for the most recent Tax Year

**Income types listed in ALL CAPS are not calculated in MAGI, but are required fields*
^For any income losses, enter negative $ amount

Client Name: _____ DOB: ____ / ____ / ____

Income Sources Total Monthly $ Amount for all Legal Household Members				
	COLUMN 1		**COLUMN 2**	
Wages, Salaries, Tips, etc.		Pensions & Annuities (Veteran/Employer Based Pensions, Retirements, or Disability)		
Taxable Interest				
Tax Exempt Interest		Rental Real Estate, Partnerships, S Corporations, Trusts, etc.		
Ordinary Dividends		Farm Income or Loss^		
Taxable Refunds of State/Local Income Taxes		Unemployment Income		
Alimony or Other Spousal Support Received		Retirement Income from Social Security (SSA)		
Business Income/Loss^		Disability Income from Social Security (SSDI)		
Capital Gain/Loss^		SUPPLEMENTAL INCOME FROM SOCIAL SECURITY (SSI)*	**Specialty Line A**	
Other Gains/Losses^		Other Income (Jury Duty Pay, Gambling Winnings)		
IRA Distributions–Taxable Amount		CHILD SUPPORT RECEIVED, WORKERS COMP, MONETARY GIFTS*	**Specialty Line B**	
COLUMN 1 Total:	$ -	**COLUMN 2 Total:**	$	-
TOTAL INCOME = *(COLUMN 1 Total + COLUMN 2 Total):*		**$0.00**		

Non-MAGI (Not calculated, but required) Total Monthly $ Amount for all Legal Household Members			
	COLUMN 3		**COLUMN 4**
Educator Expenses		Penalty on Early Withdrawal of Savings	
Business Expenses		Alimony Paid	
Health Savings Account		IRA Deduction	
Moving Expenses		Student Loan Interest Deduction	
Deductible Part of Self Employment Tax		Tuition and Fees	
Self Employed SEP, SIMPLE Plans		Domestic Production Activities	
Self Employed Health Insurance Deduction			
COLUMN 3 Total:	$ -	**COLUMN 4 Total:**	$ -
Total Adjustments *(COLUMN 3 Total + COLUMN 4 Total)*		**$0.00**	
Add Specialty Line A		**$0.00**	
Add Specialty Line B		**$0.00**	
NON-MAGI SUBTOTAL = *(Total Adjustments + Specialty Line A + Specialty Line B)*		**$0.00**	

Modified Adjusted Gross Income (MAGI)	
TOTAL INCOME – NON-MAGI SUBTOTAL =	**$0.00**

Notes:

Client Signature _____ Date _____

(Signature, Date and Supporting Documentation is also required)

Ryan White Part A

Patient Approval Form

Date: _____/_____/_____

Dear Healthcare Provider:

The following patient is approved and validated to receive medical services under your Ryan White Part A contract until the expiration date listed below:

Client's First Name: _____ Client's Last Name: _____

Date of Birth: _____/_____/_____

Ryan White # *(if applicable)*: _____ ETO # *(if applicable)*: _____

Approval Date: _____/_____/_____ Expiration Date: _____/_____/_____

Ryan White Part A Approval

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

_____ _____
Professional's Printed Name *Title*

_____ _____
Organization *Phone Number*

_____ _____/_____/_____
Professional's Signature *Date*

THE CITY OF COLUMBUS
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COLUMBUS PUBLIC HEALTH

Ryan White Part A

Referral for Mental Health Services

Date: _____/_____/_____

1. Client Information

Client's First Name: _____ **Client's Last Name:** _____

Date of Birth: _____/_____/_____

Ryan White # *(if applicable)***:** _____ **ETO #** *(if applicable)***:** _____

Approval Date: _____/_____/_____ **Expiration Date:** _____/_____/_____

Does the client have health insurance? ☐ Yes ☐ No

If YES: **What is the client's primary type of insurance?**

☐ Private-Employer ☐ Private-Individual (ACA) ☐ Medicare ☐ Medicaid/CHIP/other private plan
☐ Indian Health Service ☐ Veteran's Health Administration (VA), military health care (TRICARE), other military care
☐ Other: _____

Client's Home Address *(including city and zip code)***:** _____

Client's Phone Number: _____ **Client's Email Address:** _____

Preferred Method of Contact: *(check all that apply)* ☐ Mail ☐ Phone ☐ Email
May confidential messages be left on voicemail? ☐ Yes ☐ No

2. Referral Information

Describe the client's circumstances and reason for the referral for mental health services:

Assessments to be included with the referral: *(check all that apply)* ☐ GAD-7 ☐ PHQ-9 ☐ DAST-20 ☐ NA

3. Ryan White Part A Approval

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

_____ _____
Professional's Printed Name *Title*

_____ _____
Organization *Phone Number*

_____ _____/_____/_____
Professional's Signature *Date*

THE CITY OF COLUMBUS
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COLUMBUS PUBLIC HEALTH

Ryan White Part A
Housing Referral Form

Please complete all sections of the referral form and fax it to 614.291.0682, along with the client's most recent Columbus Public Health Part A Eligibly Form. Incomplete forms may be returned to the referral source.

Date: ____/____/____

Referral Source Information

Name of Professional: _____ Agency Name: _____

Phone Number: (____) _____ E-mail Address: _____

Would the referral source like to attend the intake meeting with the housing case manager and client? ☐ Yes ☐ No

If NO, Are there any concerns about the housing case manager meeting one-on-one with the client? ☐ Yes ☐ No

If YES, Please explain. _____

By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health policy and that the client is approved to access Columbus Ryan White Part A services.

Signature of Referring Professional *(required)*: _____

Client's Ryan White Part A Eligibility Expiration Date: ____/____/____

Client Contact Information

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: ___/____/____

Gender Identity: ☐ Male ☐ Female ☐ Transgender (MTF) ☐ Transgender (FTM)

Home Address *(including city, state, and zip code)*: _____

Phone Number: (____) _____ E-mail Address: _____

Preferred Method(s) of Contact *(check all that apply)*:
☐ Mail ☐ Phone ☐ E-mail

May confidential messages be left on voicemail?
☐ Yes ☐ No

Client Housing Information

1. Monthly Income: $_____ 2. Source of Income *(e.g. SSI, SSDI, employment)*: _____

If the client has no source of income, 3. Is there a plan to gain income, e.g. employment, application for benefits? ☐ Yes ☐ No

If YES, 3a. Provide a brief description of the status of the plan. _____

4. Who does the client currently live with? _____

5. Is the client a Veteran? ☐ Yes ☐ No

If YES, 5a. Has the client been referred to the VA for housing assistance? ☐ Yes ☐ No

If YES, 5b. Provide a brief description of the outcome of the referral? _____

6. Does the client receive a housing subsidy and/or other form of financial assistance to pay rent? ☐ Yes ☐ No

If YES, 6a. What rental assistance does the client receive? (check all that apply) ☐ Section 8 ☐ HOPWA ☐ FEMA ☐ Other: ____

7. Does the client access utility assistance, e.g. HEAP, PIPP? ☐ Yes ☐ No

IF YES, 7a. What utility assistance does the client receive? _____

IF NO, 7b. Would the referral source like the housing provider to assist with linking the client to utility assistance? ☐ Yes ☐ No

8. Does the client have, or at risk of receiving, an eviction notice? ☐ Yes ☐ No ☐ NA

9. Does the client have, or at risk of receiving, a utility disconnection notice? ☐ Yes ☐ No ☐ NA

10. Is the client willing to enter the shelter system if no other options are available? ☐ Yes ☐ No ☐ NA

Request Information

11. What assistance does the client need *(check all that apply)*?

☐ Housing Case Management:
- ☐ Benefits Assistance ☐ Mediation Services
- ☐ Budgeting ☐ Obtaining Housing
- ☐ Other: _____

☐ Financial Assistance
- ☐ Rent $_____ ☐ Application Fee $_____
- ☐ Utility $_____ ☐ Moving Expense $_____

12. Describe the client's circumstances and the reason for the request.

13. Has the client independently, or with the aid of a professional, attempted to access assistance to address their need? ☐ Yes ☐ No

If YES, 13a. Check each agency contacted and indicate if the client did this independently (I) or with the aid of a professional (A).

Rent and Utility:
- ☐ Broad Street Presbyterian Church __ I __ A
- ☐ FCDJFS (PRC) __ I __ A
- ☐ IMPACT __ I __ A
- ☐ JOIN __ I __ A
- ☐ Salvation Army __ I __ A
- ☐ Other: _____ __ I __ A

Housing Locator:
- ☐ CMHA __ I __ A
- ☐ Columbus Urban League __ I __ A
- ☐ Community Housing Network __ I __ A
- ☐ Homeport __ I __ A
- ☐ Other: _____ __ I __ A

Shelter Services:
- ☐ Homeless Hotline __ I __ A
- ☐ Other: _____ __ I __ A

Mediation Services:
- ☐ Community Mediation Services __ I __ A
- ☐ Other: _____ __ I __ A

Budgeting:
- ☐ Columbus Urban League __ I __ A
- ☐ Other: _____ __ I __ A

☐ Other Type(s) of Assistance/Agency(ies): _____

14. Briefly explain the outcome of the effort to obtain assistance.

Additional Information

15 Primary Language Spoken: _____

15a. Is an interpreter needed? ☐ Yes ☐ No

16. Does the client need assistance with reading/writing? ☐ Yes ☐ No

17. Is transportation needed for housing services? ☐ Yes ☐ No

18. Does the client have a mental health concern/diagnosis that may impact housing service needs? ☐ Yes ☐ No

If YES, 17a. Please explain. _____

19. Does the client have a substance use concern that may impact housing service needs? ☐ Yes ☐ No

If YES, 18a. Please explain. _____

20. Is the client currently/in the process to be linked to a mental health care provider(s)? ☐ Yes ☐ No ☐ NA

If NO, 20a. Should the housing case manager assist with linking the client to mental health services? ☐ Yes ☐ No

21. Is the client currently/in the process to be linked to a treatment program? ☐ Yes ☐ No ☐ NA

If NO, 21a. Should the housing case manager assist with linking the client to treatment services? ☐ Yes ☐ No

22. Has the client ever had problems with any of the following? ☐ Memory ☐ Organization ☐ Confusion ☐ Other: _____

If YES, 22a. Please explain. _____

23. Provide any additional information regarding the client.

Success In Housing Office Use Only

Referral Received: _____/_____/_____

Was Information Missing? ☐ Yes ☐ No

Request Email to Referral Source: _____/_____/_____

Missing Information Received: _____/_____/_____

Describe Missing Information/Interaction w/Referral Source: _____

Assigned Housing Case Manager: _____

E-mail Confirmation to Referral Source: _____/_____/_____

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Ryan White Part A

Housing Service Limit Exception Form

Due to funding constraints, there is a limit on the amount of times financial assistance for rent, utilities, application fees, and/or moving expenses may be provided to a client. Clients may receive financial assistance a maximum of three times per calendar year. Additionally, there is a 24 month maximum lifetime limit. Circumstances may require individual exceptions to the service limit policy. Exceptions are made on a case-by-case basis and are determined by the identified cause for the request and availability of funding. All determinations are final. Please complete all sections of the Exception form and fax it to 614.291.0682.

Date of Request: _____/_____/_____

Client Information

First Name: _____ **Last Name:** _____

Preferred Name: _____ **Date of Birth:** _____/_____/_____

Home Address *(including city, state, and zip code)*: _____

Phone Number: (_____) _____ **E-mail Address:** _____

Request Information *(check all that apply)*

☐ **Rent** **$**_____ ☐ **Application Fee** **$**_____

☐ **Utility** **$**_____ ☐ **Moving Expense** **$**_____

Reason for Exception (*check all that apply)*

☐ **Severe medical condition**
☐ **Major delay in service delivery**
☐ **Significant safety concern**
☐ **Other** (*please list*) _____

Exception Request Description *(Please provide additional information that will help justify the need for an exception)*

Referral Source Information

Professional's Name: _____ **Title:** _____

Agency Name: _____

Phone Number: (_____) _____ **E-mail Address:** _____

Professional's Signature *(required)*: _____

Success In Housing Use Only

Request Approved: ☐ Yes ☐ No ☐ More information needed

Notes:

Date of Decision Notification: _____/_____/_____

Ryan White Part A

Bus Pass/Gas Card Request Form

Date: _____/_____/_____

_____ (name of agency and hereinafter referred to as "agency") is requesting _____ gas cards and _____ bus passes to be distributed to Ryan White Part A-eligible clients (eligible clients are those currently enrolled in the Columbus TGA Ryan White Part A program and have a Ryan White Part A Eligibility Form on file at Columbus Public Health).

Ryan White Part A medical transportation services are available for eligible clients to access core medical and support services. This includes travel between the funded providers, as well as transportation assistance to government agencies or medical facilities required by any of the service's eligibility requirements.

The agency agrees to distribute transportation assistance according to the following guidelines:

- Bus Passes: Bus passes are distributed in an increment of a one-day bus pass (COTA Mainstream bus passes are available on a case-by-case basis, approved by Columbus Public Health).
- Gas Cards*: Gas cards are distributed in an increment of $5 and are based on the distance to each documented appointment. Appointments conducted in one day should have mileage calculated together. Appointments scheduled over multiple days should have mileage calculated for each day of the appointments.
    - 20 miles or less = $5 gas card
    - 21 miles-50 miles = $10 gas cards
    - For every 25 miles after 50 = $5 gas card

  **Gas card increments were calculated based upon average gas prices of $3.25 and 15 miles/gallon. When dramatic increases/decreases in gas prices occur, temporary guideline adjustments will be issued.*

The agency further agrees that any time medical transportation assistance is provided the Ryan White Part A Transportation Assistance Form will be completed and maintained in the client's file. A copy should be maintained in a binder with the agency, making it available to Columbus Public Health upon request.

_____ _____

Requestor Name *Title*

_____ _____

Requestor Signature *Requested Date of Pick-Up*

_____ _____

Columbus Public Health Signature *Date of Pick-Up*

Bus Pass #_____ - #_____ Gas Card #_____ - #_____

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Ryan White Part A

Transportation Assistance Form

Date: _____/_____/_____

Client Information

Client Name: _____ **Date of Birth:** _____/_____/_____

Appointment Information

☐ Medical Case Management Visit
☐ Non-Medical Case Management – Support Visit
☐ Linkage to Care Visit
☐ Outpatient Ambulatory
☐ Mental Health
☐ Dental
☐ Other: _____
☐ Ryan White Programming *(e.g., COHPA)*
☐ Social Service Agency

Appointment Date(s): _____

Provider Name(s): _____

Clients Receiving Gas Cards:

Originating Address(es): _____

_____

Destination Address(es): _____

_____

Transportation Assistance

- Bus passes are distributed in an increment of a one-day bus pass (COTA Mainstream bus passes are available on a case-by-case basis, approved by Columbus Public Health).
- Gas cards are distributed in an increment of $5 and are based on the distance to each documented appointment. Mileage should be calculated together for appointments conducted in one day and calculated for each day for appointments scheduled over multiple days.
    - 20 miles or less = $5 gas card
    - 21 miles-50 miles = $10 gas cards
    - For every 25 miles after 50 = $5 gas card

Type of Service:

☐ Gas Card(s)	# _____	# _____	# _____	# _____	# _____
☐ Bus Pass(es)	# _____	# _____	# _____	# _____	# _____

Will the bus pass/gas card be mailed to the client? ☐ Yes ☐ No

If YES: It is not necessary to obtain the client's signature below.

Client Agreement

I understand that transportation assistance is provided for me to access my medical appointments and/or support services and that I will not be provided with cash payments. I am aware that my provider may be contacted to verify that I attended my appointment(s).

_____ _____

Client Signature *Date*

_____ _____

Professional's Signature *Date*

Appendix C:
Ryan White Part A and B Forms

This section contains the following Ryan White Part A and B Forms:

1. Ryan White Client Intake Form
2. Ryan White Case Management Expectations of Care Form
3. Central Ohio HIV Case Management Network Release Form
4. Ryan White Client Information Form
5. Ryan White Medical Case Management Psychosocial Assessment Form
6. Ryan White Psychosocial Assessment Summary Form
7. Ryan White Medical Case Management Client Historical Assessment and Glossary of Opportunistic Infections Form
8. Anxiety Screen (GAD-7)
9. Depression Screen (PHQ-9)
10. Substance Abuse Screen (DAST-20)
11. Ryan White Screening Form (for Medical Case Management Services)
12. Ryan White Case Management Individualized Service Plan
13. Ryan White Request for Non-Medical Case Management-Support Form
14. Ryan White Client Transfer and Case Conference Form
15. Ryan White Client Case Closure Form

RYAN WHITE CLIENT INTAKE FORM

Date of Intake: ____/____/_____
Client Acknowledgement of Understanding Confidentiality and HIPAA: ☐ Yes ☐ No ☐ NA

Client Contact Information

Legal First Name: _____ Legal Last Name: _____

Street Address: _____ ☐ Currently Homeless

City: _____ County: _____ Zip Code: _____

Contact Phone Number(s): _____ E-mail Address: _____

Preferred Method(s) of contact: ☐ Call ☐ Text (if applicable) ☐ E-mail ☐ Letter ☐ Home Visit

May confidential messages be left on voicemail? ☐ Yes ☐ No

If YES: What information can we leave? ☐ Name ☐ Number ☐ Agency information

Has the court appointed someone to make decisions on your behalf? ☐ Yes ☐ No

If YES: Guardian/Conservator Name: _____

Phone Number(s): _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number(s): _____

Client Demographic Information

Client ID: _____ Date of Birth: ____/____/_____

Sex at Birth: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Female ☐ Transgender (Male to Female) ☐Transgender (Female to Male)

Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other: _____

Preferred Name: _____ Relationship/marital Status: _____

Have you ever gone by another name: ☐ Yes ☐ No *If YES:* Other name: _____

Race: *(Check all that apply)*

☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander

If ASIAN: Specify: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other

If NATIVE HAWAIIAN/PACIFIC ISLANDER: Specify: ☐ Native Hawaiian ☐ Samoan ☐ Guamanian/Chamorro ☐ Other

Ethnicity: ☐ Not Hispanic/Latino(a) ☐ Hispanic/Latino(a)

If HISPANIC/LATINO(A): Specify: ☐ Mexican, Mexican American, Chicano(a) ☐ Puerto Rican ☐ Cuban ☐ Other

Preferred Language: _____

HIV / Medical Care History

HIV Status: ☐ HIV-positive, not AIDS ☐ HIV-positive, AIDS status unknown ☐ CDC-defined AIDS

HIV-positive Date: ____/____/_____

History of Care: ☐ In care ☐ Never in care ☐ Out of care *If OUT OF CARE:* Date of last doctor's visit: ____/____/_____

HIV care Provider: _____ Appointment Dates: _____

Anti-retroviral Therapy (ART) History: ☐ Never on ART ☐ Not currently on ART ☐ Currently on ART

Basic Need Information—GREEN

Support System

Do you have friends/family you can rely on? ☐ Yes ☐ No

Do you receive services from any other agencies? *(For example: JFS, Department of Developmental Disabilities, WIC)*
☐ Yes ☐ No *If YES:* Which one(s)?

_____

Knowledge of HIV Disease

Were you diagnosed with HIV in the last 12 months?
☐ Yes ☐ No

Sexual Health/Risk Reduction

Risk Factors:
☐ Male who has sex with male(s) ☐ Heterosexual contact
☐ Injection drug use ☐ Perinatal transmission
☐ Hemophilia/coagulation disorder ☐ Not reported or N/A

Legal

Have you been released from jail/prison in the past 6 months? ☐ Yes ☐ No

Moderate Need Information—YELLOW

Oral Health

Do you have any immediate needs for oral health treatment? ☐ Yes ☐ No

Health Insurance/Medical Care Coverage

Do you have health insurance? ☐ Yes ☐ No
If YES: What is your primary type of insurance?
☐ Private—Employer ☐ Private—Individual (ACA)
☐ Medicare ☐ Medicaid/CHIP/other public plan
☐ Indian Health Service ☐ Other (not listed above)
☐ Veterans Health Administration (VA), military health care (TRICARE), other military health care

Have you ever served in the military? ☐ Yes ☐ No

Financial Planning

What is your monthly gross household income? $_____
What is your household size? _____
(Spouse and legal dependents only)

Transportation

Do you need assistance with transportation to medical appointments? ☐ Yes ☐ No

Language and Literacy

Do you need an interpreter? ☐ Yes ☐ No
Do you need assistance with reading/writing?
☐ Yes ☐ No

Developmental Disability/Cognitive

Have you ever been diagnosed with a developmental disability? ☐ Yes ☐ No

Intensive Need Information—RED

Basic Needs

Do you have any immediate needs for food? ☐ Yes ☐ No

Housing

Do you have any immediate housing needs? ☐ Yes ☐ No

Medical Needs

Is there a chance that you or your partner might be pregnant? ☐ Yes ☐ No ☐ N/A

Have you been hospitalized in the last 6 months? ☐ Yes ☐ No
If YES: Why? _____

Care and Medication Adherence

If you are currently on ART, do you have less than 14 days of medication left? ☐ Yes ☐ No

Substance Abuse

Current/recent use of drugs/alcohol? ☐ Yes ☐ No

Mental Health

Do you have any mental health concerns? ☐ Yes ☐ No
If YES: Please describe: _____

Intake Sign-Off

_____
Printed Name of Person Completing this Form

_____
Agency Name

_____
Signature of Person Completing this Form

_____/_____/_____
Date Completed

CASE ASSIGNMENT USE ONLY

Date Intake Form Received: _____/_____/_____ Client Acuity: ☐ GREEN ☐ YELLOW ☐ RED

Name of Assigned Medical Case Manager: _____ Date of Assignment: ____/_____/_____

Name of Case Assignment Staff: _____ Signature: _____

RYAN WHITE CASE MANAGEMENT EXPECTATIONS OF CARE

1) As a Client, you can expect:
   a) Prompt, individualized, quality services by your case management team to improve your health outcomes
   b) Meet with you at least once every 6 months
   c) Advocacy and assistance in navigating health care services
   d) Referrals to appropriate community resources
   e) Reply to calls within two business days
   f) A professional relationship
   g) Guidance to obtaining self-sufficiency (*i.e.*, graduation)
   h) Notification of any changes that may affect your care or enrollment
   i) Confidentiality, with exception of mandated reporting requirements* Client Initials: _____
   j) To be informed of your rights and responsibilities* Client Initials: _____
   k) To be informed of the agency's grievance procedure* Client Initials: _____

2) We cannot commit to:
   a) Pay for services obtained from a non-Ryan White approved provider
   b) Pay for services that are obtained through inpatient, urgent care, emergency department and ambulance transport
   c) Provide transportation outside of our agency's policy* Client Initials: _____
   d) Provide advice outside of the scope of our practice (*e.g.*, legal, medical diagnosis)

3) The Client agrees to:
   a) Provide required information (*e.g.*, insurance, income, proof of Ohio residency and HIV Diagnosis)
   b) Keep appointments
   c) Keep us updated on your change of phone number or address
   d) Keep us updated on income or benefits changes
   e) Keep us updated on changes to your health status
   f) Provide advanced notice of your needs when possible to help us serve you better

**When indicated, the client should initial the statement as confirmation of having received the corresponding documentation.*

Primary contact for all services:

Case Manager Name: _____

Phone Number: _____

E-mail Address: _____

Case Manager:	Client:
_____	_____
Printed Name	*Printed Name*
_____	_____
Signature / Date	*Signature / Date*

CENTRAL OHIO
HIV CASE MANAGEMENT NETWORK
RELEASE FORM

I, _____, (DOB_____) authorize appropriate staff and/or volunteers of the following Ryan White funded agencies:

- Equitas Health
- Southeast, Inc.
- Columbus Public Health
- Ohio Department of Health
- Nationwide Children's Hospital
- Ohio State University Wexner Medical Center
- AIDS Healthcare Foundation

to release/share information regarding services I have received, my HIV status, my physical, financial, chemical dependency, and/or mental health conditions, among those same agencies for the express purpose of receiving or gaining access to all services related to my current or future needs. I understand that information regarding the above will be maintained in electronic data management systems. These systems have been explained to me, and I grant permission for them to be utilized to provide services for me.

This consent may be revoked at any time in writing or by informing the agency holding the original form; except to the extent that action has already occurred in reliance thereupon. I understand that I may add other specific agencies to this form by listing and signing below. I understand that this authorization for the release of information will automatically expire 365 or _____days after the date on the release, unless otherwise indicated below.

Date of expiration _____Reason and date of Earlier Expiration_____

_____ _____
Client's Signature Date

_____ _____
Agency Representative's Signature Date

<u>Prohibition Against Re-Disclosure:</u> This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.) Any information regarding an individual's HIV test, AIDS diagnosis, or AIDS-related condition has been disclosed to you from confidential records protected from disclosure by state law. You are not authorized to disclose this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. Please note that a general authorization for the release of medical or other information, as signed by the patient, is not sufficient for the release of the HIV test results or diagnosis.

RYAN WHITE CLIENT INFORMATION FORM

Date: ____/____/_____ ☐ No Changes – Date: ____/____/_____

Client Contact Information

Legal First Name: _____ Legal Last Name: _____

Preferred Name: _____ Date of Birth: ____/____/_____

Street Address: _____ ☐ Currently Homeless

City: _____ County: _____ Zip Code: _____

Contact Phone Number(s): _____ E-mail Address: _____

Preferred Method(s) of contact: ☐ Call ☐ Text (if applicable) ☐ E-mail ☐ Letter ☐ Home Visit _____
(client initials)

May confidential messages be left on voicemail? ☐ Yes ☐ No

If YES: What information can we leave? ☐ Name ☐ Number ☐ Agency information

Has the court appointed someone to make decisions on your behalf? ☐ Yes ☐ No

If YES: Guardian/Conservator Name: _____

Phone Number(s): _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number(s): _____

Is your emergency contact aware of your HIV diagnosis? ☐ Yes ☐ No

Updated Client Contact Information

Date: ____/____/_____

Street Address: _____ ☐ Currently Homeless

City: _____ County: _____ Zip Code: _____

Contact Phone Number(s): _____ E-mail Address: _____

RYAN WHITE MEDICAL CASE MANAGEMENT
PSYCHOSOCIAL ASSESSMENT

Medical case managers are responsible for meeting with clients annually and semi-annually to assess and evaluate client acuity in seventeen areas of functioning.

- Annually: Complete all questions and acuity tables to determine acuity in each of the seventeen areas of functioning. Document notes and complete the four appendices as needed.
- Semi-Annually: Complete all questions and acuity tables to determine acuity in each of the seventeen areas of functioning. Document notes and complete the four appendices as needed.

To evaluate acuity and score each functional area's acuity box:

- Utilize information gathered (*i.e.*, responses to questions on the psychosocial assessment and/or information obtained through direct interaction with the client within the past thirty (30) days) to evaluate client acuity.
- Check boxes in each functional area's acuity table according to what best corresponds with the client's current state (*e.g.*, the client may have three intensive needs and one self-management need and all four boxes should be checked accordingly). At minimum, at least one box should be checked in each of the functional area's acuity tables.
- Determine acuity level for each area of functioning by taking the highest level of need checked in the acuity table and documenting it next to annual or semi-annual review accordingly.
    - If two or more levels of need are checked for any area of functioning, the client should be assigned the number corresponding to the highest level of need for that area of functioning (*e.g.*, if two boxes are checked for basic need (4) and one box is checked for moderate (6), the level of need for the functional area would be moderate (6)).
    - The highest score the client may ever receive per functional area is eight (8) (*e.g.*, if three boxes are checked for intensive need (8), the score would be eight (8), not 24).

To determine the total annual/semi-annual acuity score:

- Total (add) the numbers from each area of functioning's annual or semi-annual score and document this number in the "total annual acuity score" or "total semi-annual acuity score" accordingly.
- Utilize the total acuity score result to determine the frequency of contact with the client. Clients with an acuity score of:
    - 45 - 99 are considered an "intensive effort case" and requires contact with the client monthly at minimum and more frequently as needed.
    - 21 - 44 are considered a "moderate effort case" and requires contact with the client every three months at minimum and more frequently as needed.
    - 2 - 20 are considered a "basic effort case" and requires contact with the client every six months at minimum and more frequently as needed.

ASSESSMENT SIGN-OFF & TOTAL ACUITY SCORE	Total Annual Score=	
	Total Semi-Annual Review Score =	

**Reminder*- Review intake information with client to confirm that it is up-to-date.*

Client Legal Name: _____ Client Date of Birth: _____/_____/_____

Case Manager Name: _____ Case Management Agency: _____

Date of Annual Assessment: _____/_____/_____ Date of Semi-Annual Review: _____/_____/_____

Annual Assessment:

_____ _____/_____/_____

Case Manager Signature Date

Semi-Annual Review:

_____ _____/_____/_____

Case Manager Signature Date

1. BASIC NEEDS	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's ability to independently obtain food and clothing and take care of activities of daily living.

Food and Clothing:

1. Do you have access to food? ☐ Yes ☐ No
2. Do you have access to appropriate clothing (*e.g.*, per season, per gender, clean)? ☐ Yes ☐ No
3. Do you utilize: ☐ Food Stamps ☐ Food Pantries ☐ Free Stores
4. Do you need help accessing assistance programs (*e.g.*, food stamps, WIC, pantries) to meet your basic needs (*e.g.*, food, clothing)? ☐ Yes ☐ No

   If YES: 4a. How frequently? _____

   4b. What resources do you use for food assistance? _____

Activities of Daily Living Skills (ADLs):

5. Do you experience difficulty with any of the following?

   5a. Feeding yourself ☐ Yes, Frequency: _____ ☐ No

   5b. Walking ☐ Yes, Frequency: _____ ☐ No

   5c. Getting in and out of a bed/chair ☐ Yes, Frequency: _____ ☐ No

   5d. Taking a bath/shower ☐ Yes, Frequency: _____ ☐ No

6. Do you have a caregiver (*i.e.*, someone who assists you with your activities of daily living)? ☐ Yes ☐ No

   If YES: 6a. How do they help you on a daily basis?

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	Food, clothing, and other items available through client's own means	☐	☐	Basic needs met on a regular basis with occasional need for help accessing assistance programs	☐	☐	Routinely needs help accessing assistance programs for basic needs	☐	☐	Has no access to food, or needs nutritional supplements
☐	☐	Has ongoing access to assistance programs that maintain basic needs consistently	☐	☐	Unable to routinely meet basic needs without emergency assistance	☐	☐	History of difficulties in accessing assistance programs	☐	☐	Without most basic needs
☐	☐	Able to perform ADLs independently	☐	☐	Needs assistance to perform some ADLs weekly	☐	☐	Often without food, clothing or other basic needs	☐	☐	Unable to perform most ADLs
						☐	☐	Needs daily in-home assistance with ADLs			

2. HOUSING	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the stability of the client's current housing situation, including safety, ability to meet payment responsibilities, risk for losing housing, and barriers towards obtaining/maintaining housing.

7. What is your past *(check all that apply)* and current living situation?

	Past	Current		Past	Current		Past	Current
Homeless/Street	☐	☐	Transitional Housing	☐	☐	Permanent Supportive Housing	☐	☐
Homeless/Emergency Shelter	☐	☐	Living with Relative/Friend	☐	☐	Renting Unsubsidized Apartment	☐	☐
Jail/Prison	☐	☐	Hospital/Medical Facility	☐	☐	Renting Subsidized Apartment	☐	☐
Hotel/Motel	☐	☐	Substance Abuse Treatment Facility	☐	☐	Owning House/Apartment	☐	☐
Other: _____				☐	☐			

8. Who do you currently live with? _____

9. Do you receive a housing subsidy and/or other form of financial assistance to pay your rent? ☐ Yes ☐ No

If YES: 9a. What rental assistance do you receive? _____

10. Do you access utility assistance (*e.g.*, HEAP, PIPP)? ☐ Yes ☐ No

If YES: 10a. What utility assistance do you receive? _____

If NO: 10b. Would you like assistance with enrolling into a utility assistance program? ☐ Yes ☐ No

11. Do you have, or are you at risk of receiving, an eviction notice? ☐ Yes ☐ No

12. Do you have, or are you at risk of receiving, a utility disconnection notice? ☐ Yes ☐ No

13. Is your current housing habitable? ☐ Yes ☐ No

If NO: 13a. What are your housing concerns? _____

14. Do you have any current issues with bed bugs or other pests/rodents? ☐ Yes ☐ No

If YES: 14a. Have you reported the issue to your landlord? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	Clean, habitable, stable, affordable housing	☐	☐	Needs short-term assistance with rent/utilities to maintain stable housing	☐	☐	Eviction imminent	☐	☐	Homeless
			☐	☐	Housing is in jeopardy	☐	☐	Home completely uninhabitable due to health and/or safety hazards	☐	☐	Recently evicted
			☐	☐	Housing is marginally habitable	☐	☐	Living in shelter	☐	☐	Arrangements to stay with friends and family have fallen through
			☐	☐	Formerly independent person temporarily residing with friends or relatives, reasonably stable	☐	☐	Lives in transitional or temporary housing	☐	☐	Not able to live independently and needs referrals (refer to responses from basic needs, medical needs, mental health, and substance abuse sections)

3. MEDICAL NEEDS	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's quality of care to assure that the client is receiving comprehensive care, which will impact the client's HIV/AIDS, including primary, preventive, and specialty care.

If this is the client's first psychosocial assessment, complete the Client Historical Assessment (Appendix A) before proceeding

General Medical Care:

15. List the client's medical providers and date(s) of last visit (s) below:

Provider	Name of Provider(s)	Last Seen (Month/Year)
Primary Care		
HIV Specialist		
Other Specialists: (specify type) _____ _____ _____		

**If client identifies as transgender:*

15a. Do you need a referral and/or additional information on transgender health care? ☐ Yes ☐ No

16. Have you had any new diagnoses or medical changes in the past 6 months? ☐ Yes ☐ No

If YES: 16a. Please explain. _____

17. Have you ever been screened for Hepatitis C? ☐ Yes ☐ No ☐ Don't Know

If YES: 17a. Have you ever been diagnosed with Hepatitis C? ☐ Yes ☐ No

If YES: 17a1. Date of Diagnosis: _____/_____/_____

17a2. Have you ever been treated for Hepatitis C? ☐ Yes ☐ No

If YES: 17a2a. Date of Treatment: _____/_____/_____

If NO: 17b. Would you like to be screened for Hepatitis C? ☐ Yes ☐ No

18. Have you ever been screened for Syphilis? ☐ Yes ☐ No ☐ Don't Know

If YES: 18a. Have you ever been diagnosed with Syphilis? ☐ Yes ☐ No

If YES: 18a1. Date of Diagnosis: _____/_____/_____

18a2. Have you ever been treated for Syphilis? ☐ Yes ☐ No

If YES: 18a2a. Date of Treatment: _____/_____/_____

If NO: 18b. Would you liked to be screened for Syphilis? ☐ Yes ☐ No

Provide education on risk factors, transmission, signs, and symptoms

19. When did you have your last HIV-related labs drawn?

CD4 Count: _____ Viral Load: _____ ☐ Lab Values Pending

Date: _____/_____/_____ Date: _____/_____/_____ ☐ No Labs Drawn

20. Were you hospitalized in the past 6 months? ☐ Yes ☐ No

If YES: 20a. What was the reason(s) you were hospitalized? _____

21. Are you experiencing any current symptoms (*e.g.*, nausea, weight loss, night sweats)? ☐ Yes ☐ No

If YES: 21a. What symptoms are you experiencing? _____

MEDICAL NEEDS, continued

21b. Are you talking to your doctor about these symptoms? ☐ Yes ☐ No

If the client indicates they are not talking to a doctor, explore their plans to do so.

If NO: 21b1. How can I help you to facilitate this conversation? _____

Pregnancy Care:

22. Is there a chance that you or your partner might be pregnant? ☐ Yes ☐ No

If YES: 22a. Are you or your partner in prenatal care? ☐ Yes ☐ No

If YES: 22a1. Does your prenatal care provider know that you or your partner has HIV? ☐ Yes ☐ No

Cognitive Functioning:

23. Have you been diagnosed with a cognitive impairment? ☐ Yes ☐ No

If YES: 23a. Are you receiving care? ☐ Yes ☐ No

If YES: 23a1. Please explain. _____

24. Have you ever had problems with any of the following: *(check all that apply)*

☐ Memory ☐ Organization ☐ Confusion ☐ Other: _____

If YES: 24a. Please explain. _____

25. Have you ever had a head injury? ☐ Yes ☐ No

If YES: 25a. Please explain. _____

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	Stable health with access to ongoing HIV medical care	☐	☐	Needs primary care referral	☐	☐	Needs referral for treatment or medication for non-HIV related condition	☐	☐	Client is pregnant
☐	☐	Virally suppressed (Viral Load <40)	☐	☐	Short-term acute condition; receiving medical care	☐	☐	OI diagnosis or hospitalization within 6 months	☐	☐	Client post-partum (within 6 weeks of delivery)
			☐	☐	Chronic, non-HIV related condition is being treated with medication/treatment	☐	☐	Detectable viral load (>1000)	☐	☐	Newly diagnosed within last 6 months (refer to responses on the intake form)
			☐	☐	HIV symptomatic (*i.e.*, nausea, weight loss, night sweats) with one or more conditions that impair overall health	☐	☐	History of cognitive impairment – moderately functioning (TBI, Dementia)	☐	☐	CD4 < 200 (AIDS diagnosis) and detectable viral load >1000 and inconsistent or refusing meds
			☐	☐	Detectable viral load (40-1000)	☐	☐	Requires Part B pre-authorization for services	☐	☐	History of cognitive impairment – diminished functioning (TBI, Dementia)
									☐	☐	Needs immediate linkage to medical care due to acute problems related to low body weight, poor appetite, nausea, vomiting, or other urgent health issues that impact nutritional status

4. CARE & MEDICATION ADHERENCE	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's compliance with HIV/AIDS medications and its implications for transmission and drug resistance, including barriers towards taking medications, risk for transmitting the disease, and impact on quality of life from side effects from medications.

26. What medications have been prescribed to you and why?

List below, or attach a copy, of all medications prescribed to the client. Please specify in purpose section the reason the client is taking the medication. If the client indicates they are not taking medication(s) as prescribed, discuss methods to improve medication adherence.

Medication	Purpose	Frequency	Taken as Prescribed
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

27. Do you have any medication concerns? ☐ Yes ☐ No

If YES: 27a. What are your medication concerns?

28. How are you currently getting your prescriptions filled? _____

29. In the past 7 days, how many HIV medication doses have you missed? _____

If 1 or more: 29a. What were the circumstances that caused you to miss these doses?

_____

30. Where do you store your medications? _____

31. Are you experiencing any side effects with your medications? ☐ Yes ☐ No

If YES: 31a. Do you discuss these side effects with your health care provider? ☐ Yes ☐ No

If the client indicates they are not talking to a doctor, explore their plans to do so.

If NO: 31a1. How can I help you to facilitate this conversation? _____

32. In the past 6 months, have you missed any medical appointments? ☐ Yes ☐ No

If YES: 32a. How many medical appointments have you missed? _____

If 1 or more: 32a1. What were the circumstances that caused you to miss these appointments?

_____

CARE & MEDICATION ADHERENCE, continued

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	Adherent to medications as prescribed for 6 months without assistance	☐	☐	Newly diagnosed	☐	☐	Requires ongoing assistance for adherence to medications and treatment plan	☐	☐	Resistance/minimal adherence to medications and treatment plan even with assistance
☐	☐	Able to maintain primary care	☐	☐	Adherent to medications in the last 6 months with minimal assistance	☐	☐	Moderate adverse side effects that occasionally impact adherence	☐	☐	Refuses/declines to take medications against medical advice
☐	☐	Keeps medical appointments as scheduled	☐	☐	Has attended all HIV medical appointments in the last 6 months but may have missed an appointment within the last 12 months or has rescheduled multiple appointments	☐	☐	Misses several doses of scheduled HIV medications weekly	☐	☐	Medical care is sporadic due to many missed appointments (refer to responses from Medical Needs section)
☐	☐	Not currently being prescribed medications-not medically indicated				☐	☐	Takes long/extended "drug holidays" against medical advice	☐	☐	Only uses emergency department in lieu of primary care (refer to responses from Medical Needs section)
☐	☐	Expresses no issues with side effects or schedule				☐	☐	Has missed one or two HIV medical appointments in the last 6 months	☐	☐	Inability to take meds as scheduled; requires professional assistance to take meds and keep appointments
☐	☐	Can name or describe current medications and common side effects							☐	☐	Experiences significant adverse side effects that impacts adherence
☐	☐	Can identify the importance of medication adherence									

5. MENTAL HEALTH	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's mental health status and the impact of this status on client functioning in all areas of the client's life.

33. How do you manage difficult feelings or situations?

34. Do you have any current unmet mental health concerns or symptoms? ☐ Yes ☐ No

If YES: 34a. Please explain. _____

Use clinical judgement to determine if anxiety (GAD-7 Appendix B) and/or depression (PHQ-9 Appendix C) screens are needed and proceed accordingly.

35. Have you ever received a mental health diagnosis? ☐ Yes ☐ No

If YES: 35a. What was the diagnosis? _____

36. Have you ever been hospitalized for mental health concerns? ☐ Yes ☐ No

If YES: 36a. When were you hospitalized? _____

37. Are you currently linked to any mental health care provider(s)? ☐ Yes ☐ No

If YES: Record provider(s) in the table below.

If NO: 37a. Would you like a referral for mental health services? ☐ Yes ☐ No

Name of Provider(s)	Phone Number	Last Seen (Month/Year)

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	No history of mental illness, psychological disorders or psychotropic medications	☐	☐	Needs emotional support to avert crisis	☐	☐	Experiencing an acute episode and/or crisis*	☐	☐	Unable to adhere to prescribed psychiatric medications* (refer to responses from care and medication adherence section)
☐	☐	No need for counseling referral	☐	☐	History of mental health disorders/treatment in client	☐	☐	Clinical diagnosis with current mental health provider but inconsistent treatment compliance*	☐	☐	Danger to self or others**
			☐	☐	Clinical diagnosis with current mental health provider and consistent treatment compliance	☐	☐	History of inpatient mental health hospitalizations within last 12 months*	☐	☐	Needs immediate psychiatric assessment/evaluation/treatment**
			☐	☐	Client desires mental health services	☐	☐	Requires Part B pre-authorization for services	*Conduct an anxiety (GAD-7) and depression screen (PHQ-9) **Refer to immediate crisis intervention		
						*Conduct an anxiety (GAD-7) and depression screen (PHQ-9)					

6. SUBSTANCE ABUSE	Annual Score=	
	Semi-Annual Review Score=	

Evaluate how the client's substance use impacts their HIV care and functioning in all areas of the client's life.

38. Do you smoke cigarettes or use other nicotine products? ☐ Yes ☐ No

If YES: 38a. There are resources available to help you quit; would you be interested in a referral? ☐ Yes ☐ No

If YES: Educate and refer to the tobacco quit line, 1-800-QUIT-NOW.

39. Do you have any history with substance abuse? ☐ Yes ☐ No

If YES: 39a. Please describe.

40. Do you drink alcohol? ☐ Yes ☐ No

If YES: 40a. How often do you drink alcohol? _____

Based upon frequency of alcohol consumption, use your clinical judgement to determine if you should ask the following CAGE questions:

40b. Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No

40c. Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

40d. Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No

40e. Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

If YES to 2 or more of the CAGE questions:

40f. There are resources available to help you quit; would you be interested in a referral? ☐ Yes ☐ No

41. Have you used drugs other than for medical reasons (*e.g.*, unprescribed medications, marijuana, methadone, crack, cocaine, ecstasy, heroin, etc.)? ☐ Yes ☐ No

If YES: 41a. What drugs (other than for medical reasons) are you using? _____

If YES: Ask the questions on the DAST-20 (Appendix D).

41b. Do you use needles to inject drugs? ☐ Yes ☐ No

If YES: Educate and refer to the needle access program (e.g., Safe Point through Equitas Health).

42. Have you ever been in a recovery program? ☐ Yes ☐ No

If YES: 42a. When were you in a recovery program? _____

43. Are you currently in a recovery program? ☐ Yes ☐ No

If YES: 43a. Recovery program name: _____

43b. Length of time in recovery program: _____

If NO: 43c. There are resources available for treatment assistance; would you be interested in a referral? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

SUBSTANCE ABUSE, continued

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 4	Annual	Review	Score = 6	Annual	Review	Score = 8
☐	☐	No current or past issues with alcohol or drug use	☐	☐	Current or recent drug or alcohol use does not interfere with adherence to care, treatment, and/or activities of daily living but indicates need for additional support or regular check-in* (refer to responses from DAST-20)	☐	☐	Current or recent drug or alcohol use that sometimes interferes with adherence to HIV care and/or daily living (refer to responses from care and medication adherence section)	☐	☐	Chronic daily use or dependence that consistently interferes with adherence to HIV care and treatment and/or activities of daily living
☐	☐	In stable recovery with sufficient supports, and no indication of need for additional support	☐	☐	In recovery for 12 months or less	☐	☐	Currently or intermittently in substance abuse treatment	☐	☐	Refusal to connect to substance abuse treatment
			**Refer to AOD supportive services (e.g., AA, CA, NA)*			☐	☐	Indication of need for clinical substance use assessment	☐	☐	Doesn't acknowledge negative impact on health and safety from substance abuse
						☐	☐	Participating in a needle access program	☐	☐	Substance use while pregnant (refer to responses from care and medical needs section)
									☐	☐	Sharing needles; not participating in a needle access program

7. ORAL HEALTH	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's need for regular dental care and/or their ability/willingness to address dental issues as they arise.

44. Do you have a dentist? ☐ Yes ☐ No

If YES: 44a. What is the name of your dentist? _____

45. When was the last time you saw a dentist? Date of last visit: _____/_____/_____

46. Do you have any current dental health concerns (*e.g.*, pain, difficulty eating)? ☐ Yes ☐ No

If YES: 46a. What is the concern? _____

46b. Are you currently seeing a dentist to address this concern? ☐ Yes ☐ No

If applicable: 47. Would you be interested in a referral to a dentist? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Is currently in active dental care	☐	☐	Does not have a regular dentist	☐	☐	Reports episodic pain and/or sensitivity in teeth, gums or mouth	☐	☐	Current tooth, gum or mouth pain and severe discomfort
☐	☐	Has seen dentist in past six months	☐	☐	No dental insurance or needs co-pay assistance (refer to responses from health insurance and financial planning sections)	☐	☐	Missing days from work because of problems with teeth, gums or mouth	☐	☐	Very few or no teeth and no denture plan in place
☐	☐	No complaint of mouth, tongue, tooth or gum pain	☐	☐	Has not seen a dentist in more than six months	☐	☐	Observe appearance of dark, discolored teeth, missing teeth, bleeding, red gums or other problems with mouth	☐	☐	Client reports significant difficulty eating due to oral health problems
☐	☐	Client has means for paying for oral health care				☐	☐	Client reports episodic or moderate difficulty eating	☐	☐	Client has difficulty talking because of oral health problems
						☐	☐	Part B Dental pre-authorization required	☐	☐	Client needs emergency dental services

8. HEALTH INSURANCE	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's ability to independently enroll in and obtain health insurance coverage.

48 Do you have health insurance? ☐ Yes ☐ No

If YES: 48a. What is your primary type of insurance?

- ☐ Private – Employer
- ☐ Private – Individual (ACA)
- ☐ Medicare
- ☐ Medicaid/CHIP/other public plan
- ☐ Indian Health Service
- ☐ Veteran's Health Administration (VA, military health care (TRICARE), other military health care
- ☐ Other (not listed above): _____

If NO: 48b. Do you need assistance with obtaining health insurance coverage? ☐ Yes ☐ No

48c. Do you need assistance with obtaining prescription coverage? ☐ Yes ☐ No

49. Are you able to pay your physician co-pays? ☐ Yes ☐ No

50. Are you able to pay your prescription co-pays? ☐ Yes ☐ No

51. Are you able to pay your insurance premium? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score =3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Has insurance/medical care coverage (refer to responses on Intake form)	☐	☐	Client needs information/ referral with accessing insurance or other coverage for medical/prescription costs	☐	☐	Needs direct assistance in accessing insurance or other coverage for medical costs	☐	☐	Needs immediate assistance in accessing insurance or other coverage for medical costs due to medical crisis (refer to responses from medical needs section)
☐	☐	Has ability to pay for care on own	☐	☐	Needs direct assistance with OHDAP application	☐	☐	Needs direct assistance with navigating complex insurance needs (refer to responses from care and medication adherence and financial planning/counseling sections)	☐	☐	Not currently eligible for insurance or public benefits
☐	☐	Can independently complete the OHDAP application				☐	☐	Needs assistance with co-pays	☐	☐	Needs assistance completing/follow-up with Rx exceptions

9. FINANCIAL PLANNING / COUNSELING	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's ability and barriers towards meeting their financial obligations and accessing benefit programs.

Education and Employment Information:

52. What is the highest level of education you completed?

☐ Some High School ☐ High School Diploma ☐ GED ☐ Some College
☐ Associate's Degree ☐ Bachelor's Degree ☐ Vocational Training ☐ Graduate Degree

53. Are you currently:

Enrolled in school	☐ Yes	☐ No	Enrolled in job training	☐ Yes	☐ No
Employed	☐ Yes	☐ No	Seeking employment	☐ Yes	☐ No
Retired	☐ Yes	☐ No			

If EMPLOYED: 53a. Average number of hours worked/week: _____

If applicable:

53b. Would you like a referral to employment resources? ☐ Yes ☐ No

53c. Would you like a referral to education resources? ☐ Yes ☐ No

53d. Has a doctor determined that you are medically unable to work? ☐ Yes ☐ No

Financial Information:

54. Do you have children or others who depend upon you financially? ☐ Yes ☐ No

If YES: Complete the chart below for all children and dependents, including those not living with the client.

Name	Age	Relationship to Client	Living with Client?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

55. What is your source(s) of income? _____

If applicable: 55a. Do you need assistance with applying for benefits? ☐ Yes ☐ No

56. Has your source(s) of income changed in the last 6 months? ☐ Yes ☐ No

If YES: 56a. Please explain. _____

57. Are you able to pay for all of your monthly expenses? ☐ Yes ☐ No

58. Would you like help with developing a personal budget? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

FINANCIAL PLANNING / COUNSELING, continued

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Steady source of income which is not in jeopardy	☐	☐	Has steady source of income which is in jeopardy	☐	☐	No income or income is inadequate to consistently meet basic needs	☐	☐	Immediate need for emergency financial assistance
☐	☐	Able to meet monthly obligations	☐	☐	Occasional need for financial assistance	☐	☐	Unfamiliar with application process for benefits	☐	☐	Needs referral to representative payee (refer to responses from developmental disabilities section)
☐	☐	No financial planning or counseling required	☐	☐	Awaiting outcome of benefits applications	☐	☐	Unable to apply without benefit assistance	☐	☐	Benefits denied or under appeal and has no financial support
			☐	☐	Needs information about benefits, financial matters	☐	☐	Needs financial planning & counseling			

10. TRANSPORTATION	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's ability to get to medical appointments and other support service visits.

59. How do you get to your HIV-related appointments and services such as medical, mental health, food, etc.?

☐ Bus ☐ Personal Vehicle ☐ Ride from Family/Friend ☐ Cab ☐ Other: _____

60. Do you have difficulty arranging transportation? ☐ Yes ☐ No

If YES: 60a. What are the barriers in arranging transportation?

61. Can we assist you in accessing your eligible transportation resources (*e.g.,* Medicaid transportation, Ryan White bus passes/gas cards)? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Has own or other means of transportation consistently available	☐	☐	Has limited access to transportation	☐	☐	No means via self/others	☐	☐	Lack of transportation is a serious contributing factor to current crisis (refer to responses from medical needs section)
☐	☐	Can afford private or public transportation	☐	☐	Needs occasional assistance with finances for transportation	☐	☐	In area not served or under served by public transportation	☐	☐	Lack of transportation is a serious contributing factor to lack of regular medical care (refer to medical needs and care and medication adherence sections)
						☐	☐	Unaware of or needs help accessing transportation services	☐	☐	Consistently unreliable in coordinating transportation to and from appointments (refer to medical needs and care and medication adherence sections)
						☐	☐	Unable to use public transportation	☐	☐	Requires ongoing assistance for transportation
						☐	☐	Has physical or emotional challenges that limit ability to coordinate transportation (refer to responses from basic needs, mental health, and developmental disability sections)			

11. LANGUAGE & LITERACY

Annual Score=	
Semi-Annual Review Score=	

Evaluate the client's need for interpretation and translation services.

Review preferred language, need for an interpreter, and need for assistance with reading/writing on intake form to determine acuity level

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	Understands service system and is able to navigate it	☐	☐	Demonstrates basic understanding of information with some assistance	☐	☐	Needs appropriate interpretation services for medical/case management services	☐	☐	Always needs interpretation for all services
☐	☐	Language and literacy are not barriers to accessing services							☐	☐	Functionally illiterate

12. DEVELOPMENTAL DISABILITY

Annual Score=	
Semi-Annual Review Score=	

Evaluate the client's ability to manage their own affairs if living with a developmental disability.

62. Have you ever been diagnosed with a Developmental Disability? ☐ Yes ☐ No

If YES: 62a. Please explain. _____

63. Are you currently linked to a Developmental Disability service? ☐ Yes ☐ No

If YES: 63a. What Developmental Disability service do you receive? _____

If YES: 63b. What is the name of the agency that provides you with Disability Services? _____

64. Did you ever have problems in school? ☐ Yes ☐ No

If YES: 64a. Please explain. _____

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	No signs of impairment	☐	☐	Signs of impairment with no diagnosis	☐	☐	Diagnosis of Developmental (DD) Disability with DD Services in place	☐	☐	DD Diagnosis without DD Services
☐	☐	Has ability to function independently									

13. SAFETY	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's experience with, and level of risk for, emotional, physical, and/or sexual abuse, neglect, and/or human trafficking.

Remind the client that at this point in the assessment process, you would like to meet with them alone. Also, remind the client about confidentiality and its limits (e.g., mandated reporting).

If there is an indication of potential or current domestic violence, based upon your clinical judgement and/or responses to the following questions, review with the client options for referrals, such as domestic violence services, human trafficking outreach, rape crisis centers, mental health services, etc.

65. Do you currently have any personal safety concerns? ☐ Yes ☐ No

If YES: 65a. Please explain.

66. Have you been affected by domestic violence? ☐ Yes ☐ No

If YES: 66a. Please explain.

67. Is anyone hurting and/or threatening you, making you feel afraid, or forcing you to do something against your will?
☐ Yes ☐ No

If YES: 67a. Who and how? _____

68. Are you being forced by another person to engage in sexual acts to receive needs (*e.g.*, food, clothing, shelter, drugs, money, protection, etc.)? ☐ Yes ☐ No

If YES: 68a. Please explain. _____

69. Are your IDs or passports unwillingly being held by another person? ☐ Yes ☐ No

If YES: 69a. Please explain. _____

70. Have you ever been involved with Child Protective Services? ☐ Yes ☐ No

71. Have you ever been involved with Adult Protective Services? ☐ Yes ☐ No

72. Are there any firearms in your home? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 3	Annual	Review	Score = 4	Annual	Review	Score = 5
☐	☐	No history or current instances of abuse or domestic violence	☐	☐	History, past relationships with violence	☐	☐	Agency(ies) involved due to signs of potential abuse (emotional, sexual, physical)	☐	☐	Medical, legal or outside intervention has occurred
☐	☐	Client feels safe				☐	☐	Reports current violent episodes	☐	☐	Life-threatening violence and/or abuse chronically and presently occurring*
						☐	☐	Unsafe history and pattern in current relationship	☐	☐	Volatile home environment
						☐	☐	Involvement with Child Protective Services	**Refer to domestic violence resources*		

14. SUPPORT SYSTEM	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's level of connectedness to others and need for assistance with disclosing their HIV status.

73. Who are the people you go to when you feel like you need support (*e.g.*, friends or family)?

74. How satisfied are you with your support system?

☐ Very Dissatisfied ☐ Dissatisfied ☐ Neutral ☐ Satisfied ☐Very Satisfied

If applicable: 74a. What could help to increase your satisfaction?

75. Who have you chosen to share your health status with? (*Include name and relationship to client*)

76. Is disclosing your health status something that you are considering? ☐ Yes ☐ No

If YES: 76a. Would you like support and/or resources on disclosing your diagnosis to family or friends? ☐ Yes ☐ No

77. Would you be interested in receiving information about social opportunities? ☐ Yes ☐ No

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 2	Annual	Review	Score = 3	Annual	Review	Score = 4
☐	☐	Indicates satisfactory social support	☐	☐	Indicates adequate support systems, but identified need for additional supports	☐	☐	Indicates inadequate support system	☐	☐	Indicates no identified support system
☐	☐	Has disclosed HIV status to all sexual and drug injection partners and household members (refer to substance abuse and legal issues sections)	☐	☐	Has disclosed HIV status to most members of the household and sexual or drug injection partners, but requests disclosure support (refer to substance abuse and legal issues sections)	☐	☐	Reports feeling isolated or unsupported in relationships	☐	☐	Has not disclosed HIV status to any members of the household including sexual and drug injection partners (potential barrier to medication adherence, risk for transmission) (refer to substance abuse and legal issues sections)
☐	☐	Does not identify disclosure of HIV status as a barrier to medication adherence				☐	☐	Has not disclosed HIV status to all members of the household, including some sexual or drug injection partners (potential barrier to medication adherence, risk for transmission) (refer to substance abuse and legal issues sections)	☐	☐	Death/loss of primary support person

15. SEXUAL HEALTH / RISK REDUCTION	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's sexual health risks as it relates to their overall health and well-being.

Inform the client that there are some basic things about sexual health that the medical case manager discusses with all clients when completing an assessment. While this topic may be uncomfortable, it is important to acknowledge sexuality and sexual relationships as important elements of an individual's overall health and well-being. Be sure to provide education surrounding risk reduction and methods to obtain safe sex protection (e.g., barrier protection, PrEP, etc.).

78. How many sex partners have you had in the past 6 months? _____

79. Do you have a significant other? ☐ Yes ☐ No

If YES: 79a. Is your partner HIV-positive? ☐ Yes ☐ No

If NO, not HIV-positive: 79a1. Are they on PrEP? ☐ Yes ☐ No

If NO, not on PrEP: 79a1a. Would they be interested in a referral? ☐ Yes ☐ No

80. In the past 6 months, which sexual activities have you engaged in? ☐ None

☐ Vaginal Sex	☐ with a Male	☐ with a Female	☐ with a Transgender person
☐ Anal Sex	☐ with a Male	☐ with a Female	☐ with a Transgender person
☐ Oral Sex	☐ with a Male	☐ with a Female	☐ with a Transgender person

81. In the past 6 months, how often have you used protection for:

Vaginal Sex	☐ Always (100%)	☐ Often (more than 50%)	☐ Seldom (less than 50%)	☐ Never (0%)	☐ N/A
Anal Sex	☐ Always (100%)	☐ Often (more than 50%)	☐ Seldom (less than 50%)	☐ Never (0%)	☐ N/A
Oral Sex	☐ Always (100%)	☐ Often (more than 50%)	☐ Seldom (less than 50%)	☐ Never (0%)	☐ N/A

82. In the past 6 months, were any of your partners?

☐ A person who is HIV positive
☐ An IV drug user
☐ A person who exchanges sex for drugs or money
☐ A person who you didn't know or only knew by first name

83. Do you have sex while drunk or high? ☐ Yes ☐ No

84. Do you have access to condoms? ☐ Yes ☐ No (*If NO: offer resources.)*

85. Do you have access to lube? ☐ Yes ☐ No (*If NO: offer resources.)*

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

SEXUAL HEALTH / RISK REDUCTION, continued

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 2	Annual	Review	Score = 3	Annual	Review	Score = 4
☐	☐	Abstaining from risky behavior by safer practices	☐	☐	Often uses protection during sex (more than 50%)	☐	☐	Seldom uses protection during sex (less than 50%)	☐	☐	Never uses protection during sex (0%)
☐	☐	Client has good understanding of risk reduction/transmission (refer to knowledge of HIV disease section)	☐	☐	Sero-discordant couple, partner is using PrEP or protection	☐	☐	Has access to protection and sometimes able to negotiate use	☐	☐	Engages in sex with multiple partners without protection
☐	☐	Understands the importance of preventing the spread of HIV (refer to knowledge of HIV disease section)	☐	☐	Sero-concordant couple, both virally suppressed	☐	☐	Sero-discordant couple, partner interested in PrEP or protection	☐	☐	No or limited access to protection, and unable to negotiate use with sexual partners
☐	☐	Understands the importance of avoiding reinfection (refer to knowledge of HIV disease section)							☐	☐	Sero-discordant couple, not using PrEP or protection
☐	☐	Engages in sex with one or multiple partners, always uses protection							☐	☐	Engages in commercial sex work (exchange for money, food, drugs, or survival)
☐	☐	Sero-discordant couple, virally suppressed client, partner is using PrEP or protection									

16. KNOWLEDGE OF HIV DISEASE	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's understanding of their diagnosis and the impact on their overall health.

86. Please explain your understanding and impact of the following on your overall health:

86a. CD4 Count:

86b. Viral Load:

86c. HIV Transmission:

87. What other questions can I help you answer regarding HIV/AIDS?

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 2	Annual	Review	Score = 3	Annual	Review	Score = 4
☐	☐	Verbalizes clear understanding about disease	☐	☐	Some understanding verbalized, but needs additional information in some areas	☐	☐	Limited understanding	☐	☐	Lack of understanding of HIV disease progression, etc.*
						☐	☐	Needs additional education to make informed decisions about health	☐	☐	Unable to make informed decisions about health*
						☐	☐	Newly diagnosed within past 12 months	☐	☐	Newly diagnosed within past 3 months
									*Refer to medical provider		

17. LEGAL ISSUES	Annual Score=	
	Semi-Annual Review Score=	

Evaluate the client's legal needs, including involvement with the legal system and advance directives, as it relates to their overall care.

88. Do you have any current legal concerns? ☐ Yes ☐ No

If YES: 88a. Please explain.

89. Have you ever been incarcerated? ☐ Yes ☐ No

If YES: 89a. Where and when were you incarcerated? _____

90. Are you aware of the felonious assault law? ☐ Yes ☐ No *(Regardless of answer, explain the felonious assault law.)*

91. Do you have a durable power of attorney for healthcare? ☐ Yes ☐ No

If YES: 91a. Name: _____ Phone Number: _____

91b. Have there been any changes to your durable power of attorney? ☐ Yes ☐ No

If YES: 91b1. What is the new contact information for your durable power of attorney?

Name: _____ Phone Number: _____

92. Do you need assistance with any of the following? *(Check all that apply.)*

☐ Will ☐ Power of Attorney
☐ Guardianship ☐ Payee
☐ Health Care Proxy ☐ Other
☐ Living Will

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

Self-Management			Basic Need			Moderate Need			Intensive Need		
Annual	Review	Score = 0	Annual	Review	Score = 2	Annual	Review	Score = 3	Annual	Review	Score = 4
☐	☐	No recent or current legal problems	☐	☐	Recent or current legal involvement	☐	☐	Present involvement in civil or criminal matters	☐	☐	Immediate crisis involving legal matters
☐	☐	Understands felonious assault law	☐	☐	Some understanding of the felonious assault law but needs additional education	☐	☐	Pending incarceration	☐	☐	Recently released from jail or federal prison
						☐	☐	Recently released from State prison	☐	☐	Currently residing in community based facility (*e.g.*, halfway house, residential treatment facility, etc.)

ADDITIONAL NOTES

Annual Notes:

Semi-Annual Notes:

Annual Referrals Needed/Made:

Semi-Annual Referrals Needed/Made:

RYAN WHITE PSYCHOSOCIAL ASSESSMENT SUMMARY FORM

Using the completed Psychosocial Assessment as a reference, place a checkmark in the corresponding level of need for each functional area and respond to the questions and prompts that follow. This form may be completed when determining whether a client should remain in medical case management or be transferred to non-medical case management—support. Information summarized in this form may also be used to develop a client's Individualized Service Plan.

Date: _____/_____/_____

Client Information

Legal First Name: _____ Legal Last Name: _____

Psychosocial Assessment Summary Table

FUNCTIONAL AREA	SELF-MANAGEMENT	BASIC	MODERATE or INTENSIVE
Basic Needs	☐	☐	☐
Housing	☐	☐	☐
Medical Needs	☐	☐	☐
Care and Medication Adherence	☐	☐	☐
Mental Health	☐	☐	☐
Substance Abuse	☐	☐	☐
Oral Health	☐	☐	☐
Health Insurance	☐	☐	☐
Financial Planning	☐	☐	☐
Transportation	☐	☐	☐
Language and Literacy	☐	☐	☐
Safety	☐	☐	☐
Developmental Disability	☐	☐	☐
Support System	☐	☐	☐
Sexual Health/Risk Reduction	☐	☐	☐
Knowledge of HIV Disease	☐	☐	☐
Legal Issues	☐	☐	☐

1. Does the client have moderate or intensive need in ANY of the shaded functional areas? ☐ Yes ☐ No
   (Housing, Medical Needs, Care and Medication Adherence, Mental Health, Substance Abuse, Safety, or Developmental Disability)
   - If YES: The client should remain in medical case management. Complete the Ryan White Medical Case Management Individualized Service Plan (and any other required forms).
   - If NO: Go to question two (2).

2. Does the client have need in ONLY the unshaded functional areas? ☐ Yes ☐ No
   (Basic Needs, Oral Health, Health Insurance, Financial Planning, Transportation, Language and Literacy, Support System, Sexual Health/Risk Reduction, Knowledge of HIV Disease, or Legal Issues)
   - If YES: The client should be transferred to non-medical case management. Complete the Ryan White NMCM – Support Individualized Service Plan and Ryan White Transfer Form (and any other required forms).
   - If NO: Go to the next question three (3).

3. Does the client have basic need in ANY of the shaded areas and basic/moderate/intensive need in ANY of the non-shaded areas? ☐ Yes ☐ No
   - If YES: Use clinical judgement to determine if the client should remain in medical case management or be transferred to non-medical case management and complete the Ryan White Individualized Service Plan accordingly (and Ryan White Transfer Form, if applicable). If in doubt, it is recommended the client be retained in medical case management services.
   - If NO: Return to questions one (1) and two (2). If still uncertain, consult a supervisor.

RYAN WHITE MEDICAL CASE MANAGEMENT
CLIENT HISTORICAL ASSESSMENT

Client Legal Name: _____ Client Date of Birth: _____/_____/_____

Case Manager Name: _____ Case Management Agency: _____

Client ID: _____ Date Assessment: _____/_____/_____

Have you ever been diagnosed with any of the following Opportunistic Infections (OIs)? ☐ No
Please see Appendix A for Glossary of Opportunistic Infections.

Diagnosis:	Date:
☐ Candida Esophagitis	
☐ Cryptococcal Meningitis	
☐ Cryptosporidiosis	
☐ Cytomegalovirus-eyes (CMV)	
☐ Disseminated Mycobacterium Avium Complex (MAC)	
☐ Encephalopathy (HIV Dementia)	
☐ Histoplasmosis	
☐ Invasive Cervical Cancer	
☐ Invasive Herpes Simplex infection	
☐ Isosporiasis (with diarrhea for more than a month)	
☐ Kaposi's Sarcoma (KS)	
☐ Lymphoma-type	
☐ Pneumocystis pneumonia (PCP)	
☐ Progressive Multifocal Leukoencephalopathy (PML)	
☐ Recurrent Bacterial Pneumonia	
☐ Retinitis (CMV)	
☐ Salmonella	
☐ T-cell count <200	
☐ Toxoplasmosis	
☐ Tuberculosis (TB)	
☐ Wasting Syndrome	
☐ Other:	

Have you ever been diagnosed with any of the following? ☐ No

Diagnosis:	Date:
☐ Cancer	
☐ Chlamydia	
☐ Cholesterol/Triglycerides	
☐ Chronic Yeast Infections	
☐ Diabetes	
☐ Epilepsy (seizure disorder)	
☐ Gonorrhea	
☐ Heart Disease	
☐ Hepatitis A	
☐ Hepatitis B	
☐ Hepatitis C	
☐ Herpes Simplex	
☐ Human Papillomavirus (HPV)	
☐ Hypertension	
☐ Liver Disease (Cirrhosis)	
☐ Other STDs: _____	
☐ Syphilis	
☐ TBI (Traumatic Brain Injury)	
☐ Other condition(s): _____	

APPENDIX A: GLOSSARY OF OPPORTUNISTIC INFECTIONS

Candida Esophagitis or Esophageal thrush is a yeast infection of the throat.

Cryptococcal meningitis is a fungal infection of the tissues covering the brain and spinal cord (meninges). Cryptococci's is not contagious and it is caused by a fungus.

Cryptosporidiosis (crypto) is an illness caused by a parasite. The parasite lives in soil, food and water. It may also be on surfaces that have been contaminated with waste. You can become infected if you swallow the parasite.

Cytomegalovirus (CMV) is a common virus that can infect almost anyone. Most people don't know they have CMV because it rarely causes symptoms. It is a part of the herpes virus family. Once a person has had a CMV infection, the virus usually lies dormant (or inactive) in the body, but it can be reactivated. The virus is more likely to be reactivated — and cause serious illness — in people who have weakened immune systems due to illness.

CMV retinitis is an infection that attacks the light-sensing cells in the retina. It is a serious disease that should be diagnosed and treated immediately, because it can lead to loss of vision, and in the worst cases, blindness.

Mycobacterium avium complex (MAC) is a group of bacteria that are related to tuberculosis. These germs are very common in food, water, and soil. MAC is an opportunistic infection that takes advantage of a weakened immune system. It can infect one part of your body, such as your lungs, bones, or intestines. This is called localized infection. It can spread and cause disease throughout your body. This is called disseminated infection.

Encephalopathy or HIV dementia is a condition that leads to the loss of intellectual abilities such as memory, judgment, and abstract thinking. It can also cause changes in personality. AIDS Dementia Complex (or ADC) is a type of dementia that occurs in advanced stages of AIDS.

Histoplasmosis is a fungal infection and grows as a mold in the soil. You may get sick when you breathe in spores produced by the fungus.

Invasive Cervical Cancer is cancer that has spread from the surface of the cervix to tissue deeper in the cervix or to other parts of the body.

Invasive Herpes Simplex infection is known has genital herpes and is a common STD. Genital herpes is caused by two types of viruses. The viruses are called herpes simplex type 1 and herpes simplex type 2. Most people with the virus don't have symptoms. It is important to know that even without signs of the disease; it can still spread to sexual partners.

Isosporiasis is a disease caused by the protozoan *Isospora belli*. The organism infects the lining of the small intestine and can cause severe diarrhea and malabsorption (an inability to absorb nutrients).

Kaposi's sarcoma (KS) is a type of cancer that mainly affects the skin, mouth, and lymph nodes (infection-fighting glands) but can also affect other organs such as the lungs and gastrointestinal tract.

Lymphomas are cancers that affect the white blood cells of the lymph system, part of the body's immune system. The lymph system is made up of the following: Lymph, Lymph vessels, Lymph nodes, Spleen, Thymus, Tonsils and Bone marrow.

Pneumocystis pneumonia (PCP) is a serious infection that causes inflammation and fluid buildup in the lungs. It is caused by a fungus likely spread through the air and is very common.

Progressive multifocal leukoencephalopathy (PML) is a brain disorder that affects the white matter part of the brain, specifically targeting the cells that make myelin (an oily substance that helps protect nerve cells in the brain and spinal cord).

Recurring pneumonia is a serious health condition that involves chronic inflammation or infection in one or both lungs.

Salmonella is a type of food poisoning caused by the Salmonella enteric bacterium. You can get salmonellosis by eating food contaminated with salmonella.

Toxoplasmosis is an infection due to the parasite *Toxoplasma gondi*. This infection is caused by a microscopic parasite that can live inside the cells of humans and animals, especially cats and farm animals.

Tuberculosis, commonly known as TB, is a bacterial infection that can spread through the lymph nodes and bloodstream to any organ in your body. It is most often found in the lungs. Most people who are exposed to TB never develop symptoms because the bacteria can live in an inactive form in the body. But if the immune system weakens, such as in people with HIV or elderly adults, TB bacteria can become active. In their active state, TB bacteria cause death of tissue in the organs they infect.

AIDS wasting syndrome is when a person loses at least 10 percent of her body weight and has at least 30 days of either diarrhea or weakness and fever. A person with HIV-associated wasting is considered to have AIDS. Severe loss of weight and muscle, or lean body mass, leads to muscle weakness and organ failure.

GAD-7

Identifier | Date

Please read each statement and record a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

1	Feeling nervous, anxious or on edge	
2	Not being able to stop or control worrying	
3	Worrying too much about different things	
4	Trouble relaxing	
5	Being so restless that it is hard to sit still	
6	Becoming easily annoyed or irritable	
7	Feeling afraid as if something awful might happen	

Total GAD-7 score =

Privacy - please note - this form neither saves nor transmits any information about you or your assessment scores. If you wish to keep your results you will need to print this document. These results are intended as a guide to your health and are presented for educational purposes only. They are not intended to be a clinical diagnosis. If you are concerned in any way about your health, please consult with a qualified health professional.

Scoring guide

Normal	Mild	Moderate	Severe
0 - 4	5 - 9	10 - 14	15 - 21

The maximum score of the GAD-7 is 21, lower scores are better. Scores are assigned in the following manner:

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

The total score is simply the sum of question items one through seven. Scores of 5, 10 and 15 are taken as the cut off points for mild, moderate, and severe anxiety respectively. When used as a screening tool, further evaluation is recommended should the score be ten or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for generalised anxiety disorder. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%), and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Document Version: 2.3
Last Updated: 14 December 2010
Planned Review: 14 December 2015

Kroenke, K., Spitzer, R.L., Williams, J.B. *et al;* Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. Ann Intern Med. 2007 Mar 6; 146(5):317-25

Spitzer, R.L, Kroenke, K. & Williams, J.B. *et al.* A brief measure for assessing generalised anxiety disorder: the GAD-7. *Arch. Intern. Med.* 2006: 166:1092-7.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
		add columns:	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

ZT274388

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   —if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   —if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Drug Use Questionnaire (DAST-20)

Name: _____

Case Number: _____

Charges: _____

Test Date: _____

Score: _____

Preliminary Comments

Adapted from language provided by Dr. Harvey Skinner (January 5, 2009)

The following questions concern your potential involvement with drugs other than alcohol. When you answer the questions, remember that the term "drug abuse" does not include alcohol. Instead, it refers to your use of prescribed or over the counter drugs in excess of the recommended dosage. For example, if you were given a prescription for pain killers, but took more than you were supposed to, that would be included. The phrase "drug abuse" also includes *any* non-medical drug use, including illegal drugs. This includes substances like marijuana, valium, cocaine, amphetamines, LSD, and heroin. Remember that the term "drug abuse" does not include alcohol. If you have difficulty with a statement, then choose the response that is mostly right.

Do you understand?

Questions

These questions refer to the past 12 months.	**Circle the Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7. Do you ever feel bad or guilty about your drug use?	Yes	No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes	No
13. Have you lost your job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use? (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)	Yes	No
19. Have you gone to anyone for help for a drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No

Scoring the DAST-20

Adopted or excerpted from materials provided by Dr. Harvey Skinner (January 5, 2009)

Scoring The DAST-20

Score 1 point for each question answered "yes," except for Questions 4 and 5, for which a "no" receives 1 point.

DAST-20 Interpretation Guide

Score	Severity	Intervention Recommended
0	N/A	N/A
1 – 5	Low	Brief Intervention
6-10	Intermediate (likely meets DSM criteria)	Outpatient (Intensive)
11-15	Substantial	Intensive
16-20	Severe	Intensive

Mental Health, Toronto, Canada. The test and accompanying documents may only be used for non-commercial purposes (clinical, research, and training purposes).

RYAN WHITE SCREENING FORM

Non-medical case manager-supports are responsible for meeting with and completing this screen with clients semi-annually to identify potential need for medical case management services. All questions should be asked and responses should be documented accordingly. A response of "yes" to any question requires a consultation with a supervisor to determine if the client will be transferred to medical case management for a complete psychosocial assessment.

Date of Screening: _____/_____/_____

Client Information

Legal First Name: _____ Legal Last Name: _____

Screening Information

Housing

1. Are you currently homeless? ☐ Yes ☐ No
2. Are you at risk of losing your housing? ☐ Yes ☐ No

Medical Needs

3. Is there a chance that you or your partner might be pregnant? ☐ Yes ☐ No
4. Have you had any new diagnoses or medical changes in the last six months? ☐ Yes ☐ No

   If YES: 4a. Please explain. _____
5. Were you hospitalized in the past six months? ☐ Yes ☐ No

   If YES: 5a. What was the reason(s) you were hospitalized? _____

Care and Medication Adherence

6. Have you missed more than one medical appointment in the past six months? ☐ Yes ☐ No

   If YES: 6a. What were the circumstances that caused you to miss these appointments? ☐ Yes ☐ No

   _____
7. Do you have any difficulty getting your prescriptions filled? ☐ Yes ☐ No
8. Have you missed any HIV medication doses in the past seven days? ☐ Yes ☐ No

   If YES: 8a. What were the circumstances that caused you to miss these doses? ☐ Yes ☐ No

   _____

Mental Health

9. Do you have any current mental health concerns? ☐ Yes ☐ No

   If YES: 9a. Please explain. _____

Substance Abuse

10. Have you used drugs other than for medical reasons? ☐ Yes ☐ No
11. Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No
12. Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No
13. Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No
14. Have you ever had a drink first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

Safety

15. Do you currently have any personal safety concerns? ☐ Yes ☐ No

    If YES: 15a. Please explain. _____

Non-Medical Case Manager—Support Sign Off

_____ _____ _____/_____/_____

Printed Name *Signature* *Date*

RYAN WHITE CASE MANAGEMENT
INDIVIDUALIZED SERVICE PLAN

The purpose of the individualized service plan is to create goals, action steps, and timeframe for achievement. Case managers and clients will work together to develop the individualized service plan annually and review and update it every six months.

Client Legal Name: _____ Client Date of Birth: _____/_____/_____

Case Manager Name: _____ Case Manager Phone Number: _____

Date of ISP Development: _____/_____/_____ Date of ISP Review: _____/_____/_____

Target Functional Areas (*Check all that apply.*)

- ☐ ☐ Basic Needs
- ☐ ☐ Housing
- ☐ ☐ Medical Needs
- ☐ ☐ Care and Medication Adherence
- ☐ ☐ Mental Health
- ☐ ☐ Substance Abuse
- ☐ ☐ Oral Health
- ☐ ☐ Health Insurance
- ☐ ☐ Financial Planning/Counseling
- ☐ ☐ Transportation
- ☐ ☐ Language & Literacy
- ☐ ☐ Developmental Disability
- ☐ ☐ Safety
- ☐ ☐ Support System
- ☐ ☐ Sexual Health Reduction
- ☐ ☐ Knowledge of HIV Disease
- ☐ ☐ Legal Issues

Client Agreement

I have helped make this plan. I understand that I am responsible for parts of this plan. My case manager has explained this plan to me. I agree to follow this plan and to tell my case manager if anything changes.

_____ _____ _____/_____/_____

Printed Name *Signature* *Date*

Review: _____ _____/_____/_____

Signature *Date*

Case Manager Verification

By signing this form, I verify that I have developed, explained, and reviewed this plan with the client.

_____ _____ _____/_____/_____

Printed Name *Signature* *Date*

Review: _____ _____/_____/_____

Signature *Date*

Active Goals

#

What functional area will be addressed?	
Over the next six months, what goal will address the functional area?	
What action steps will the client take to achieve the goal?	What is the timeframe for each action step to be completed by the client?
What action steps will the case manager take to assist the client achieve the goal?	What is the timeframe for each action step to be completed by the case manager?
What is the target date for the goal to be achieved? _____/_____/_____	
Summarize the progress towards meeting the goal:	
Was the goal achieved? ☐ Yes ☐ No	
Over the next six months, what goal will address the functional area? NA ☐ Same ☐ Updated ☐:	
What action steps will the client take to achieve the goal? NA ☐ Same ☐ Updated ☐:	What is the timeframe for each action step to be completed by the client?
What action steps will the case manager take to assist the client achieve the goal? NA ☐ Same ☐ Updated ☐:	What is the timeframe for each action step to be completed by the case manager?
What is the target date for the goal to be achieved? _____/_____/_____	

Deferred Goals

1.	Functional Area:	What is the reason the goal for the functional area will be deferred? ☐ Client Declined ☐ Lower Priority ☐ Other: _____ _____
	Summarize the progress towards moving deferred goal to active status:	What is the status of the functional area: ☐ Remain Deferred ☐ Move to Active Goal ☐ NA
2.	Functional Area:	What is the reason the goal for the functional area will be deferred? ☐ Client Declined ☐ Lower Priority ☐ Other: _____ _____
	Summarize the progress towards moving deferred goal to active status:	What is the status of the functional area: ☐ Remain Deferred ☐ Move to Active Goal ☐ NA
3.	Functional Area:	What is the reason the goal for the functional area will be deferred? ☐ Client Declined ☐ Lower Priority ☐ Other: _____ _____
	Summarize the progress towards moving deferred goal to active status:	What is the status of the functional area: ☐ Remain Deferred ☐ Move to Active Goal ☐ NA
4.	Functional Area:	What is the reason the goal for the functional area will be deferred? ☐ Client Declined ☐ Lower Priority ☐ Other: _____ _____
	Summarize the progress towards moving deferred goal to active status:	What is the status of the functional area: ☐ Remain Deferred ☐ Move to Active Goal ☐ NA
5.	Functional Area:	What is the reason the goal for the functional area will be deferred? ☐ Client Declined ☐ Lower Priority ☐ Other: _____ _____
	Summarize the progress towards moving deferred goal to active status:	What is the status of the functional area: ☐ Remain Deferred ☐ Move to Active Goal ☐ NA

RYAN WHITE REQUEST FOR NON-MEDICAL CASE MANAGEMENT–SUPPORT FORM

Date: _____/_____/_____

Client Contact Information

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____/_____/_____

Home Address (including city and zip code): _____

Phone Number(s): _____ E-mail Address: _____

Preferred Method(s) of Contact (check all that apply): ☐ Mail ☐ Phone ☐ E-mail

May confidential messages be left on voicemail? ☐ Yes ☐ No

Service(s) Requested (*check all that apply*)

☐ Provide transportation to _____ for _____
Address *Service*

by _____/_____/_____

☐ Deliver _____ to _____
Item *Address*

by _____/_____/_____

☐ Complete referral form for _____ service by _____/_____/_____

☐ Complete _____ by _____/_____/_____
Application/paperwork

☐ Research and document community resources for _____ by _____/_____/_____
Type of service

☐ Other: _____ by _____/_____/_____

Additional Information

Medical Case Manager Information

_____ _____ _____/_____/_____
Medical Case Manager Name *Medical Case Manager Signature* *Date*

Supervisor Approval

Supervisor Approval: ☐ Yes ☐ No

_____ _____ _____/_____/_____
Supervisor Name *Supervisor Signature* *Date*

SUPPORT STAFF ASSIGNMENT USE ONLY

Date Form Received: _____/_____/_____

Name of Assigned NMCM-Support: _____ Date of Assignment: _____/_____/_____

Name of Case Assignment Staff: _____ Signature: _____

RYAN WHITE CLIENT TRANSFER & CASE CONFERENCE FORM

Transfer Date: _____/_____/_____

Client Legal Name: _____ Date of Birth: _____/_____/_____

Has the court appointed someone to make decisions on behalf of the client? ☐ Yes ☐ No

If YES: Guardian/Conservator Name: _____ Phone Number(s): _____

Transfer Information

Transfer From: ☐ Linkage to Care ☐ Medical Case Management ☐ Non-Medical Case Management–Support

_____ _____
Name *Agency*

_____ _____
Phone Number *E-mail Address*

Transfer To: ☐ Medical Case Management ☐ Non-Medical Case Management–Support

_____
Agency Name

Reason for Transfer:

Client Information

RW Part A Eligibility Expiration Date: _____/_____/_____ RW Part B Eligibility Expiration Date: _____/_____/_____

Current Total Acuity Score (*if applicable*): _____ Name of HIV-Doctor: _____

Materials to be Transferred

Eligibility Documents to be Transferred:
- ☐ HIV Verification
- ☐ Income Verification *(including any benefit award letters)*
- ☐ Proof of Residency
- ☐ Proof of Insurance
- ☐ Documents currently in RWAD

Assessment Documents to be Transferred: **From MCM Only, **From NMCM–Support Only*
- ☐ Current ISP
- ☐ Most Recent PSA* (*including acuity score*)
- ☐ Network Release
- ☐ Ryan White Intake Form
- ☐ Ryan White Historical Assessment*
- ☐ Current Ryan White Screening Form**

Supervisor Approval

Supervisor Approval: ☐ Yes ☐ No

_____ _____ _____/_____/_____
Supervisor Name *Supervisor Signature* *Date*

CASE ASSIGNMENT USE ONLY

Date Transfer Form Received: _____/_____/_____

Name of Assigned Case Manager: _____ Date of Assignment: _____/_____/_____

Name of Case Assignment Staff: _____ Signature: _____

Case Conference Participation

Case Conference Meeting Date: _____/_____/_____

Type of Meeting: ☐ In-Person ☐ Phone

Participants:

Name of Professional	Title	Phone Number	E-mail Address	Agency

Case Conference Discussion

Items Discussed *(check all that apply)*:

- ☐ Preferred Method of Contact with Client
- ☐ RW Eligibility
  - ☐ RW Part A Eligibility Expiration Date
  - ☐ RW Part B Eligibility Expiration Date
  - ☐ Status of RW Eligibility Documents
- ☐ Psychosocial Assessment
  - ☐ Functional Areas to be Addressed with the Client
  - ☐ Observations of Client
- ☐ RW Screening Form
  - ☐ Functional Areas of Concern
- ☐ RW Case Management Individualized Service Plan
  - ☐ Progress Towards Meeting Goals (in the past six months)
  - ☐ Action Steps to be Taken (in the next six months)
- ☐ Safety Issues
- ☐ Client Participation
- ☐ Client's Memory/Organization/Confusion
- ☐ Pending Issues
- ☐ Active Referrals
- ☐ Upcoming Appointments
- ☐ Other Information (please list):

Sign-Off

_____ _____ _____/_____/_____

Name of Professional Receiving Case *Signature of Professional Receiving Case* *Date*

RYAN WHITE CLIENT CASE CLOSURE FORM

Case Closure Date: ____/____/_____ Network Release Form Expiration Date: ____/____/_____

Client Legal Name: _____ Date of Birth: ____/____/_____

Reason for Case Closure

☐ Client moved outside service area
☐ Client incarcerated
☐ Client request
☐ Client lost to care
☐ Client had zero/low acuity score
☐ Client death

Case Closure Activities

Is the client aware that their Ryan White case management case has been closed? ☐ Yes ☐ No

Check the type(s) of attempts to notify the client and/or methods in which the client was notified and list the date(s) of attempts/methods of notification:

☐ Phone ____/____/_____ ☐ Email ____/____/_____ ☐ Mail ____/____/_____ ☐ Home Visit ____/____/_____

☐ In-Person Meeting ____/____/_____ ☐ Other: _____ ____/____/_____

Referrals Provided: ☐ NA

Agency Name	Purpose of Referral	Agency Contact Information

Additional Information

Case Closure Sign-Off

_____ _____ ____/____/_____
Case Manager Name *Case Manager Signature* *Date*

_____ _____ ____/____/_____
Supervisor Name *Supervisor Signature* *Date*