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**MARICOPA COUNTY**

**HEALTH CARE MANDATES**

**Ryan White Part A Policies & Procedures**

PHOENIX ELIGIBLE METROPOLITAN AREA  
February 2007



**Maricopa County**

## Ryan White CARE Service Policies & Procedures Phoenix EMA

The Maricopa County Department of Health Care Mandates, Ryan White Title I Program, has formulated the following policies and procedures to competently fulfill the responsibilities of the Administrative Agent for Title I funds in the Phoenix EMA. These policies have been developed to provide clear and consistent administrative guidance across all programs and contracts based on provider feedback, program audits, and HRSA policy. Title I contracts/agreements provide additional information regarding the basis for these policies. All policies and procedures included in this document are consistent with the Ryan White HIV/AIDS Treatment Modernization Act, federal Public Health Services (PHS) Grants Management Policies, and applicable federal Office of Management and Budget (OMB) circulars. The Ryan White Title I Program will continually update these policies and share with the providers as appropriate. The enclosed policies establish guidelines for the following:

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*Further details on federal restrictions on the use of Title I funds are also included in each contract.*

# I. Guidelines for Determining Client Eligibility and Documentation

## POLICY:

All persons seeking services must be determined “eligible” to receive services under the Ryan White Title I program. To be or remain eligible for the Title I program, a client must meet and have on file proof of the following conditions:

- A. Verification of HIV Positive Diagnosis
- B. Verification of residency within the Phoenix EMA
- C. Verification of current household income
- D. Verification of Other Insurance

Ryan White Title I is the payer of last resort. As such, all providers must make every effort to ensure that all funding options are exhausted prior to billing services under Title I contracts. All clients must be screened with the above to determine that Title I is that payer of last resort. In instances when AHCCCS or any other state or federal programs are available for that service, a client must show proof of ineligibility.

All documentation, with the exception of HIV diagnosis, must be verified every six months to ensure that the information is current and the client remains eligible for Title I services.

### A. Guidelines for Verification of HIV Positive Diagnosis (Medical Eligibility):

The following documentation has been deemed acceptable within Federal and County guidelines:

1. Confidential (named) lab report of positive HIV antibody reactivity; or
2. A statement or letter signed by a medical professional (acceptable signatories are listed below), with an original physician’s signature on office letterhead indicating that the individual is HIV positive; fax copies of this document will be acceptable under the following conditions:
  - a. It is forthcoming directly from a medical professional’s office;
  - b. The client has no feasible way to obtain an original, (e.g., out of state), and;
  - c. The fax copy is for a period of 60 days.

It is the responsibility of the provider to follow up and receive an original from the medical provider’s office within that time frame.

3. Named hospital discharge report, or other document signed by a medical professional (acceptable signatories are listed below), indicating the HIV positive diagnosis of the client.
4. HIV quantitative viral load by bDNA or PCR showing detectable virus level with the client’s name imprinted on the laboratory report; or
5. Un-named ADHS lab result accompanied by named lab slip, ensuring that the lab slip number appears on both documents as a cross reference

Acceptable signatories include:

- A licensed physician
- A licensed physician assistant
- A licensed nurse practitioner
- A registered nurse working under the supervision of a physician

*Discrepancy  
Point 2*

No other data are acceptable. If the client documentation does not meet this standard and is not consistent with this policy, it is to be corrected to meet the above standard at time of re-certification (*i.e.*, every six months). Therefore, for all active clients, this documentation will be fully adherent to HRSA policies within six months. For clients re-entering the system or transitioning from inactive to active status, the HIV documentation must meet the above standard. Once a correct HIV status document is collected and available for review, an HIV status document does not need to be collected every six months.

## **B. Guidelines for Documenting Verification of Residency within the Phoenix EMA**

A recipient of Title I services must be a resident of Maricopa or Pinal counties, with documentation in chart and verified by the provider. Proof must be current (within six months). **Items 1 and 2** below contain document types which are considered *primary* verification documents for use by Title I contractors when determining EMA residency.

1. Any one of these documents will be accepted as proof of residency if the address is not a P.O. Box, is a “land” address, is valid in date and not expired, and is the same as the client’s stated address on intake/application documents. Such official documents with address present include:
  - a. Food stamp documentation,
  - b. General assistance documentation,
  - c. TANF documentation,
  - d. AHCCCS approval or denial letter,
  - e. Social Security or Veteran’s Administration Benefits award letter,
  - f. Unemployment award/benefits statement,
  - g. Property tax statement,
  - h. Homeowners Association (HOA) assessment/fee statement, or
  - i. Mortgage or lease agreement indicating the client’s name and residence
  
2. In the absence of the above, any two of the below will be accepted as proof of residency if the address is not a P.O. Box, is a “land” address, valid in date and not expired, and the same as the client’s stated address on intake/application documents:
  - a. Non-property tax bill or tax assessment statement,
  - b. W-2 (tax) form from employer (most recent tax year),
  - c. Check stub from employer (most recent tax year),
  - d. Bank statement (most recent month),
  - e. Drivers license,
  - f. Motor Vehicle Department-issued identification card, and/or,
  - g. Immigration identification card
  - h. Utility bills (most recent). These are bills that generally represent services received at a residence, and are linked to the residence rather than to the person. Examples include:
    - *Cable TV*
    - *Internet*
    - *APS*
    - *SRP*
    - *Southwest Gas*
    - *Water/sewer/garbage*
    - *Land line phone (vs. cell phone)*

3. When neither paragraph 1. or 2. of the above types of documentation are available, two of the following secondary items can serve as proof of residency if the address is not a P.O. Box, is a "land" address, is valid in date and not expired, and is the same as the client's stated address on intake/application documents:
  - a. Letter from transitional housing or extended care facility, mentioning client by name and address;
  - b. Written statement from a homeless service provider (shelter, clinic, food program, etc.) verifying homelessness;
  - c. A billing statement from a department store, doctor's office, insurance company, cell phone company;
  - d. An official piece of mail such as a voter registration card; and/or
  - e. A statement from client's case manager indicating the case manager has met with client in a home visit at a specific address in the Phoenix EMA.

The address for a Ryan White Title I funded case management provider will be accepted as a mailing address in cases where homelessness and proof of residency have been established, as approved/initiated by these service providers.

Occasionally a special circumstance may occur when a client cannot provide residency documentation consistent with the policy, but is a resident of the EMA. These situations will be considered on a case-by-case basis by the provider and the Maricopa County Department of Health Care Mandates, Ryan White Title I Program. The MCHCM, Ryan White Title I Program shall have final authority.

**C. Guidelines for Documenting Verification of Current Household Income**

Client annual income must be documented in relation to current Federal Poverty Guidelines (FPG) and documented to be eligible according to the contract requirements. Regulations require that Title I services are restricted to clients with specific household income limits based on Federal Poverty Guidelines (FPG). The specific limitations may vary according to service category. The chart below indicates multiples of the FPG for clients.

**Table 1: Federal Poverty Guidelines 2006**

Persons in Family or Household	300%	200%	185%
1	\$ 29,400	\$ 19,600	\$ 18,130
2	39,600	26,400	24,420
3	49,800	33,200	30,710
4	60,000	40,000	37,000
5	70,200	46,800	43,290
6	80,400	53,600	49,580
7	90,600	60,400	55,870
8	100,800	67,200	62,160
<i>For each additional person, add</i>	6,120	6,120	6,120

**SOURCE:** *Federal Register*, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

Clients must not have health insurance and /or other benefits which could pay for the services provided by the Ryan White funded program.

If the service is a covered benefit provided by AHCCCS (Arizona Health Care Cost Containment System – Arizona’s version of Medicaid), the client must not be eligible for AHCCCS. If the client is AHCCCS eligible, service must be provided by AHCCCS, and not Ryan White, system of care. Similarly, proof of AHCCCS coverage is acceptable proof of low-income status.

Client must provide proof of income. Proof of income, with payee’s name indicated, includes all of the following types of documentation that apply to client and each member of his/her household (a household consists of the participant, spouse and dependent children less than 18 years of age);  
Check stubs listing gross wages/employer’s statement listing gross wages,  
Self-employment business records,  
Income award letters/grant or educational benefits letter,  
Social Security award letters, food stamp, G.A., or AFDC award letters, and /or  
Other current documentation showing income or source of assistance received (this may include a latest W-2 [tax] form).

If income status is unchanged from the previous certification/determination and documentation is valid in date, the agency and client should so attest at time of re-certification (see Attachment A-1). If the client is unemployed, and not receiving any federal/state assistance such as General Assistance, SSI or SSDI, agencies may use the attached to document the client’s status every six months. This procedure and policy is consistent with that of the ADHS for management of the AIDS Drug Assistance Program (ADAP).

*In all cases for all clients, residency, income, and proof/attestation of ineligibility for other benefits must be reassessed and re-documented every six (6) months.*

**D. Guidelines for Documenting Verification of Other Insurance**

Ryan White is the payer of last resort. Providers are responsible to ensure that client’s are screened for ineligibility of other funding sources covered by Federal or State programs (e.g., AHCCCS, Veteran’s benefits, or other programs).

The provider of services is responsible to maximize all other revenue streams including self-pay and all sources of third party reimbursements prior to serving a client with Ryan White funds. All clients must be screened to determine eligibility of services from the Regional Behavioral Health Authority (RBHA), Arizona Health Care Cost Containment System (AHCCCS), Arizona Long Term Care Services (ALTCS), Veterans Affairs (VA), and any other funding source available within the EMA.

**E. Release of HIV Information**

The following requirements and guidelines are consistent with Maricopa County Department of Health Care Mandates Ryan White Title I Program contracts, MCHCM policy, and the Arizona Revised Statutes (A.R.S.) §§360663 and 664.

All contractors must secure from all clients receiving Ryan White funded services a release authorizing disclosure of named information, for audit purposes only, to the Maricopa County Department of Health Care Mandates. Each client file documenting the provision of Title I services must contain such a release form signed by the client. This release must grant access to named confidential file information to the MCHCM for the purpose of grant administration/monitoring for a period of five (5) year from date of signature.

Failure to secure such signed releases from all non-anonymous clients may result in disallowance of all claims to County for contracted services provide to those eligible individuals. If the Contractor is authorized by the County to provide services anonymously, such a release is not required.

Contractors must secure releases to the MCHCM, and are not required by contract to secure release to the Arizona Department of Health Services, or any other entity. All release references to the Maricopa County Commission AIDS Partnership (MCCAP) or Arizona AIDS Foundation (AAF) must be removed.

Inter-agency information exchange—verbally, electronically, in writing or fax—by named HIV positive client, is clearly subject to Arizona statute. No agency should release named HIV-positive client data to any other entity without a signed client release authorizing specific release to a specific agency/person for a specific purpose. All authorizations for release of named client level confidential information must be signed, dated and clearly state to whom the data are to be provided, from whom the data are to be released, and the specific purpose of its release. Be specific about to whom the data are to be released (*e.g.*, “Care Directions”) not “case manager” or case management entity. General releases are not allowed via A.R.S. §§36-663 and 664, and will not be accepted by the MCDHCM.

Further information and specific contractor requirements in the area of securing data releases and authorizing transfer of named data subject to A.R.S. §§36-663 and 664 are included in each provider contract. A simple, model example that may be customized for Contractor use is attached (see Attachment A-4).

**F. Client confidentiality**

Funded providers must have established policies and procedures for ensuring confidentiality of all clients served. This includes maintaining records in a secure place.

- All Providers must comply with HIPAA (Health Insurance Portability and Accountability Act).

Providers shall maintain all records and other documents related to services provided for a period of five (5) years from the date of service, except in cases where unresolved audit questions require retention for a longer period as determined by the Maricopa County Department of Health Care Mandates, Ryan White Title I Program. The provider shall make such records and documents available for inspection and audit at any time to authorized representatives.

## **II. Billing/Contractual Issues**

**A. HAB/DSS Expectations**

The Title I grantee is responsible for the proper stewardship of all grant funds and activities. This requires business management systems that meet the requirements outlined by the Office of Management and Budget (OMB) for recipients of Federal funding. It is the responsibility of the Title I grantee to ensure that all subcontracted entities maintain a high level of accountability in the services that they provide under the Ryan White CARE Act Title I grant. This section details the procedures set by the Maricopa County Department of Health Care Mandates (MCHCM), Ryan White Title I Program in regards to fiscal accountability for all entities that provide services under contract with the Ryan White Title I grant.

Programs must have appropriate financial systems that can provide for internal control, safeguarding assets, ensuring stewardship of federal funds, maintaining adequate cash flow to meet daily operations, assuring access to care and maximizing revenue from non-federal sources. These systems must meet the requirements outlined by the Office of Management and Budget (OMB) for receipt of Federal funding. The OMB Circulars A-102, A-110 as well as the cost principles in Circular A-21,

A-87, and A-122 specify the requirements for obtaining prior approvals for certain budget and program revisions.

#### **B. Administrative Costs**

Administrative costs relate to oversight and management of CARE Act funds and include such items as contracting, accounting, and data reporting. The Ryan White Title I CARE Act and the Maricopa County Department of Health Care Mandates limits administrative costs for all subcontracts to not more than **10%** of the total contract award for each contract issued for services under the Title I Program.

Section 2604(f)(3) defines allowable “subcontractor administrative activities” to include:

1. Usual and recognized overhead, including established indirect rates for agencies;
2. Management and oversight of specific programs funded under this title; and
3. Other types of program support such as quality assurance, quality control, and related activities.

Typical examples of administrative costs would include: salaries and expenses of executive officers, personnel administration, accounting, operating and maintaining facilities, and depreciation on buildings and equipment.

#### **C. Subcontractors and Administrative Costs**

The use of subcontractors and/or consultants must be pre-approved by the County. If the use of subcontractors is approved by the County, the Contractor agrees to use written subcontractor/consultant agreements which conform to Federal and State laws, regulations and requirements of the contract appropriate to the service or activity covered. Direct Providers are responsible for the contract performance whether or not subcontractors are utilized. The Provider will submit a copy of each executed subcontract to Maricopa County Health Care Mandates, Ryan White Title I Program within fifteen (15) days of its effective date.

- All subcontract agreements must provide a detailed scope of work, indicating the provisions of service to be provided by both the Direct Provider and the subcontractor.
- All subcontract agreements must include a detailed budget and narrative, identifying all administrative costs as defined in section B, above.
- All subcontract agreements must document the qualifications and ability to provide services by the subcontracted agency.

Maricopa County shall have access to the subcontractor’s facilities and the right to examine any books, documents, and records of the subcontractor, involving transactions related to the subcontract and that such books, documents, and records shall not be disposed of except as provided herein.

For all subcontracts of the Title I Program, the administrative cost cap will be enforced. For each contract, the budget submitted, see budget section, administrative costs and direct service costs must be delineated. Administrative costs, including any Indirect Cost Rate, cannot exceed **10%** of the total contract award for each contract awarded.

In an effort to limit administrative costs, MCHCM also imposes the **10%** administrative cost cap for all subcontracts granted by the original subcontractor for services. This means that a provider that utilizes subcontracts for services under the Title I contract must also ensure that their subcontractor limits their administrative costs to no more than **10%** of their subcontract.

**Indirect Cost Rates:** An Indirect Cost Rate is a mechanism for determining, in a reasonable manner, the proportion of an organization's total indirect costs that each program should bear. It is usually stated as a percent of total direct costs for the program.<sup>1</sup>

Subcontractors are allowed to use an indirect rate for their contracts under the following conditions: A formalized Indirect Cost Rate Agreement is in effect for the organization, properly approved by the appropriate federal agency. A copy of the current agreement will be submitted the MCHCM, Ryan White Title I Program. The Indirect Cost rate calculated on direct service costs PLUS any administrative costs listed in the budget do not exceed **10%** of the total contract award.

#### **D. Allowable Costs**

- 1.** Allowable costs are costs incurred and eligible for reimbursement for the activities associated with providing services under a grant award. The Office of Management and Budget (OMB) has developed cost principles relating to the general requirements of all entities receiving federal funds. Subcontractors should become familiar with the applicable cost principles as described in the OMB Circulars: A-122, "Cost Principles for Non-Profit Organizations"; A-87, "Cost Principles for State, Local, and Indian Tribal Governments"; and A-133, "Audits of States, Local Governments, and Non-Profit Organizations." As a broad guideline, the General Principles of Circular A-122 are outlined in the following section:
  - a.** *Factors affecting appropriateness of costs* – To be allowable under an award, costs must meet the following general criteria:
    - i.** *Be reasonable for the performance of the award and be allocable thereto under these principles;*
    - ii.** *Conform to any limitations or exclusions set forth in these principles or in the award as to types or amount of cost items;*
    - iii.** *Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the organization;*
    - iv.** *Be accorded consistent treatment;*
    - v.** *Be determined in accordance with generally accepted accounting principles (GAAP);*
    - vi.** *Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period;*
    - vii.** *Be adequately documented.*
  - b.** *Reasonable costs* – As described in the OMB Circulars listed above, providers are responsible for determining if costs incurred are reasonable for the provisions of providing the service within the scope of the contract award. A cost is reasonable if, in its nature or amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs. Consideration for reasonableness could include the following:
    - i.** *Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the organization or the performance of the award.*
    - ii.** *The restraints or requirements imposed by such factors as generally accepted sound business practices, arms length bargaining, Federal and State laws and regulations, and terms and conditions of the award.*

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<sup>1</sup> Ryan White CARE Act Title I Manual, Section II, Chapter 2



- j. **Residential Substance Abuse Treatment** – CARE Act funds may not be used for inpatient detoxification in a hospital setting.
  - k. **Vision Care** – Funds may only be used for optometric or ophthalmic services and purchase of corrective prescription eye wear that is necessitated by HIV infection.
  - l. **Employment services** – Funds may not be used to support employment, vocational rehabilitation, or employment-readiness services.
  - m. **Clothing** – Funds may not be used for purchase of clothing.
  - n. **Transportation** – Funds may not be used for clients to travel to appointments other than those that support their HIV medical care and the support services required to keep them in care.
3. Ryan White Title I Program funds are not allowable for prevention education services such as: Basic HIV-education, HIV testing, addressing sexually-transmitted diseases or condom distribution. Education related activities must be directly linked to increasing access of the target populations to HIV care services.
4. Title I funds may NOT be used:
- To purchase or improve any building or other facility;
  - For items or services that have already been paid for, or can reasonably be expected to be paid for by another source;
  - To pay for automobile parts, repairs, or maintenance;
  - To make cash payments to people receiving services under the Act;
  - To pay for pet care or supplies;
  - To purchase tobacco or lottery tickets;
  - To be used for mortgage payments;
  - To cover the costs of funeral, burial, cremation or other related expenses;
  - To purchase clothes;
  - To support legal services for criminal defense;
  - To pay property tax;
  - To support research; or
  - To support fundraising activities

Further information on some of the limitations for funding may be found in “Allowable Uses of Funds for Discretely Defined Categories of Services,” available at <http://hab.hrsa.gov/law/dss2.htm>

#### **E. Reporting and Documenting Client-Generated Revenue**

Many contracts require that revenue (as client co-pays consistent with an approved client sliding fee scale) be collected from clients with incomes greater than **200%** of the Federal Poverty Guideline (FPG). These program budgets reflect the anticipated revenue as a budget component, or as additional service units to be provided beyond those contractually obligated. If the collection of revenue is required, then the revenue should be collected and reported by discrete service (*i.e.*, specific to each contract). Revenue may only be applied to the service and contract for which it was collected. As an example, revenue collected from case management services may only be used to provide service units as included in the respective case management contract. If the collection of revenue is required, providers should include the estimated amount of revenue to be collected during the contract period in the underlying budget, and report collection of revenue in the monthly Fiscal and Program Monitoring Report (FPMR).

In such cases where client generated revenue is collected, federal law prohibits imposing a first party charge on individuals whose income is at or below **100%** of the Federal Poverty Level and requires that individuals with incomes above the official poverty level be charged for services. Providers that receive Title I funds and charge for services must develop consistent and equitable policies and procedures related to verification of client’s financial status, implementation of a sliding fee scale and ensuring a cap on client charges for HIV related services. The sliding fee scale schedule must take into account the client’s level of income and limits total service charges to a percentage of the individual’s yearly income. The agency must have a system in place to ensure that these annual caps on charges to clients are not exceeded.

<b>Family Income</b>	<b>Maximum Charge</b>
At or below 100% of Poverty	\$0
101% to 100% of Poverty	<i>No more than 5% of gross annual income</i>
201% to 300% of Poverty	<i>No more than 7% of gross annual income</i>
Over 301% of Poverty	<i>No more than 10% of gross annual income</i>

Accounting or other records must track revenue collection and use by contract and client consistent with this policy. Ryan White Services staff will review the collection of applicable revenue and resultant use at the time of each site visit/assessment.

**F. Cost Reimbursement**

As a rule, all Ryan White Title I service providers are to bill for services provided on a “cost reimbursement” basis rather than a “service unit” basis. The County will not approve or reimburse the Contractor for costs expended in excess of the contracted amount.

**G. Changes to Program Budgets – Staff Changes, Indirect and Increased Costs**

Amendments to existing contracts to add contract value and/or to re-align the number of service units should maintain the cost basis of the original underlying budget and payment and fee schedule. Increases to contract value due to reallocations directed by the Phoenix Eligible Metropolitan Area (EMA) Ryan White Title I Planning Council are expected to be utilized by Contractors to provide additional services. Increases to personnel salaries and other costs that are not affected by increase to the contract value should be reflected in the program budget during the initiation or renewal of contracts. Contractors are required to notify the Ryan White Title I Program of staff changes to the program budget in writing.

Contractors may re-allocate *up to 10%* of a line item within their approved budgets. Contractors must receive written permission from the County before re-allocating funds between approved budgeted line items *in excess of 10%* of the line items in question.

**H. 3-Year Bidding Cycle**

The Program has established a 3-year cycle for bidding *all* EMA service categories.

**I. Re-allocation Approval by Planning Council**

In the event that a re-allocation of funds is deemed appropriate via the Administrative Agency’s monitoring of the provider contracts, a recommendation regarding the re-allocation will be submitted to the Planning Council for its approval *before* such a re-allocation occurs to ensure compliance with Title I regulations.

Open Bidding on Re-allocations: In the event that re-allocation or re-distribution of Title I funds is deemed necessary, the process for re-distributing these funds will be open to all EMA providers who are capable of providing the particular service into which the needed funds are being shifted. This

process is being implemented to preclude any perception of conflict of interest on the part of the County.

**J. Changes in Task Order**

The Maricopa County Department of Health Care Mandates, with cause, by written order, may make changes within the general scope of providers' Task Orders in any one or more of the following areas:

- Work Statement activities reflecting changes in the scope of services, funding source, or Federal or County regulations;
- Administrative requirements such as changes in reporting periods, frequency of reports, or report formats required by funding source or County regulations, policies or requirements, and/or
- Contractor fee schedules and/or program budgets.

Examples of cause would include, but are not limited to: non-compliance, under performance, reallocations from the Planning Council, or approved directives from the Planning Council.

**K. Reporting Requirements**

Providers are required to submit monthly fiscal and program reports to Maricopa County Department of Health Care Mandates, Ryan White Title I program no later than the fifteenth (15<sup>th</sup>) day of the month following the month services were provided. No payment will be made to the provider if the required programmatic and fiscal reports have not been received. Noncompliance with the reporting requirements will be reason to impose a penalty of up to 10% of the payment requested.

At a minimum, the following reports will be due to the Ryan White Title I Program office by the fifteenth (15<sup>th</sup>) of each month in the format required by the Ryan White Title I program:

- Signed cover page by the agency's authorized signatory;
- Invoice cover page, indicating the service month, service category, contract/PO number, and amount being requested;
- CARE Ware financial report that matches to the Invoice cover page;
- Demographic/data entry review reports with zero(0) "incomplete", "unknown", or "not specified" data
- Narrative report detailing activities performed during the service month

**L. Monthly Billing – 5% Variance from Expected Billing Rate**

The Ryan White Title I Program may request supporting documentation or conduct a fiscal review of any program whose monthly billing exceeds or falls below 5% of the average expected amount. This is to ensure that agencies will provide services during the entire 12-month period of the contract, and that services are being provided adequately to clients. Seasonal variance of services and other factors that do not allow for 1/12 expenditure of the contract amount will be taken into consideration, as will billings that cross the time period of the contract are in line with expected expenditures. Instances when there are unique aspects that make it unfeasible for the program or service to be subject to a 1/12 expenditure and billing will be handled on a case-by-case basis to reflect these unique aspects of some programs. Contractors who provide written justification and back up for the greater-than-expected variance from their average monthly billing will not be subject to further fiscal review for this purpose.

**M. Documenting Personnel Vacancies in the Contract Budget**

Most Title I contracts require a categorical budget and budget narrative justification. If at the time of submission of a service budget one or more of the personnel positions are vacant, contractors must indicate such and provide an estimated date when the positions will be filled, and prorate/apportion personnel and other associated costs to reflect reduced personnel allocation to the service.

Alternatively, contractors may note the vacancy, with no associated cost, and develop the contract to reflect actual personnel staffing at the time of budget preparations, amending the budget to reflect on-going personnel changes as they occur. For changes of staff and/or vacancies for existing contacts, all contractors must, within thirty (30) days of change, amend the budget and/or unit costs to reflect actual budget experience resulting from the change.

**N. Authorized Signatures for Monthly Fiscal and Program Monitoring Reports (FPMRs)**

For non-governmental contractors all FPMRs must be signed by the agency's authorized signatories (Executive Director, CEO, or Chair of the Board of Directors). No other signatures will be accepted.

**O. Provision of Agency Audits Consistent with OMB A-133**

All contractors subject to federal Office of Management and Budget (OMB) circular A-133 (*i.e.*, non-governmental agencies expending federal funds from all sources in excess of \$500,000 in the latest fiscal year) must complete agency audits consistent with the circular. All agencies must submit completed audits to the Maricopa County Department of Health Care Mandates, Ryan White Title I Program, within thirty (30) day of submission and approval by the agency's Board of Directors. A Plan of Corrective Action addressing all material findings and areas of auditor's concern must be submitted by the contractor's Board of Directors to the MCHCM within sixty (60) days.

**P. Contract Compliance monitoring**

The Maricopa County Health Care Mandates, Ryan White Title I Program will monitor the Provider's compliance with, and performance under, the terms and conditions of the Contract. On-site visits for contract monitoring may be made by the County and/or its grantor agencies at any time during the Providers normal business hours, announced or unannounced. The Provider will make available for inspection and/or copying by the County, all records and accounts relating to the work performed or the services provided under this Contract.

- Site Visits for compliance monitoring will take place at a minimum of one time per annual grant year, depending on circumstances that may justify more frequent review, *i.e.*, severe compliance issues previously noted.
- Any amounts paid under the Provider agreement that are disallowed, by a Federal or State or Maricopa County audit, will be reimbursed to Maricopa County Health Care Mandates, Ryan White Title I Program. The County will notify the Provider in writing of the disallowance and the required course of action.

### **III. Other Program Policies:**

**A. Provision of Services Outside of the Phoenix EMA (Maricopa and Pinal Counties)**

Title I funded services may only be provided within the Phoenix EMA (Maricopa and Pinal counties). Similarly, all service recipients must be residents of Maricopa or Pinal counties. See Policy No. 3— Guidelines for Documenting Client Residency in the EMA. The Ryan White Title I Program will not approve or reimburse for services provided outside of the EMA. This is to ensure that services are equally accessible to all eligible individuals in Maricopa and Pinal counties.

**B. Services to Persons in the Correctional System**

No services may be provided to persons in the correctional system, except for services related to the transition to community HIV services pending their release. Such services may be provided up to ninety (90) days prior to anticipated release, and only for the planning for and coordination of needed services outside of the correctional health system. All services must be consistent with HRSA policy in this area (see Attachment A-2).

**C. Use of Volunteers, Interns and Other Non-Paid Staff**

Contractors may use volunteers, interns, and other non-paid staff at their discretion; however, services provided by such personnel are not billable via Title I. All units of service must be provided by the staff included in the approved budget. Contractors shall be compensated only for services provided by the staff and the staff classification/positions included or referenced in the approved budget.

**D. Reference of Funding Source – Websites, Print, Electronic Media**

In addition to all printed and electronic media, all website references to agency programs or services funded in whole or in part with Ryan White CARE Title I funds must reference funding source of: “The Ryan White HIV/AIDS Treatment Modernization Act of 2006, United States Department of Health and Human Services, Health Resources and Services Administration and the Maricopa County Department of Health Care Mandates” or “Federal Department of Health and Human Services, Health Resources and Services Administration, the Ryan White CARE Act Amendments of 2000, and the Maricopa County Department of Health Care Mandates.” This reference must be clearly legible and of sufficient size to be easily recognizable.

**E. Program/Events Notices**

All advertisements, flyers, brochures, copies of newspaper/magazine advertisements, and other print media developed to promote Title I funded services must be pre-approved and the final versions must also be sent concurrently to:

The Ryan White Title I Program  
4041 North Central Avenue, Suite 1400  
Phoenix, AZ 85012.

Promotion of the agency’s Ryan White Title I services is mandatory. Section 2607(a)(7)(C) of the Care Act requires that vendors provide a program of outreach to low income individuals with HIV-disease to inform such individuals of services.

- Providers are required to submit, at least annually, a complete and detailed program outreach for each service to be provided by their agency. This includes any flyers, brochures, or any other documents that provide information including, but not limited to location, hours of service, and services provided.
- Providers shall obtain prior written approval regarding such promotional materials from the Maricopa County Department of Health Care Mandates, Ryan White Title I program before such information is released.

**F. Circumstances/Criteria for Notification of Agency Executive Director, CEO and/or Board of Directors**

The Maricopa County Department of Health Care Mandates, Ryan White Title I Program shall, at a minimum, notify the Chair of the contractors’ Board of Directors and the Executive Director of the following:

1. *Increases or decreases to contract values;*
2. *Contract terminations;*
3. *Policy changes and announcements;*
4. *Site visit reports/assessments; and*
5. *Other issues of concern or success impacting the contractual relationship or the quality or appropriateness of services delivered.*

**G. Social/Recreational Activities**

Ryan White funds may not be used for on-site or off-site social/recreational activities.

## **H. Family Support Coordination**

All Family Support Coordination services must clearly be related to the unique nature of families living with HIV. All services must have, and demonstrate, an explicit connection between the service and the goal of strengthening/maintaining the families' health and well being and/or coordinating unique family based needs. Generalized educational or other skills-building courses, events, or gatherings are not allowable unless the criteria can be demonstrated.

Title I funds may be used to support only the HIV-related needs of eligible individuals. All activities must be consistent with this and other contract provisions. It is our expectation that billable services will meet these criteria for minimal time duration and venues as specified as the contract unit.

## **I. Quality Management Requirements**

All Ryan White funded contractors, per joint agreement of the Administrative Agent, the Maricopa County Department of Health Care Mandates, Office of Quality Management (QM), and the Phoenix EMA Ryan White Title I Planning Council are required to implement strategies to ensure the quality of service delivery to Ryan White Title I clients is the highest possible. Providers are required to submit, at least annually, a Quality Plan utilizing the Title I QM Program template. The following elements as required components for all Title I providers' quality management initiatives:

- 1. Provider compliance with Public Health Guidelines and the local Standards of Care as adopted by the Phoenix EMA Planning Council is required. Title I providers are required to develop and implement an agency-specific quality management plan for Title I services. Additionally, providers are to conduct QM projects utilizing the Plan-Do-Check-Act (PDCA) model. Providers are further required to participate in the Quality Management Ad Hoc Advisory Committee as requested by the Administrative Agency.*
- 2. Participation in QM training sponsored by the Ryan White Title I Program is mandatory. Non-participation in these types of events may result in not complying with the Standards of Care training and could result in prompting an Administrative Agency performance monitoring site visit.*
- 3. The Quality Management Office of the Ryan White Title I Program conducts periodic site reviews of providers in the Phoenix EMA. QM site reviews focus upon provider's compliance with the Standards of Care for the service categories established and prioritized by the Planning Council. Provider participation and cooperation in the site review process is contractually required.*
- 4. Annual administration of a survey to each client for each service provided to him/her per that year, consistent with the agreed-upon schedule delineated by the Ryan White Title I Program, Office of Quality Management. Attachment A-3 is a sample survey; all providers must utilize the service form. All surveys are returned to the on-site consumer survey box or mailed to the Title I Office.*
- 5. Maintenance of a comprehensive unduplicated client level database of all eligible clients served and demographic and service measures required and submit this information in the format and frequency as requested by the MCHCM. The MCHCM will make available software and training for the collection of this information.*
- 6. Retain consent-to-serve forms signed by the clients to gain permission to report their data to MCHCM, State and Federal authorized entities and to view their records as a part of site visits and Quality Management review activities.*

**J. Cultural Competency**

Providers will meet any and all federal standards on cultural competency and develop and implement organizational policies that comply with federal standards.

**K. CAREWare**

All Title I Providers are required to utilize CAREWare for client level data reporting. *Please see the attached procedures regarding CAREWare data entry requirements.*

#### **IV. Additional Documents included in Policies and Procedures**

- A. Service Specific Policies for Allowable Services**
- B. CAREWare Policies and Procedures**
- C. CAREWare Financial Reporting Procedures**
- D. CAREWare an VPN Authorization Policies and Procedures**
- E. Monthly Reporting/Billing Forms**
- F. Quality Management Plan**
- G. Cultural Competency Policies and Procedures**
- H. Universal Standards**
- I. Service Specific Standards of Care**
- J. Conditions of Award**

Attachment A: Sample Task Order

**TASK ORDER**

Pursuant to RFP # \_\_\_\_\_, for Ryan White Title I Services

**Date:** \_\_\_\_\_

**Task Order No.:** \_\_\_\_\_

**Description of work:** Provision of services under the Ryan White HIV/AIDS Treatment Modernization Act of 2006, Ryan White Title I Program

**Deliverables:**

- Provide \_\_\_\_\_ (Service Category) services for the Ryan White Title I Program in accordance with the approved Planning Council Definition, applicable Standards, and Maricopa County Health Care Mandates Policies for (Service Category):
  - (Service Category Standards of Care – as attachment \_\_\_\_)
  - (MCHCM Service Category Standards of Care – as attachment \_\_\_\_)
- Conditions of Award – All narratives and reports, as described in Attachment \_\_\_\_ will be due to the Ryan White Title I Program as defined in the Conditions of Award attachment (Attachment \_\_\_\_).

**Dates of Service:** From \_\_\_\_\_ To \_\_\_\_\_

**MARICOPA COUNTY,  
HEALTH CARE MANDATES,  
Ryan White Title I Program**

**Provider:  
(Provider Agency)**

**By:** \_\_\_\_\_

**By:** \_\_\_\_\_

**Program Manager**

**Title:** \_\_\_\_\_

**Attachment B: Statement of No Income**

**Statement of No Income**

**Ryan White Title I Program**

**To Be Completed Only If Unemployed**

I, \_\_\_\_\_ confirm that I do not have income from any of the following  
*(print name)*  
sources: General Assistance, Temporary Aid for Needy Families (TANF), Unemployment Compensation, Workers' Compensation, Social Security Disability Income (SSDI), Supplemental Security Income (SSI), Old-Age, Survivors', and Disability Insurance (OASDI), Veterans Affairs benefits, pension, or employment for which I receive a pay stub or any other source.

I am supporting myself in the following manner:

- I have an income that varies for which I receive no pay stub whatsoever.
- I am homeless and living on the streets or in a shelter.
- I am receiving assistance from family or friends.
- Other \_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Representative (printed name)

\_\_\_\_\_  
Agency

**Attachment C: Intake Form**

Date: \_\_\_\_\_ Agency: \_\_\_\_\_

Name: \_\_\_\_\_

Eligibility Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Eligibility County:  Maricopa  Pinal Date of Birth: \_\_\_\_\_ Gender: M / F Other: \_\_\_\_\_

**Race/Ethnicity:** Check all that apply

<input type="checkbox"/> Hispanic		
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Other
<input type="checkbox"/> Black or African-American	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Pacific Islander

**Risk Factors:** Check all that apply

<input type="checkbox"/> Male who has sex with male(s)	<input type="checkbox"/> Heterosexual contact	<input type="checkbox"/> Receipt of transfusion of blood, blood components, or tissue
<input type="checkbox"/> Injected drug use	<input type="checkbox"/> Perinatal transmission	<input type="checkbox"/> Other
<input type="checkbox"/> Hemophilia/coagulation disorder		

**HIV Related Diagnosis:**

Diagnosis	Date of 1 <sup>st</sup> Diagnosis	State of Diagnosis
<input type="checkbox"/> HIV+		<input type="checkbox"/> In Arizona <input type="checkbox"/> Other State
<input type="checkbox"/> Aids		<input type="checkbox"/> In Arizona <input type="checkbox"/> Other State
<input type="checkbox"/> HIV- /Affected/ Undetermined		<input type="checkbox"/> In Arizona <input type="checkbox"/> Other State
<input type="checkbox"/> Never Tested		

**HIV Related Treatment Status:**

Primary Care Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_

Clinical Review	Test Date	Results
CD4 Count		
Viral Load		

**Primary Source of Medical Insurance:**

<input type="checkbox"/> Private	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid (AHCCCS)
<input type="checkbox"/> Other Public	<input type="checkbox"/> No Insurance	<input type="checkbox"/> Other: _____

**Primary HIV Medical Care is Received at:**

<input type="checkbox"/> Public funded clinic	<input type="checkbox"/> Private Practice Physician	<input type="checkbox"/> Hospital Outpatient Center
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> No primary source of care	<input type="checkbox"/> Other: _____

**Household Information:**

Household Size: \_\_\_\_\_ Annual Household Income: \_\_\_\_\_

**Contact Information:**

Mailing Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_  
 Phone Number(s): \_\_\_\_\_  
 Emergency Contact(s), Name and phone number(s): \_\_\_\_\_

**Attachment D: Release Of Information**

I authorize \_\_\_\_\_ [Insert Agency] to disclose protected health information (PHI) and other information from my records to Maricopa County Healthcare Mandates, Ryan White Title I Program, and any other client authorized Ryan White Title I service for the purpose of intake into a shared data system for demographic, eligibility, and other statistical reporting.

**Specific description of the information to be disclosed:**

The purpose of the disclosure of PHI will be for the exchange of statistical information between the party, provider, and administrative agency for the purposes described below.

**Specific description of the purpose of the disclosure:**

- Intake and maintenance in a shared data system for demographic, eligibility, and other statistical reporting
- Payment of vendor (Agency) for services rendered
- Quality assurance reviews
- Audits of Ryan White Title I services provided

**I authorize the Agency to disclose the following type of information related if required for the purposes listed above:**

- AIDS/HIV and other Communicable Diseases
- Behavioral Health Care/Psychiatric Care/Mental Health Information
- Alcohol and/or Drug Abuse Treatment
- Genetic Testing Information

I understand that I may revoke this authorization at any time, unless the Agency and MCHCM have already relied on my authorization to disclose information. To revoke my authorization, I must submit a written request to:

\_\_\_\_\_  
\_\_\_\_\_  
(Agency)

Unless I revoke this authorization earlier, it will expire in five years.

I understand that MCHCM will maintain the confidentiality of any disclosed information and will use and disclose this information only for the purposes listed above. I understand the matters discussed on this form. I release MCHCM and Agency, its employees, officers and directors, medical staff members, and agents from any legal responsibility of liability for the disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature of Ryan White Title I client  
Authorizing disclosure

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship to Patient or Description of  
Authority

## Attachment E: HAB Letter re EIS and Referrals

HIV/AIDS Bureau

Issue: Early Intervention Services  
Maintaining Appropriate Referral Relationships

Dear Title I Colleagues:

This is the seventh letter in the series of communications from the HIV/AIDS Bureau (HAB), Division of Services Systems (DSS), that addresses changes in the Title I and Title II programs funded under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. On October 20, 2000, former President Clinton signed P.L.106-345, a law to reauthorize the CARE Act, containing provisions that affect all CARE Act programs. Some new requirements will become effective immediately, while others will require longer implementation periods. HAB/DSS will communicate our expectations to you through this series of letters focused on specific issues, as well as through future guidance documents, technical assistance calls, and reports.

This letter provides specific information regarding new requirements described in Section 2604 "Use of Amounts" and Section 2605 "Application." These sections describe the way Ryan White funds can facilitate access to individuals with HIV disease into treatment, by: 1) funding Early Intervention Services (EIS) under Title I and II, and 2) requiring appropriate linkage relationship with key points of entry. The new EIS service category supports efforts to identify and create linkages with key points of entry for individuals newly diagnosed with HIV or those knowledgeable of their HIV status but not in care. The long term impact will be to normalize screening for HIV in diverse social service and health care settings and to help reduce barriers to care for the traditionally underserved by expanding the network of referrals.

Planning activities will be required to make the option available to integrate EIS into the service delivery plan for fiscal year (FY) 2002. The new requirements are explained below, beginning with legislative citations for each, followed by descriptions of HAB/DSS implementation expectations for EIS and for maintaining appropriate referral relationships.

### Legislative Citations

"Section 2604 (42 UDC 300ff-14). USE OF AMOUNTS

(b)(3) EARLY INTERVENTION SERVICES – (A) IN GENERAL – The purpose for which a grant under section 2601 may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services of HIV related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease and counseling and testing sites, health care points of entry specified by eligible area, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships."

"(B) CONDITIONS – With respect to an entity that proposes to provide early intervention services under subparagraph (A), such subparagraph applies only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that

- (i) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and
- (ii) the entity will expend funds pursuant to such subparagraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved."

"Section 2605 [300ff-15]. APPLICATION"

"(a) IN GENERAL To be eligible to receive a grant under section 2601, an eligible area shall prepare and submit to the Secretary an application containing such information as the Secretary shall require, including assurances adequate to ensure-

- (3) that entities within the eligible area that receive funds under a grant under this part will maintain appropriate relationships with entities in the eligible area served that constitute key points of access to the health care system for individuals with HIV disease (including emergency rooms, substance abuse

treatment programs, detoxification programs, adult and juvenile detentions facilities, sexually transmitted disease clinics, HIV disease counseling and testing sites, mental health programs, and homeless shelters) and other entities under section 2604(b)(3) and 2652(a) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their HIV status but not in care.”

### **HAB/DSS Expectations:**

As of FY 2001, EIS is a fundable service category for Title I CARE Act grantees, under certain conditions outlined in the planning process in Section 102, Duties of Councils of the CARE Act. The reauthorized legislation specifies the entities and the conditions under which they may provide EIS. In addition, as of FY 2001, a new Chief Elected Official (CEO) assurance has been added which requires that appropriate relationships be maintained by service providers with points of entry for the purpose of facilitating early intervention. All these requirements are detailed in the following sections.

## **Early Intervention Services (EIS)**

### **Purpose of Title I EIS**

The HAB relied on the Congressional Managers Statement which defines EIS as counseling, test, and referral activities designed to bring HIV positive individuals into the local HIV continuum of care. This definition is similar to that for Title III in Section 2651 of the CARE Act. The goals are to decrease the number of underserved individuals with HIV/AIDS while increasing their access to the local continuum of care by providing:

- Test results that identify HIV status earlier in the progression of the disease;
- Information on living with HIV disease and managing therapeutic regimens;
- Counseling on modifying behaviors that compromise own or other’s health status;
- Referrals to appropriate prevention and risk reduction programs and to primary care or case management for those testing positive; and,
- Referrals to prevention programs for high risk individuals who test negative.

### **Conditions for Providing Title I EIS**

Since several State and Federal programs currently fund an array of EIS, the reauthorized CARE Act is very specific about the conditions under which counseling, testing, and referral activities should take place under Title I. In contracting for Title I EIS, the HAB/DSS expects that those services will be:

- Included in annual Eligible Metropolitan Area (EMA) planning activities;
- Consistent with Centers for Disease Control guidelines for HIV counseling, testing, and referral;
- Consistent with the requirement that post-test counseling place an emphasis on the individual’s responsibility to inform their sex and/or injection drug equipment sharing partners about their status in order to reduce transmission; and
- Inclusive of established referral relationships to be maintained by EIS providers including a mechanism for receiving feedback from health and social support service providers to which clients are referred.

### **Entities That Are Eligible to Provide Title I EIS**

Title I EIS should be designed to expand the settings in which HIV positive individuals are brought into care. Funding EIS should be considered primarily as a mechanism to establish critical and key relationships and linkages between the local Ryan White system of care and points of entry within the EMA. Through contractual relationships between the EMA and community-based access points, HIV-positive clients not in care may be identified and referred into the health care system. These points of entry locations, include, but are not limited to:

- emergency rooms,
- substance abuse treatment programs,
- detoxification programs,
- adult and juvenile detentions facilities,
- STD clinics,
- Federally qualified health centers,
- HIV disease counseling and testing sites,
- mental health programs, and
- homeless shelters:

These entities, along with others referenced in section 2604(b)(3) and 2652(a) should be considered among the pool of applicants for all, or some components of, an EMA's EIS counseling, testing, and referral funding. These include public health departments, Title I, II, and III providers, hemophilia diagnostic and treatment centers, migrant health centers, community health and family planning center, and non-profit private entities that provide comprehensive primary care services to populations at risk of HIV disease.

#### Planning for Early Intervention Services

All EMAs should identify local key points of entry for persons who know their status and are not in care. These are the likely health care access points for traditionally underserved HIV positive individuals. This information should be part of the EMA's Comprehensive Plan to be submitted with the FY 2003 application and should guide the EMA in strategically planning for optimal location and composition of EIS.

Due to the new emphasis on increasing access to care using EIS, the FY 2002 application guidance will require EMAs to discuss the process for considering EIS as a service category as part of their regular planning process for setting priorities and allocations for FY 2002. All EMAs should collect information on current EIS providers in their communities, including those funded by other CARE Act Titles and State and local governments. Using this resource inventory and the points of entry referral information, Planning Councils can identify gaps in services for those not in care and determine how to best fill those gaps, which may include funding an EIS service category. If EIS funding is needed to increase access to care, it should then be integrated into the EMA service delivery implementation plan for FY 2002. Future year funding of Title I EIS should only take place after these planning steps have taken place.

In the coming months, HAB/DSS will provide more specific information regarding Title I EIS, including a conceptual model for EIS. HAB/DSS also will provide further written, telephone communications, and technical assistance to help grantees with EIS planning.

#### Maintaining Appropriate Referral Relationships

The CEO of each EMA must provide assurances with the grant application to the Health Resources and Services Administration in September 2001 related to the maintenance of appropriate relationships by funded entities with key points of entry to facilitate early intervention. Grantees and Planning Councils should engage in discussions regarding the nature of appropriate relationships between funded HIV service providers and should develop referral relationships and linkages between funded providers and the nine key points of entry listed in the legislation, as well as others identified locally.

HAB/DSS will ask for information on how the EMA defines and maintains these relationships as part of the FY 2002 grant application, and in subsequent applications. Relationships should be documented through contract language requiring providers to establish ongoing relationships with the local points of entry. They can be further supported through expansion of the provider network to include funded relationships with local points of entry or regular joint meetings between CARE Act providers and points of entry administrators.

To assist EMAs in determining appropriate relationships, HAB/DSS will provide information on best practices for establishing and maintaining referral linkages based on models currently under development by the Special Projects of National Significance projects. HAB/DSS will monitor grantees to ensure compliance in maintaining appropriate relationship requirements through progress reports, monthly monitoring calls, and site visits.

If you have additional questions, please contact your Project Officer.

Sincerely,

Joseph F. O'Neill, M.D., M.P.H.  
Associate Administrator

**Attachment F: Consumer Satisfaction Survey  
Ryan White Title I Program  
Consumer Satisfaction Survey**

In order to help us serve you better please take a few minutes to let us know whether or not you were satisfied with the services you received today. All responses are completely **CONFIDENTIAL**.

Agency \_\_\_\_\_ Date \_\_\_\_\_

Please check the service you are using. Please ask a staff member if you are unsure.  
(Use a separate form for each service.)

- |  |  |
|--|--|
| <input type="checkbox"/> Medications for HIV                                     | <input type="checkbox"/> Transportation to medical appointments and support services                               |
| <input type="checkbox"/> Doctor visit  | <input type="checkbox"/> Nutritional counseling and vitamins   |
| <input type="checkbox"/> Case Manager (staff who help clients find HIV services) | <input type="checkbox"/> Home care (nursing, cooking, cleaning, etc.)  |
| <input type="checkbox"/> Emergency money paid to doctors for health care         | <input type="checkbox"/> Alternative/Complementary Therapies (naturopathic doctor visit, herbal supplements, etc.) |
| <input type="checkbox"/> Education or information about HIV                      | <input type="checkbox"/> Mental Health Services  |
| <input type="checkbox"/> Legal aid   | <input type="checkbox"/> Outreach Services   |
| <input type="checkbox"/> Interpreting for the hearing impaired                   | <input type="checkbox"/> Substance abuse treatment   |
| <input type="checkbox"/> English interpreting                                    | <input type="checkbox"/> Dentist   |
| <input type="checkbox"/> Counseling or support group                             |  |
| <input type="checkbox"/> Food boxes or group meals                               |  |

*For each question below, check the box which best describes how you feel about the service you received.*

	POOR 	FAIR 	GOOD 	EXCELLENT 	DOES NOT APPLY TO ME
Reaching the agency by phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hours service is available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agency location is good for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	POOR 	FAIR 	GOOD 	EXCELLENT 	DOES NOT APPLY TO ME
Waiting time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am told where I can get other services I need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt respected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand what I need to do next	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This service is useful and meets my needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	POOR 	FAIR 	GOOD 	EXCELLENT 	DOES NOT APPLY TO ME
I believe my care is confidential and private	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to make a complaint about this service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can be seen in an emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff members are polite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel comfortable where I received the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would rate the service I received today as	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My ethnicity is:  
 Hispanic  
 African American  
 Native American  
 White, Not Hispanic  
 Asian  
 Native Hawaiian or  
Asian Pacific Islander

I am:  
 Female  
 Male  
 Transgender

My age is \_\_\_\_\_

I found out that I have HIV from  
a test that I took:  
 In Arizona  
 Outside of Arizona

Other: \_\_\_\_\_

What I liked about this service was: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How I think this service could be improved: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Alternative/Complementary Services  
03/01/2007 – 02/29/2008

**SERVICE DEFINITION:**

Upon written referral by the client's primary health care provider (or substance abuse counselor in the case of referrals for acupuncture associated with substance abuse treatment), provides services related to alternative/complementary therapies, including but not limited to non-RDA supplements such as herbs and other non-vitamin/mineral supplements, chiropractic services, therapeutic massage, acupuncture, hydrotherapy, naturopathic services, hypnotherapy and Naturopathic Medical Doctors (NMD) services. These services must be linked to primary medical care access and retention.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Alternative/Complementary Services (a support service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Alternative/Complementary Services  
03/01/2007 – 02/29/2008

**POLICIES:**

- The funds are intended to provide supplemental treatment for medical needs directed by a HRSA recognized primary care physician.
- Specific written approvals for care, communications of care and treatment plans must be maintained with the primary care physician.
- A scoring scale is used which is driven by funding fluctuations for qualification of service.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited by current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Alternative/Complementary Services  
03/01/2007 – 02/29/2008

**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for alternative/complementary services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that RW Title I is the payer of last resort, i.e. all other funding sources have been exhausted;
- Documented PCP referral, communications, care plan and acuity score within the guidelines as described in the policy.

**ELIGIBLE COSTS AND SERVICES:**

NMD Consultation:

- Provide NMD consultations to eligible clients inclusive of evaluation and treatment using various modalities to improve quality of life and promote retention in primary medical care.

***Client income must be at or below 200% FPL***

*1 unit = 30 minutes*

Supplements:

- Provide non-RDA supplements such as herbs and other non-vitamin/mineral supplements to eligible clients to improve quality of life and promote retention in primary medical care.

***Client income must be at or below 200% FPL***

*1 unit = \$1 value of supplements*



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Case Management Services  
03/01/2007 – 02/29/2008

**SERVICE DEFINITION:**

Provides a range of client-centered services that link clients with primary HIV medical care, psychosocial, and other services to insure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and a linkage that expedites discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic reevaluation and revision of the plan as necessary during the life of the client. Services may include client-specific advocacy. Following the assessment of individual need, advice and assistance in obtaining medical, social, community, legal, financial, benefits counseling and assistance, and other needed services is provided.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Case Management (with components that are both a core and support service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines core medical services (including for co-occurring conditions) as including: outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Case Management Services  
03/01/2007 – 02/29/2008

**POLICIES:**

- The funds are intended to provide case management services to link eligible clients to primary medical care and other support services available that insure continuity of care and increase the likelihood of desired health outcomes.
- Medical case management is the primary service that is considered a core service and involves clinical review and two way communications with medical providers, mental health providers along with coordination of linkage to core services from a comprehensive assessment based on clinical and non-clinical factors that increase the likelihood of desired health outcomes as determined by both the clinical review and client assessment.
- Non-Medical case management is a support service that includes supportive activities that focus on the psychosocial aspects of coordinating services and meeting the needs of the client as determined from the client assessment focusing on increasing the likelihood of desired health outcomes.
- Case management providers will be responsible for the eligibility and payment processing for eligible clients that need emergency financial assistance as defined in the policy and procedures for emergency financial assistance.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited in billing rates to the current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.
- All activities are only billable once an initial face to face assessment has been performed with appropriate eligibility and release of information being attained and recorded in the client chart.
- Transitional Case Management services are only available within 90 days of release and ceases upon the client's initial contact with a traditional case management provider.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Case Management Services  
03/01/2007 – 02/29/2008

**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for case management services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that RW Title I is the payer of last resort, i.e. all other funding sources have been exhausted;

**ELIGIBLE COSTS AND SERVICES:**

**Medical Case Management (Core Service)**

Medical Case Management Assessment:

- Provide face to face comprehensive assessments to eligible clients to determine the care plan that meets the client's needs and the clinical requirements of care. This includes face to face contacts with client, client's representatives and providers on behalf of the client.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*

Other Medical Case Management Assessment:

- Provide non face to face activities that relate to the comprehensive assessment to eligible clients to determine the care plan that meets the needs from the client's needs and the clinical requirements of care. This includes telephone contacts with client, client's representatives and providers on behalf of the client and development of the care plan.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*

Medical Case Management:

- Provide face to face case management to eligible clients to review, coordinate referrals to core services and reevaluate the care plan to maintain a continuity of care focused on the coordination of the client's needs and the clinical requirements of care. This includes face to face contacts with client, client's representatives and providers on behalf of the client.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Case Management Services  
03/01/2007 – 02/29/2008

Other Medical Case Management:

- Provide non face to face case management to eligible clients to review, coordinate referrals to core services and reevaluate the care plan to maintain a continuity of care focused on the coordination of the client's needs and the clinical requirements of care. This includes telephone contacts with client, client's representatives and providers on behalf of the client.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*

RN Case Management:

- Provide face to face nurse case management to eligible clients to review, coordinate referrals to core services and reevaluate the care plan to maintain a continuity of care focused on the coordination of the client's needs and the clinical requirements of care. This includes face to face contacts with client, client's representatives and providers on behalf of the client.

***Services must be performed by a licensed RN***

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*

Other RN Case Management:

- Provide non face to face nurse case management to eligible clients to review, coordinate referrals to core services and reevaluate the care plan to maintain a continuity of care focused on the coordination of the client's needs and the clinical requirements of care. This includes telephone contacts with client, client's representatives and providers on behalf of the client.

***Services must be performed by a licensed RN***

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Case Management Services  
03/01/2007 – 02/29/2008

## **Non Medical Case Management (Support Service)**

### Non Medical Case Management:

- Provide face to face case management to eligible clients to review, coordinate referrals and reevaluate the care plan to maintain a continuity of care focused on the client's psychosocial and/or support services needs. This includes face to face contacts with client, client's representatives and providers on behalf of the client.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*

### Other Non Medical Case Management:

- Provide non face to face case management to eligible clients to review, coordinate referrals and reevaluate the care plan to maintain a continuity of care focused on the client's psychosocial and/or support services needs. This includes telephone contacts with client, client's representatives and providers on behalf of the client.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*

### ECAP Case Management Assessment:

- Provide face to face case management to eligible clients to evaluate financial assistance requests to ensure they meet the requirements for financial assistance and to process payments according to the ECAP policies and procedures. This includes face to face contacts with client, client's representatives and providers/individuals whom financial obligation is due to on behalf of the client.

***Client income must be at or below 300% FPL, Client eligibility for reimbursement is based upon the ECAP policies and procedures***

*1 unit = 15 minutes*

### ECAP Other Case Management Assessment:

- Provide non face to face case management to eligible clients to evaluate financial assistance requests to ensure they meet the requirements for financial assistance and to process payments according to the ECAP policies and procedures. This includes telephone contacts with client, client's representatives and providers/individuals whom financial obligation is due to on behalf of the client.

***Client income must be at or below 300% FPL, Client eligibility for reimbursement is based upon the ECAP policies and procedures***

*1 unit = 15 minutes*



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Case Management Services  
03/01/2007 – 02/29/2008

Transitional Case Management Assessment:

- Provide face to face assessments to currently incarcerated eligible clients to determine the care plan required to maintain a continuity of care focused on the client's needs upon release from the correctional facility. This includes face to face contacts with client, client's representatives and providers on behalf of the client.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*

Other Transitional Case Management Assessment:

- Provide non face to face assessments to currently incarcerated eligible clients to determine the care plan required to maintain a continuity of care focused on the client's needs upon release from the correctional facility. This includes telephone contacts with client, client's representatives and providers on behalf of the client.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*

Transitional Case Management:

- Provide face to face case management to currently incarcerated eligible clients review, coordinate referrals and reevaluate the care plan required to maintain a continuity of care focused on the client's needs upon release from the correctional facility. This includes face to face contacts with client, client's representatives and providers on behalf of the client.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*

Other Transitional Case Management:

- Provide non face to face case management to currently incarcerated eligible clients review, coordinate referrals and reevaluate the care plan required to maintain a continuity of care focused on the client's needs upon release from the correctional facility. This includes telephone contacts with client, client's representatives and providers on behalf of the client.

***Client income must be at or below 300% FPL***

*1 unit = 15 minutes*



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Financial Assistance Program  
03/01/2007 – 02/29/2008

**DEFINITION:**

Provision of short-term payments for portable water purification systems, HIV-related eyeglasses, or medication assistance. These short-term payments must be carefully monitored to assure limited amounts, limited use, and for limited periods of time. Expenditures must be reported under the relevant service category.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Emergency Financial Assistance Services (a support service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

**POLICIES:**

- The funds are not intended as ongoing financial assistance, but are to be used as a limited emergency service and are not an entitlement. For EFAP, case managers must assure the emergency nature of the request and document it as such.
- Applications must be submitted through a Ryan White Title I – IV case manager.
- Under no circumstances may Ryan White Title I funds be used to make direct payments to clients.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited in billing rates to the current AHCCCS reimbursement rates.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Financial Assistance Program  
03/01/2007 – 02/29/2008

- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.
- An estimate of monthly expenditures by each case management provider will be used to provide an initial fund used as the payment source to distribute payments. Billing requests will be used to replenish fund to ensure that no financial burden is placed on providers and to expedite payment requests.

**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for financial assistance, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Have an emergency financial need (EFAP only);
- Risk discontinuation of medical and/or dental services (EFAP only).



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Financial Assistance Program  
03/01/2007 – 02/29/2008

**ELIGIBLE COSTS AND SERVICES:**

Emergency Financial Assistance:

- Prescription medications & co-pays (except for Medicare Part D co-pays)
- Purchase of eyeglasses when the vision problem is a direct result of the HIV infection; not to exceed \$95/patient; there must be a letter from the client's primary care provider confirming this included with the application.
- Water filtration/purification devices either portable filter/pitcher combinations or filters attached to a single water tap. These are limited to one filtration system annually per household.

*Client income must be at or below 200% FPL*

*Maximum assistance available: \$800 per Ryan White fiscal year*

Health Insurance Assistance:

- Public or private health insurance co-pays & deductibles
- Public or private health insurance premiums if the applicant is in eminent danger of having his/her insurance lapse.

*Client income must be at or below 200% FPL*

*Maximum assistance available: \$800 per Ryan White fiscal year*

Dental Financial Assistance:

- Dental insurance co-pays & deductibles and dental care services. Payments may not be made for orthodontics, procedures that are cosmetic in nature and/or procedures which are not necessary to maintain or improve health status.

*Client income must be at or below 300% FPL*

*Maximum assistance available: \$800 per Ryan White fiscal year*



**MARICOPA COUNTY HEALTH CARE MANDATES  
Ryan White Part A Program**

**FINANCIAL ASSISTANCE PROGRAM APPLICATION  
03/01/2007 – 02/29/2008**

APPLICATION DATE: \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_ CASE MANAGER: \_\_\_\_\_

CLIENT URN: \_\_\_\_\_ LAST NAME, FIRST INITIAL: \_\_\_\_\_

URGENT, PLEASE RUSH  HOLD FOR PICK UP

**REQUEST CATEGORY (check only one):**

EFAP	DENTAL	HEALTH INSURANCE
<input type="checkbox"/> RX Payment \$ _____ <input type="checkbox"/> Water Filter <input type="checkbox"/> Eyeglasses	<input type="checkbox"/> \$ _____	<input type="checkbox"/> Premium \$ _____ <input type="checkbox"/> Medical co-pay \$ _____ <input type="checkbox"/> Deductible \$ _____

Client risks discontinuation of medical/dental services if bill is unpaid.  Yes  No

**VENDOR INFORMATION**

Check Payable To: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**TO BE COMPLETED BY APPROPRIATE CASE MANAGEMENT PERSONNEL**

Date Received \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

Denied: \_\_\_\_\_

Hold – Pending Back-up Documents: \_\_\_\_\_

Back-up Documents Received - Date: \_\_\_\_\_

Approved Invoice Number: \_\_\_\_\_ Warrant Number: \_\_\_\_\_

**MONTHLY BUDGET  
(EFA Only)**

APPLICANT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**MONTHLY INCOME:**

Salary or Wages	_____
SSI/SSD	_____
TANF/AFDC	_____
Unemployment	_____
Food Stamps	_____
Veteran's Benefits	_____
Other _____	_____
Other _____	_____
<b>TOTAL HOUSEHOLD MONTHLY INCOME:</b>	<b>=====</b>

**MONTHLY EXPENSES:**

Rent/Mortgage	_____
Electric	_____
Gas	_____
Water/Sewer	_____
Phone/Mobile Phone	_____
Food/Groceries	_____
Transportation	_____
Misc. Personal Expenses	_____
Recreation	_____
Pharmaceuticals	_____
Medical/Dental	_____
Insurance Premiums	_____
Child Care	_____
Other _____	_____
Other _____	_____
Other _____	_____
<b>TOTAL HOUSEHOLD MONTHLY EXPENSES:</b>	<b>=====</b>

**OTHER ASSETS:**

Cash	_____
Savings	_____
Checking	_____
Other _____	_____
<b>TOTAL HOUSEHOLD ASSETS:</b>	<b>=====</b>

I have attached the following documentation to confirm my eligibility for Financial Assistance:

- Proof of Income
- Proof of Maricopa or Pinal County Residency
- Proof HIV Positive Serostatus
- Copy of Invoice, Bill or Client Account Statement to be paid

I, \_\_\_\_\_, certify that the information contained in this application is, to the best of my knowledge, accurate and up-to-date. I further certify that my application for Financial Assistance is consistent with program rules. The only assistance I am requesting is short-term and for medically/dentally-necessary or medically/dentally-recommended services not available from any other entitlement program.

In addition, I understand and agree that Financial Assistance funds are not available under any circumstances to pay collection agents. Similarly, I understand that the Financial Assistance program will not approve payments owed medical and dental providers for overdue or delinquent balances unless I can provide back-up documentation that adequately describes the services that were provided, lists the date(s) when services were performed and details the fees that were charged on a per service encounter basis.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Food Bank/Meals/Nutritional Supplements  
03/01/2007 – 02/29/2008

**SERVICE DEFINITION:**

Provision of food, meals, or nutritional supplements.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Food Services (a support service under the act). The administration of funds must be consistent with Subpart 1 client eligibility criteria and the service category definitions established by the Ryan White Subpart 1 Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

**POLICIES:**

- The funds are not intended as unlimited food services and are to assist the dietary requirements to maintain adequate nutrition designated to assist with the client's HIV-related clinical status as it relates to daily living activities.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited in billing rates to the current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.
- A food box consists of a 15 day supply of nutritionally sound meals.
- A maximum of two food boxes per month per client is allowed.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Food Bank/Meals/Nutritional Supplements  
03/01/2007 – 02/29/2008

**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for food services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that Ryan White Subpart 1 is the payer of last resort, i.e. all other funding sources have been exhausted.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Food Bank/Meals/Nutritional Supplements  
03/01/2007 – 02/29/2008

**ELIGIBLE COSTS AND SERVICES:**

Food Boxes:

- Provide eligible clients with nutritionally sound food boxes in Maricopa County.

***Client income must be at or below 200% FPL***

*1 unit = 1 food box*

Pinal Food Boxes:

- Provide eligible clients with nutritionally sound food boxes in Pinal County.

***Client income must be at or below 200% FPL***

*1 unit = 1 food box*

Congregate Meals:

- Provide eligible clients with nutritionally sound congregate meals in Maricopa County.

***Client income must be at or below 200% FPL***

*1 unit = 1 meal*

Pinal Congregate Meals:

- Provide eligible clients with nutritionally sound congregate meals in Pinal County.

***Client income must be at or below 200% FPL***

*1 unit = 1 meal*

Nutrition Supplements:

- Provide eligible clients vitamin, mineral and caloric supplements.

***Client income must be at or below 200% FPL***

*1 unit = 1 food box*



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Home Health Services  
03/01/2007 – 02/29/2008

**SERVICE DEFINITION:**

Provides therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home-health agency in a home/residential setting in accordance with a written, individualized plan of care established by a client's primary care provider. Component services may also include:

- Durable medical equipment
- Homemaker or home-health aide services and personal care services
- Intravenous and aerosolized drug therapy, including the administration of related prescription drugs
- Routine diagnostic testing administered in the home of the individual
- Appropriate mental health, developmental, and rehabilitation services

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Home Health Services (a core service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines core medical services (including for co-occurring conditions) as including: outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Home Health Services  
03/01/2007 – 02/29/2008

**POLICIES:**

- The funds are not intended as ongoing home health assistance and are to assist with the activities of daily living on an intermittent or episodic basis.
- Applications must be submitted through a Ryan White contracted RN case manager (all Titles).
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited by current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Home Health Services  
03/01/2007 – 02/29/2008

**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for home health services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that RW Title I is the payer of last resort, i.e. all other funding sources have been exhausted.
- The following five conditions must be met:
  - Homebound: The client must be homebound to be eligible for the home care benefit and no other person's living in the home are available to perform the service.
  - Part-Time Need: The client must require services on a part-time, intermittent or episodic basis.
  - Medical Need: There must be a medical reason for a client to receive home health care.
  - Primary skilled services: The client must need at least one primary skilled service: registered nurse (home health and/or case manager), physical therapy, or speech-language therapy.
  - Physician approval: The client's physician must order home care services and approve the plan of care to be provided by the home health agency.
- Reassessment of clients needs at 90 days to insure that the service is still necessary for the activities of daily living.



Maricopa County Health Care Mandates  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Home Health Services  
03/01/2007 – 02/29/2008

**ELIGIBLE COSTS AND SERVICES:**

**HOME HEALTH - PROFESSIONAL**

**Registered Nurse (RN):**

- Their services include assessment of care needs, health care instruction, monitoring medication, wound care, dressing changes, feeding tubes, intravenous therapy, and other health services as ordered by a physician.

***Client income must be at or below 300% FPL***

*Maximum assistance available: 6 months of service without additional approval from the administrative agent's office.*

*1 unit = 15 minutes*

**HOME HEALTH - PARAPROFESSIONAL**

**Home Health Aide:**

- Provide health care services to eligible clients; help with activities of daily living. Work under the supervision of an RN and assist with all personal care: bathing, dressing, ambulatory movement, monitoring of vital signs, plus light housekeeping, meal preparation and laundry, as requested.

***Client income must be at or below 300% FPL***

*Maximum assistance available: 6 months of service without additional approval from the administrative agent's office.*

*1 unit = 15 minutes*

**Home Care Attendant:**

- Provide help with instrumental activities of daily living to eligible clients under the supervision of an RN: prepare simple meals, assist with feeding, do light housekeeping, change bed linen and do laundry. Also shop for groceries, run errands and may, under certain circumstances, accompany or drive clients to and from appointments.

***Client income must be at or below 300% FPL***

*Maximum assistance available: 6 months of service without additional approval from the administrative agent's office.*

*1 unit = 15 minutes*



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**SERVICE DEFINITION:**

Legal services directly necessitated by a person's HIV status including: preparation of Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Treatment Modernization Act of 2006.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Legal Services (a support service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Subpart 1 Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

**POLICIES:**

- The funds are not intended as unlimited legal services and are to assist with legal issues which adversely affect the eligible client's health and other day to day activities that are directly related to the HIV-related clinical status of an individual with HIV/AIDS.
- These services may be delivered via telephone, office visits, home or hospital visits to necessitate completion.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited by current AHCCCS reimbursement rates.



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- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.
- Hotline services are limited to 15% of the total funding for services.
- Legal services may not be used for: accommodation/discrimination, adoption/guardianship, child custody, collections/finance, dissolution of marriage, employment discrimination, incarcerated rights, individual rights or insurance issues.

**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for legal services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that Ryan White Subpart 1 is the payer of last resort, i.e. all other funding sources have been exhausted.

**ELIGIBLE COSTS AND SERVICES:**

Legal Hotline:

- Answer questions and/or concerns to anonymous callers in the area of legal services that are approved for funding under the Ryan White Title I policies in written or telephone communications appropriate to the caller's needs.

*1 unit = 15 minutes*

Bankruptcy Proceedings Assistance:

- To provide legal information, intervention and representation to eligible clients to assist with bankruptcy proceedings directly necessitated by the client's HIV status.

***Client income must be at or below 200% FPL***

*1 unit = 15 minutes*



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Estate Planning Assistance:

- Prepare simple wills, Powers of Attorneys, Do Not Resuscitate orders and other documentation which allows the eligible clients to place in writing their wishes regarding finances, healthcare, end of life issues and financial arrangements for themselves and their minor dependents living with the eligible client when applicable.

***Client income must be at or below 200% FPL***

*1 unit = 15 minutes*

Healthcare Issues Assistance:

- To provide legal information, intervention and representation to eligible clients to ensure access to eligible benefits and address necessity of life issues limited to income continuation related to Social Security Benefits, disability benefits or medical benefits denials for themselves and their minor dependents living with the eligible client when applicable.

***Client income must be at or below 200% FPL***

*1 unit = 15 minutes*

Housing Issues Assistance:

- To provide legal information, intervention and representation to eligible clients to ensure access to eligible benefits and address necessity of life issues limited to housing discrimination, landlord disputes and eviction process matters for themselves and their minor dependents living with the eligible client when applicable.

***Client income must be at or below 200% FPL***

*1 unit = 15 minutes*



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Mental Health Services  
03/01/2007 – 02/29/2008

**SERVICE DEFINITION:**

Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental-health professional who is licensed or authorized within the State, including psychiatrists, psychologists, clinical-nurse specialists, social workers, and counselors.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Mental Health Services (a core service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines core medical services (including for co-occurring conditions) as including: outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services.

**POLICIES:**

- The funds are intended to improve the mental health status of HIV-infected individuals experiencing behavioral health symptoms.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited by current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.



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**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for mental health services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that RW Title I is the payer of last resort, i.e. all other funding sources have been exhausted.



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**ELIGIBLE COSTS AND SERVICES:**

Mental Health Assessment/Screening:

- Screen and complete behavioral health assessments on eligible clients who are experiencing behavioral health symptoms.

***Client income must be at or below 300% FPL***

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*

Mental Health Counseling:

- Provide individual, family or couples counseling sessions to eligible clients who are experiencing behavioral health symptoms.

***Client income must be at or below 300% FPL***

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*

Psychiatric Evaluation:

- Provide psychiatric evaluations to eligible clients to determine diagnosis and need for psychotropic medications.

***Client income must be at or below 300% FPL***

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*

Psychiatric Medication Management:

- Provide medication management follow up to eligible clients to who have been placed on psychotropic medications for management of improved health and any side effects.

***Client income must be at or below 300% FPL***

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*



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Nutrition Counseling Services  
03/01/2007 – 02/29/2008

**SERVICE DEFINITION:**

Provision of nutrition education and/or counseling provided by a licensed/registered dietician or Naturopathic Medical Doctor (NMD), outside of a primary care visit.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Nutritional Counseling Services (with components that are both a core and support service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines core medical services (including for co-occurring conditions) as including: outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.



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**POLICIES:**

- The funds are intended to provide nutritional counseling services to eligible clients with nutritional counseling for the development of nutritional care plans that supplement primary medical care to insure continuity of care and increase the likelihood of desired health outcomes.
- Medical nutrition counseling is required to be performed by a licensed registered dietician and is considered a core service. This service involves clinical review and two way communications with medical and mental health providers from a comprehensive assessment based on clinical and non-clinical factors that increase the likelihood of desired health outcomes.
- Non Medical nutrition counseling may be performed by a Naturopathic Medical Physician (NMD) and is considered a support service. This service involves clinical review and two way communications with medical and mental health providers from a comprehensive assessment based on clinical and non-clinical factors that increase the likelihood of desired health outcomes.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited in billing rates to the current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.



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**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for nutritional counseling services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that RW Title I is the payer of last resort, i.e. all other funding sources have been exhausted;



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**ELIGIBLE COSTS AND SERVICES:**

**Medical Nutrition Counseling (Core Service)**

Medical Nutritional Counseling Assessment:

- Provide comprehensive assessments to eligible clients to determine the nutritional care plan that meets the nutritional requirements that increase the likelihood of desired health outcomes of the client's HIV-related clinical status.

***Must be performed by a licensed registered dietician***

***Client income must be at or below 300% FPL***

*1 unit = 30 minutes*

Medical Nutritional Counseling:

- Provide counseling to eligible clients to review and reevaluate the nutritional care plan that meets the nutritional requirements that increase the likelihood of desired health outcomes of the client's HIV-related clinical status.

***Must be performed by a licensed registered dietician***

***Client income must be at or below 300% FPL***

*1 unit = 30 minutes*

**Non Medical Nutrition Counseling (Support Service)**

Other Nutritional Counseling Assessment:

- Provide comprehensive assessments to eligible clients to determine the nutritional care plan that meets the nutritional requirements that increase the likelihood of desired health outcomes of the client's HIV-related clinical status.

***May be performed by a Naturopathic Medical Physician (NMD)***

***Client income must be at or below 300% FPL***

*1 unit = 30 minutes*

Other Nutritional Counseling:

- Provide counseling to eligible clients to review and reevaluate the nutritional care plan that meets the nutritional requirements that increase the likelihood of desired health outcomes of the client's HIV-related clinical status.

***May be performed by a Naturopathic Medical Physician (NMD)***

***Client income must be at or below 300% FPL***

*1 unit = 30 minutes*



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Oral Health Services  
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**SERVICE DEFINITION:**

Provides for diagnostic, prophylactic, and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Oral Health Care Services (a core service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines core medical services (including for co-occurring conditions) as including: outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services.

**POLICIES:**

- Care for persons with HIV disease should reflect competence and experience in the care and therapeutics known to be effective in the management of dental conditions of persons with HIV infection. Dental providers should educate patients to increase their awareness that good dental health is crucial to overall health.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited by current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.
- Funds may not be used for cosmetic purposes.



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**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for oral health services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that RW Title I is the payer of last resort, i.e. all other funding sources have been exhausted.

**ELIGIBLE COSTS AND SERVICES:**

Direct Dental Services):

- Provide dental services based upon Medicare guidelines for covered services to eligible clients.

***Client income must be at or below 300% FPL***

*1 unit = 1 visit*

Dental Insurance:

- Provide dental insurance coverage to eligible clients.

***Client income must be at or below 300% FPL***

*1 unit = 1 month premium*



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Outreach Services  
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**SERVICE DEFINITION:**

Programs which have as their principal purpose identifying people with HIV disease, particularly those who know their HIV status so that they may become aware of and may be enrolled in ongoing HIV primary care treatment. Outreach activities must be planned and delivered in coordination with State and local HIV-prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessments processes. Activities must be conducted in such a manner as to reach those known to have delayed seeking care. Outreach services should be continually reviewed and evaluated in order to maximize the probability of reaching individuals who do not know their HIV status or know their HIV status but are not actively in treatment. Broad activities that market the availability of health-care services for persons living with HIV are not considered appropriate Title I outreach services (for examples of these activities, please refer to the Ryan White Care Act Title I Manual, HAB Policy Notice 02-01).

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Outreach Services (a support service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

**POLICIES:**

- The funds are intended to ensure that eligible HIV-infected persons gain or maintain access to HIV-related care and treatment.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of



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desired health outcomes related to the HIV-related clinical status of an eligible client.

- All activities performed are limited by current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.
- Street Outreach may not be performed using Internet websites.
- Outreach activities must specifically target high risk populations and may not be broad activities or duplicate current State and local HIV-prevention outreach activities.



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**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for outreach services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;

**ELIGIBLE COSTS AND SERVICES:**

Case Finding:

- Identify an HIV positive individual in Maricopa and Pinal counties that have never accessed care or who failed to maintain care for more than 6 months with proof that the individual has completed an initial primary medical care visit.

*1 unit = 1 case finding*

Follow Up:

- Provide follow-up and follow-along support to clients that have been identified as a case finding to assist them with the continuum of care and linkage to primary medical care after initial case finding medical care visit has occurred.

*1 unit = 15 minutes*

Street Outreach/Brief Contacts:

- Identify venues where Maricopa and Pinal county HIV potentially at risk individuals congregate, facilitate rapport with them, engage them in conversation to determine if they are at risk and seek to link them to primary medical care.

*1 unit = 15 minutes*

Presentations:

- Facilitate presentations to potential at risk individuals to encourage linkage to primary medical care, not to providers of HIV services.

*1 unit = 1 presentation*



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Primary HIV Medical Care  
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**SERVICE DEFINITION:**

Provision of professional, diagnostic, and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or registered nurse in an outpatient, community-based, and/or office-based setting. This includes diagnostic testing, early intervention, 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 and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care. Primary HIV Medical Care includes the provision of care that is consistent with Public Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Primary HIV Medical Care Services (a core service under the act). The administration of funds must be consistent with Subpart A client eligibility criteria.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines core medical services (including for co-occurring conditions) as including: outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services.



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**POLICIES:**

- The funds are intended to provide Primary HIV Medical Services to eligible clients.
- Providers of Primary HIV Medical Services must report to case managers the progress and challenges to be utilized as a link between the case manager and the primary medical provider for the overall care plan developed by the case manager.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited by current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.

**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for primary HIV medical care, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that Ryan White Subpart A is the payer of last resort, i.e. all other funding sources have been exhausted.



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**ELIGIBLE COSTS AND SERVICES:**

Primary Medical Visits:

- Provide Primary medical services, not including labs, diagnostics, specialty services, surgery services.

***Client income must be at or below 300% FPL***

*1 unit = 1 visit*

Laboratory Testing:

- Provide medically necessary laboratory testing and screenings as required by a primary medical provider.

***Client income must be at or below 300% FPL***

*1 unit = 1 laboratory test*

Diagnostic Testing:

- Provide medically necessary diagnostic testing as required by a primary medical provider.

***Client income must be at or below 300% FPL***

*1 unit = 1 diagnostic test*

Specialist Services:

- Provide specialty medical services, not including labs, diagnostics, primary medical care, surgery services.

***Client income must be at or below 300% FPL***

*1 unit = 1 visit*

Surgery Services:

- Provide minor surgically necessary medical services, not including labs, diagnostics, and specialty services and not cosmetic in nature.

***Client income must be at or below 300% FPL***

*1 unit = 1 surgical procedure*



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Psychosocial Support Services  
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**SERVICE DEFINITION:**

Individual and/or group counseling, other than mental-health counseling, provided to clients, family, and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling, or education.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Psychosocial Support Services (a support service under the act). The administration of funds must be consistent with Subpart A client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

**POLICIES:**

- The funds are intended to provide support to eligible clients by addressing psychosocial concerns while promoting good physical and mental health as it relates to maintaining a positive clinic status of an individual with HIV/AIDS.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited by current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.



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**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for psychosocial support services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that RW Title I is the payer of last resort, i.e. all other funding sources have been exhausted.

**ELIGIBLE COSTS AND SERVICES:**

Psychosocial Assessment:

- Screen and complete psychosocial assessments on eligible clients who are experiencing psychosocial health symptoms.

***Client income must be at or below 200% FPL***

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*

Psychosocial Counseling:

- Provide individual counseling sessions to eligible clients who are experiencing psychosocial health symptoms.

***Client income must be at or below 200% FPL***

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*

Psychosocial Groups:

- Provide a variety of support groups to eligible clients depending on identified peer group of the client or the stage of the disease.

***Client income must be at or below 200% FPL***

*1 unit = 1 group session*



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**SERVICE DEFINITION:**

Provision of treatment and/or counseling to address substance abuse issues (including alcohol, legal and illegal drugs), provided in an outpatient or residential health service setting.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Substance Abuse Services (with components that are both a core and support service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Title I Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines core medical services (including for co-occurring conditions) as including: outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

**POLICIES:**

- The funds are intended to provide intensive, comprehensive Outpatient or residential Substance Abuse treatment to HIV-infected individuals with histories of substance abuse.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of



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desired health outcomes related to the HIV-related clinical status of an eligible client.

- All activities performed are limited by current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.
- Residential Substance Abuse Treatment Services are limited by the following:
  - Funds may not be used for inpatient detoxification in a hospital setting
  - If detoxification is offered in a separate licensed setting (other than under an inpatient license), funds may be used for this activity
  - If the residential treatment service is in a facility that primarily provides inpatient medical or psychiatric care, the component providing the drug and/or alcohol treatment must be separately licensed for that purpose

**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for substance abuse services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that RW Title I is the payer of last resort, i.e. all other funding sources have been exhausted.

**ELIGIBLE COSTS AND SERVICES:**

**CORE SERVICES**

**Substance Abuse Assessment:**

- Screen and complete behavioral health assessments on eligible clients who have histories of substance abuse.

***Client income must be at or below 300% FPL***

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*



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Substance Abuse Counseling:

- Provide individual, family or couples counseling sessions to eligible clients who are experiencing behavioral health symptoms.

**Client income must be at or below 300% FPL**

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*

Psychiatric Evaluation:

- Provide psychiatric evaluations to eligible clients to determine diagnosis and need for psychotropic medications.

**Client income must be at or below 300% FPL**

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*

Psychiatric Medication Management:

- Provide medication management follow up to eligible clients to who have been placed on psychotropic medications for management of improved health and any side effects.

**Client income must be at or below 300% FPL**

*1 unit = 1 visit*

*Service Unit Name – Reflects appropriate CPT codes*

**SUPPORT SERVICES**

Residential Substance Abuse Treatment:

- Provide residential abuse treatment programs, including expanded HIV-specific capacity of programs if timely access to treatment is not available.

**Client income must be at or below 300% FPL**

*1 unit = 1 day*



Maricopa County Department of Public Health  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Transportation Services  
03/01/2007 – 02/29/2008

**SERVICE DEFINITION:**

Conveyance of services provided to a client in order to access primary medical care or psychosocial support services. May be provided routinely or on an emergency basis.

**PURPOSE:**

To guide the administration of Ryan White Part A Program's Transportation Services (a support service under the act). The administration of funds must be consistent with Subpart I client eligibility criteria and the service category definitions established by the Ryan White Subpart A Program Planning Council.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes. Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

**POLICIES:**

- The funds are not intended as unlimited transportation services and are to assist with providing transportation to and from the Ryan White Subpart A defined core services and must be documented in the client chart.
- These services may be delivered via public transit services and subcontractors that perform taxi transportation services.
- All communications made on behalf of the client are to be documented in the client chart and must include a date, time, person(s) spoke with and brief summary of what was communicated.
- All activities performed must be directly related to the HIV-related clinical status of an eligible client and documented appropriately in the client chart.
- Appropriate client authorized releases of information must be on file to allow for the proper inter-provider communications needed to increase the likelihood of desired health outcomes related to the HIV-related clinical status of an eligible client.
- All activities performed are limited in billing rates to the current AHCCCS reimbursement rates.
- Specific clinical outcomes (as defined by the MCHCM's Ryan White Title I Office) need to be measured and reported for this service.



Maricopa County Department of Public Health  
Ryan White Part A (aka Title I) Program  
Policy and Procedures  
Transportation Services  
03/01/2007 – 02/29/2008

**CLIENT ELIGIBILITY CRITERIA:**

To be eligible for transportation services, a client must meet all of the following conditions:

- Document HIV positive serostatus;
- Document Maricopa or Pinal county residency;
- Document income within the eligibility guidelines for the service;
- Proof that Ryan White Subpart A is the payer of last resort, i.e. all other funding sources have been exhausted.

**ELIGIBLE COSTS AND SERVICES:**

Public Transit:

- Distribute bus passes (and tickets as appropriate) to eligible clients to facilitate access to Ryan White Subpart A defined core services.

*1 unit = 1 Bus pass*

Maricopa County Taxi Service:

- Provide taxi rides to eligible clients living in Maricopa County to facilitate access to Ryan White Subpart A defined core services.

***Client income must be at or below 200% FPL***

*1 unit = 1 ride*

Pinal County Taxi Service:

- Provide taxi rides to eligible clients living in Pinal County to facilitate access to Ryan White Subpart A defined core services.

***Client income must be at or below 200% FPL***

*1 unit = 1 ride*

Maricopa County  
Health Care Mandates  
Ryan White Part A Program  
CAREWare Policies & Procedures

Maricopa County Health Care Mandates  
CAREWare Policies and Procedures

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Maricopa County  
Centralized CAREWare Policies and Procedures

The following information has been outlined to identify for any centralized CAREWare users within the Phoenix EMA the policies and procedures to be used for entering data within the system. It is full understood that the various fields affect the ability for each provider to communicate properly with clients, to have the ability to maintain an unduplicated client database, to produce the CADR report and to Ryan White grantees. In addition, the data that is entered must comply with standard definitions by either HRSA, state authorities, grantee contracts and policies and procedures. Definitions and information that are available from a HRSA and/or a grantee based policy document will be incorporated into this document.

## General Data Entry Policies

1. Capitalization - All fields are to be entered in an upper/lower case format. The first initial of formal names are to be capitalized unless another format is deemed necessary.
2. Unknown/Unreported – Never change known info to unknown/unreported if valid data exists
3. If you see valid data along with unknown data, please remove the unknown data

## Client Demographic Tab

Client Information			
client, John		Change Log	Client Report
		Delete Client	Find List
		New Search	Close
Demographics   Services   Annual Review   Encounters   Referrals   HIV C&T   Relations   Custom Tab 1   Custom Tab 2   Custom Tab 3   Custom Subform			
First Name: <input type="text" value="John"/> Middle Name: <input type="text"/> Last Name: <input type="text" value="client"/> Date of Birth: <input type="text" value="11/11/1980"/> <input type="checkbox"/> Est?		Ethnicity <input type="radio"/> Hispanic <input checked="" type="radio"/> Non-Hispanic <input type="radio"/> Unknown	
Gender: <input type="text" value="Male"/> Client URN: <input type="text" value="JHCI1111801U"/> Encrypted URN: <input type="text" value="pm4Sswa8i"/>		Race <input checked="" type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian	
Client ID: <input type="text" value="By Provider"/> Address: <input type="text" value="111 Anytown"/> City: <input type="text" value="Phoenix"/> State: <input type="text" value="Arizona"/> Zip Code: <input type="text" value="85001"/> County: <input type="text" value="Maricopa"/> Phone Number: <input type="text"/> <input checked="" type="checkbox"/> Include on label report		Memo: <input type="text" value="Use This for emergency contact, addtl phone numbers and addtl address info"/> <input type="button" value="Case Notes"/>	
HIV Status: <input type="text" value="HIV-positive (AIDS status unknown)"/> HIV+ Date: <input type="text" value="10/4/2005"/> <input type="checkbox"/> Est?		AIDS Date: <input type="text"/> <input type="checkbox"/> Est?	
HIV Risk Factors <input type="checkbox"/> Male who has sex with male(s) <input type="checkbox"/> Heterosexual contact <input type="checkbox"/> Receipt of transfusion of blood, blood components, or tissue <input type="checkbox"/> Injecting Drug Use <input type="checkbox"/> Perinatal Transmission <input type="checkbox"/> Other, specify: <input type="text"/> <input type="checkbox"/> Hemophilia/coagulation disorder <input checked="" type="checkbox"/> Undetermined/unknown, Risk not reported or identified			

## ***Key Fields***

The primary fields used to produce an unduplicated client database within CAREWare are: **First name, Last Name, Date of Birth and Gender.**

## ***Name Fields***

The client's formal name is to be entered in the first, middle and last name fields.

Notes:

- Spelling of the name is to follow the legal format
  - Ex, TeKampe (capitalization of other letters)
  - Ex, O'Connor (use the appropriate capitalization and use of characters)
  - Ex, De La Cruz (use appropriate spacing of name as well)
- Seek clarity of names by verifying with an ID or legal documents
- In the prior version of CAREWare the middle initial was the only thing collected
- The critical fields are the first and last name
- Nicknames/aliases are to be placed in the memo field, see memo field instructions

## ***Date of Birth***

The client's true date of birth, record it from an id card if needed for verification.

Notes:

- The use of estimated birthdates is not allowed
- If you do not have the birth date you will not be able to enter the client into CAREWare

## ***Gender***

The client's self reported gender they identify as.

Notes:

- This is a self reported field
- Unknowns are unacceptable, Must have this information

### **HRSA CADR Reporting Instructions 2006 Page 15**

#### **25. Gender of clients**

Report the actual unduplicated numbers of male, female, and transgender clients (this item should be based on the self-report of the client.

*Transgender* is an individual who exhibits the appearance and behavioral characteristics of the opposite sex and is based on self-report by that individual.

## ***Client URN and Encrypted URN***

These are calculated fields and the URN can be modified to accommodate multiple clients with the same URN and the encrypted URN is an encrypted value for the URN.

Notes:

- First and Third Initials of First name
- First and Third Initials of Last name
- Date of Birth
- Gender – 1 = male, 2=female, 3=transgender, 9=unknown/unreported
- Unique character

## ***Ethnicity/Race***

Indicate if the client is Hispanic or not and then indicate what race(s) the client identifies themselves as

Notes:

- This is a required field, unknown/unreported is not valid
- This is a self report field
- If a client is marked as Hispanic, you do not need to check a race field
- A client that has an unknown Ethnicity and no Race checked will report as unknown/unreported

## **HRSA CADR Reporting Instructions 2006 Page 16**

### **27. Race/Ethnicity of clients**

Report the actual unduplicated number of clients in each racial and ethnic group, based on the self report of the client. All individuals who identify themselves with more than one race should be counted in the “More than one race” category.

The following racial category descriptions, defined in October 1997, are required for all Federal reporting, as mandated by the Office of Management and Budget (For more information go to <http://www.whitehouse.gov/omb/fedreg/2005.html>).

*White (not Hispanic)* is an individual having origins in any of the original peoples of Europe, the Middle East, or North Africa, but not of Hispanic ethnicity.

*Black or African American (not Hispanic)* is an individual having origins in any of the black racial groups of Africa, but not of Hispanic ethnicity.

*Hispanic or Latino(a)* is an individual of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

Maricopa County  
Centralized CAREWare Policies and Procedures

*Asian* is an individual having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

*Native Hawaiian or Other Pacific Islander* is an individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

*American Indian or Alaska Native* is an individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

*Unknown/unreported* is an individual who did not self-report either race or ethnicity.

#### **HRSA CAREWare User Manual 7/16/2006**

For HRSA CADR reporting purposes, Race/Ethnicity needs to be entered for each client. This is self-selected by clients, and your intake forms should reflect these categories.

Many Hispanic clients self-select Hispanic as their ethnicity and do not specify a race. CAREWare will no longer consider this as missing data for CADR purposes. However, if a non-Hispanic client's race is not specified, it will be considered missing data for that individual.

### ***Client ID***

Not Shared

This is a provider specific field that is used to identify clients between multiple systems. Each agency will determine the use of this field.

### ***Address Fields***

Address, City, State, Zip, Include on Label Report

These fields indicate the client's mailing address. The data is to be entered following the USPS guidelines for bulk mail.

Notes:

- If a client has a different eligibility address you will need to record the eligibility address in the memo field, see memo field instructions
- State Field is a drop down list, which is used to build the County Field

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- If the client homeless and does not have a mailing address, enter Homeless in the street address line
- Include on Label Report
  - Will allow you from within CAREWare to run the mailing labels report
  - Is not shared

## **County**

This field indicates the county in which their eligibility address is.

Notes:

- If the client's mailing address and eligibility addresses calculate different County's use the county that matches the eligibility address
- This is not a mailing address field, this is an eligibility field

## **Phone Number**

This field will not be used, each provider will have custom fields setup to capture this information.

Notes:

- DO NOT USE
- Move the phone number and additional contact information to the custom fields' setup for your agency.

## **Memo Field**

This field is to be used only for showing a client's aka/aliases and/or eligibility address information

Notes:

- Recording AKA/Aliases/Nicknames
  - Click into the Memo Field and go to the beginning of the field
    - Type AKA:
    - Immediately following AKA: enter the additional names the client goes by
- Recording Eligibility Address Information
  - Click into the Memo Field and go to the area below the AKA info (if applicable, otherwise you would start at the beginning of the field)
    - Type Eligibility Address:
    - On the next line enter the street address
    - On the next line enter the City State Zip
  - If a client is homeless with a mailing address, indicate in the memo field as homeless
- This is the format for this field
- Any additional information will need to be stored in the Case Notes or in custom fields

## **HIV Status and Diagnosis Dates**

This field is to indicate the current HIV Status of a client and the date(s) that the client was originally diagnosed with the either HIV or AIDS

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Notes:

- Once a client has been diagnosed as AIDS, they must be reported as AIDS
  - The status may change from HIV to AIDS
  - The status can not change from AIDS back to HIV
- The Date fields will become active depending on the HIV Status that is selected
  - Using an estimated date here is fine
  - Be sure to ask the client for the earliest date they were diagnosed

**HRSA CADR Reporting Instructions 2006 Page 18**

**31. HIV/AIDS status**

Report the total number of clients by their HIV/AIDS status at the end of the reporting period. This information is required of primary medical care providers and is requested from all other providers who collect this information.

*HIV-positive, not AIDS* clients have tested positive for and been diagnosed with HIV, but have not advanced to AIDS.

*HIV-positive, AIDS status unknown* clients have tested positive for and been diagnosed with HIV. It is unknown whether or not the client has advanced to AIDS.

*CDC-defined AIDS* clients have advanced to and been diagnosed with CDC-defined AIDS.

*HIV-indeterminate* clients are children under age 2, born to mothers who were HIV-infected, and whose HIV status is not yet definite.

*HIV-negative (affected)* clients have tested negative for HIV and are an affected partner or family member of an individual who is HIV-positive.

*Unknown (affected)* indicates the HIV/AIDS status of the client is unknown and not documented.

**NOTE:** Once a client has been diagnosed with AIDS, s/he is always counted in the CDC-defined AIDS category regardless of disease indicators (i.e., CD4 counts).

***HIV Risk Factor***

This field is to indicate the factor that places the client at risk for disease.

Notes:

- Based upon client's self report
- This is a required field
- Check all that apply

**HRSA CADR Reporting Instructions 2006 Page 24**

**44. HIV exposure category**

Report the number of unduplicated clients in each of the HIV exposure categories.

Individuals with more than one reported mode of exposure to HIV are counted in the exposure category listed first in the hierarchy, except for individuals with a history of both homosexual/bisexual contact and injection drug use. They are counted in a separate category.

*Men who have sex with men (MSM)* cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).

*Injection drug user (IDU)* cases include individuals who report use of drugs intravenously or through skin-popping.

*MSM and IDU* cases include men who report sexual contact with men and use of drugs intravenously or through skin-popping.

*Hemophilia/coagulation disorder* cases include individuals with delayed clotting of the blood.

*Heterosexual contact* cases include individuals who report specific heterosexual contact with an individual with, or at increased risk for, HIV infection (e.g., an injection drug user).

*Receipt of transfusion of blood, blood components, or tissue* cases include transmission through receipt of infected blood or tissue products given for medical care.

*Mother with/at risk for HIV infection (prenatal transmission)* cases includes the transmission of disease from mother to child during pregnancy. This category is exclusively for infants and children infected by mothers who are HIV-positive or at risk.

*Other* indicates the individual's exposure is known, but not listed above.

*Undetermined/unknown, risk not reported or identified* indicates the individual's exposure is unknown or not reported for data collection.

## Service Tab

**Client Information**

client, John Change Log | Client Report | Delete Client | Find List | New Search | Close

Demographics | Services | Annual Review | Encounters | Referrals | HIV C&T | Relations | Custom Tab 1 | Custom Tab 2 | Custom Tab 3 | Custom Subform

Year:  Vital Status:  Deceased Date:  Enrl Status:  Enrl Date:  Case Closed:

Add/Edit Service Details

Date:	Service Name:	Contract:	Units:	Price:	Total:
<input type="text"/>	<input type="text" value="Dental Ins"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Amount Received:  Save  Cancel

Date:	Service Name:	Contract:	Units:	Total:	Received:	Provider:
9/26/2006	Dental Ins	RW Title I	1	\$25.00	\$0.00	ORAL Health Ad...

Service Sharing

### Year

This is drop down list to review either the current year information or prior year information

### Vital Status

This field indicates if the client is alive/deceased/unknown

Notes:

- Should be used to indicate alive or deceased
- Unknown should not be used
- Please use this field carefully as the client will show up as deceased on all providers.

### Deceased Date

This field indicates the date a client was deceased

Notes:

- Enter the best date you know of the client's death

### ***Enroll Status***

Not Shared

This field indicates the client's status within a provider

Notes:

- Choices are
  - Active
  - Inactive/Case Closed
  - Unknown

### ***Enroll Date***

Not Shared

This field indicates the date a client was first enrolled with this provider

Notes:

- This should reflect the 1<sup>st</sup> date a client was seen by this provider
- No services can be entered before this date

### ***Case Closed Date***

Not Shared

This field indicates the date a client was closed with this provider

Notes:

- This will disable you from entering services past the date entered

### **HRSA CAREWare User Manual 7/16/2006**

Services may be entered after a deceased date (for example, when some case management is performed) but not after a case closed date and not before the enrollment date

## Annual Tab

In order to view the annual tab you must have at least one service entry posted for the year you want to view.

Client Information

client, John

Change Log | Client Report | Delete Client | Find List | New Search | Close

Demographics | Services | Annual Review | Encounters | Referrals | Relations | Custom Tab 1 | Custom Tab 2 | Custom Tab 3 | Custom Subform

Annual Year: 2006

Annual | Custom Annual | Quarter 1 (Jan. - Mar.) | Quarter 2 (Apr. - Jun.) | Quarter 3 (Jul. - Sep.) | Quarter 4 (Oct. - Dec.)

Primary Insurance: Medicaid

Household Income: \$10,000.00

Primary HIV Medical Care: Publicly-funded clinic or health

Household Size: 1

Housing/Living Arrangement: Nonpermanently Housed

Poverty Level: 102.00%

Title III

Referred outside of EIS:

Experimental referral within EIS:

Was client counseled about HIV transmission risks?

Who counseled about transmission risks?

### Primary Source of Medical Insurance

This field is to indicate what the client's primary source is for medical Insurance.

Notes:

- Medical Providers this is based upon Third Party Reimbursements
  - This should be the primary insurance at the end of the reporting period or the most recent data available
  - Other providers, based upon client's self report
- This is a required field

### HRSA CADR Reporting Instructions 2006 Page 17

#### 30. Primary source of medical insurance

Report the number of clients receiving each type of medical insurance **at the end of the reporting period**, or the most recent data available for the reporting period.

Select only one form of insurance for each client.

Report the medical insurance that provides the most reimbursement if a client has more than one source

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of insurance. If a client's only means of covering the costs of services is Ryan White CARE Act funds, report the client in the "no insurance" category. Include infants under the age of 2 whose HIV status is indeterminate in the HIVpositive/indeterminate column. Do not include any anonymous clients in these counts.

*Private* includes health insurance plans such as BlueCross/BlueShield, Kaiser Permanente, and Aetna.

*Medicare* is a health insurance program for people ages 65 years and older, people with disabilities under age 65, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

14 2006 Instructions for the CARE Act Data Report  
*Medicaid* is a jointly funded, Federal-State health insurance program for people with low incomes.

*Other public* includes other Federal, State, and/or local government programs providing a broad array of benefits for eligible individuals.

Examples include State-funded insurance plans, military health care (TRICARE), State Children's Insurance Program (SCHIP), Indian Health Services, and Veterans Health Administration.

*No insurance* indicates that the client has no insurance to cover the cost of services (i.e. selfpay).

*Other* indicates that the client has an insurance type other than those listed above.

*Unknown/unreported* indicates that the primary source of medical insurance is unknown and not documented.

What plans fall under the HRSA categories:

Medicaid:

All AHCCCS Plans (including any Dept. Of Developmentally Disabled or DDD and any Long Term Care or LTC plan)

Maricopa County Plans: Phoenix Health Plan

Health Choice AZ

Arizona Physicians IPA (APIPA)

Mercy Care Plan

Maricopa Health Plan (MHP)

First Choice

Indian Health Services (IHS)

Pinal County Plans: Community Connection

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Mercy Care Plan  
Indian Health Services (IHS)

No Insurance: Self-pay; sliding scale programs  
Title I

Private: Blue Cross/Blue Shield  
HealthSelect  
Cigna POS

### ***Primary HIV Medical Care***

This field is to indicate what the client's primary method is for Primary HIV Medical Care

Notes:

- Medical Providers this is based what your institution is categorized as
  - Other providers, based upon client's self report
- This is a required field

Choices are:

Publicly-Funded clinic or health department

Private Practice

Hospital Outpatient Center (McDowell Clinic (MIHS), Phoenix Children's Hospital, Phoenix Indian Medical Center, Veterans Administration)

Emergency Room

No primary source of care

Other (Mountain Park)

Unknown

### ***Annual Household Income/Size***

These fields are used for poverty level calculations

Notes:

- This field is to be based upon income eligibility documents received at intake and re-certification
- These are required fields

\* The Phoenix EMA uses the local standards as defined in the Title I Ryan White Policy and Procedures manual (Page 6). This text is left in the document as a reference, but the local definition applies to the CAREWare fields for household income and household size.

Maricopa County  
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**Client must provide proof of income. Proof of income, with payee's name indicated, includes all of the following types of documentation that apply to client and each member of his/her household (a household consists of the participant, spouse and dependent children less than 18 years of age);**

Check stubs listing gross wages/employer's statement listing gross wages,

Self-employment business records,

Income award letters/grant or educational benefits letter,

Social Security award letters, food stamp, G.A., or AFDC award letters, and /or

Other current documentation showing income or source of assistance received (this may include a latest W-2 [tax] form).

Text from Page 6 of the Title I – Ryan White Policies and Procedures Manual

**HRSA CADR Reporting Instructions 2006 Page 16 and 17**

**28. Annual household income**

Report the annual household income category of the client **at the end of the reporting period**, or report the most recent data available within the reporting period. Income is defined in ranges relative to the Federal poverty guidelines. Include infants under the age of 2, whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

\* *Household* includes all people who occupy a house, an apartment, a mobile home, a group of rooms, or a single room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of related or unrelated people who **share** living arrangements.

\**Household income* is the sum of money received in the previous calendar year by all household members, ages 15 years and older, including household members not related to the householder and people living alone.

Families and individuals are classified as below poverty level if their total family income or unrelated individual income was less than the poverty threshold specified for the applicable family size, age of householder, and number of

Maricopa County  
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related children under 18 present. Poverty status is determined for all families (and, by implication, all family members). For individuals not in families, poverty status is determined by their income in relation to the appropriate poverty threshold. Thus, two unrelated individuals living together may not have the same poverty status. The poverty thresholds are updated each year to reflect changes in the Consumer Price Index. See Poverty Guidelines, Research, and Measurement at <http://aspe.hhs.gov/poverty/>.

**Household income categories:**

*Equal to or below the Federal poverty level* indicates that the client's annual household income is the same as or below the Federal poverty level.

*Within 101–200% of the Federal poverty level* indicates that the client's income is equal to or no more than double the Federal poverty level.

*Within 201–300% of the Federal poverty level* indicates that the client's income is double or no more than triple the Federal poverty level.

*More than 300% of the Federal poverty level* indicates that the client's income is triple or more above the Federal poverty level.

*Unknown/unreported* indicates that the client's income is unknown or was not reported.

## **Housing/Living Arrangement**

This field is to determine the client's homeless status

Notes:

- This field is to be based upon residency eligibility to indicate what type of housing a client resides in as defined below
- This is a required field

### **29. Housing arrangement categories**

Report the number of clients according to their regular place of residence **at the end of the reporting period**, or most recent data available within the reporting period, using the categories defined below. Include infants, under the age of 2 whose HIV status is indeterminate, in the HIV positive/indeterminate column. Do not include any anonymous clients in these counts.

#### **Housing/living arrangements:**

*Permanently housed* includes clients who reside in apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited.

*Non-permanently housed* includes clients who are homeless, as well as those living in transient or transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for living. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program.

*Institution* includes residential, health care, and correctional facilities. Residential facility includes supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses.

*Other* includes other housing/living arrangements not listed above.

*Unknown/unreported* indicates that housing/living arrangements were not reported.

### **Annual Income Formulas**

Due to fluctuations in income and part time employment the following formulas should be used for calculating out annual household income.

Collect income documents for one to three months depending on how much a client's household income fluctuates. A minimum of one month's pay stubs should be attained for all members of the clients household as defined above by the Title I office (based upon a client's tax filing status)

How many pay stubs are needed:

Client is paid:	Number Needed	Number of Pay Periods
Weekly	4	52
Bi-Weekly	2	26
Semi-Monthly	2	24
Monthly	1	12

Formulas:

Note: When calculating income make sure to take into account overtime pay and such. By attaining a months worth of stubs you should be able to see averages.

#### **Weekly Pay**

- 1) Average the 4 pay stubs - Add all the gross pay amounts and divide by 4
- 2) Average Pay from step 1 X 52 = Annual Household Income

#### **Bi-Weekly Pay**

- 1) Average the 2 pay stubs - Add all the gross pay amounts and divide by 2
- 2) Average Pay from step 1 X 26 = Annual Household Income

#### **Semi-Monthly Pay**

- 1) Average the 2 pay stubs - Add all the gross pay amounts and divide by 2
- 2) Average Pay from step 1 X 24 = Annual Household Income

#### **Monthly Pay**

- 1) Monthly pay stub gross pay X 12 = Annual Household Income

NOTE: There are always exceptions to the verification of income, i.e., self employed, seasonal and or commission sales. Seek assistance from other team members for proper calculations. These cases will probably require the collection of three months of documents to average out annual household income.

## GLOSSARY OF CARE ACT DATA REPORT TERMS

### **Active client continuing in program**

An individual who was a client when the period started and continued in the program.

### **Active client new to the program**

A client whose first point of contact with the program occurred during this reporting period.

**ADAP AIDS Drug Assistance Program**—A State-administered program authorized under Title II of the CARE Act that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

### **ADAP Flexibility Policy**

HIV/AIDS Bureau's (HAB) Policy Notice 00-02 provides grantees greater flexibility in the use of ADAP funds and permits expenditures of ADAP funds for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications.

**NOTE:** Grantees *must* request in writing to use ADAP dollars for services other than medications.

### **Administrative or technical support**

The provision of qualitative and responsive “support services” to an organization. Services may include human resources, financial management and administrative services (e.g., property management, warehousing, printing/publications, libraries, claims, medical supplies, and conference/training facilities).

**Affected client** A family member or partner of an infected client who receives at least one Ryan White CARE Act supportive or case management service during the reporting period.

### **Agency reporting for multiple fee-for-service provider**

An agency that reports data for more than one fee-for-service provider.

**Aggregate data** Combined data, composed of multiple elements, often from multiple sources. For example, combining demographic data about clients from all primary care providers in a service area generates aggregate data about client characteristics.

**AIDS Acquired immune deficiency syndrome**—A disease caused by the human immunodeficiency virus.

### **Ambulatory outpatient medical care**

The provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the guidelines published by the Public Health Service. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

### **American Indian or Alaska Native**

An individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

**Anonymous client** No identifying information is collected from the client.

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**APA AIDS Pharmaceutical Assistance**—A local pharmacy assistance program implemented by a Title I EMA or Title II State. The Title II grantee consortium or Title I planning council

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contracts with one or more organizations to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., primary care, case management) to the clients that they serve through a Ryan White (or other funding sources) contract with their grantee. (See **ADAP** and **Local/Consortium Drug Reimbursement Program**)

**ARV Antiretroviral**—A substance that fights against a retrovirus, such as HIV. (See **retrovirus**)

**Asian** An individual having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**Black or African American (not Hispanic)**

An individual having origins in any of the black racial groups of Africa, but not of Hispanic ethnicity.

**Buddy/companion service**

An activity provided by volunteers/peers to assist the client in performing household or personal tasks, and providing mental and social support to combat the negative effects of loneliness and isolation.

**Capacity development**

A set of core competencies that contribute to an organization's ability to develop effective HIV health care services, including the quality, quantity, and cost effectiveness of such services. These competencies also sustain the infrastructure and resource base necessary to develop and support these services. Core competencies include: management of program finances; effective HIV service delivery, including quality assurance; personnel management and board development; resource development, including preparation of grant applications to obtain resources and purchase of supplies/equipment; service evaluation; and cultural competency development.

**CARE Act Ryan White Comprehensive AIDS Resources Emergency Act**—The Federal legislation created to address the health care and service needs of people living with HIV/AIDS (PLWHA) disease and their families in the United States and its Territories. The CARE Act was enacted in 1990 (Pub. L. 101-381), reauthorized in 1996 as the Ryan White CARE Act Amendments of 1996, and reauthorized again in 2000 as the Ryan White CARE Act Amendments of 2000.

**Case management services**

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

**CDC Centers for Disease Control and Prevention**—The DHHS agency that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process, among other programs. The CDC is responsible for monitoring and reporting infectious diseases, administers AIDS surveillance grants, and publishes epidemiologic reports such as the HIV/AIDS Surveillance Report.

**CD4 or CD4+ cells** Also known as "helper" T-cells, these cells are responsible for coordinating much of the immune response. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections.

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**CD4 cell count** The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal range for CD4 cell counts is 500 to 1,500 per cubic millimeter of blood. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm<sup>3</sup>. If the count is lower, testing every 3 months is advised. A CD4 count of 200 or less indicates AIDS.

**CEO *Chief Elected Official***—The official recipient of Title I CARE Act funds within the EMA, usually a city mayor, county executive, or chair of the county board of supervisors. The CEO is ultimately responsible for administering all aspects of the CARE Act in the EMA and ensuring that all legal requirements are met. In EMAs with more than one political jurisdiction, the recipient of Title I CARE Act funds is the CEO of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of people with AIDS in the EMA.

**Child care services** The provision of care for the children of clients who are HIV-positive while the clients are attending medical or other appointments or attending CARE Act-related meetings, groups, or training. This does not include child care while the client is at work.

**Child welfare services**

The provision of family preservation/unification, foster care, parenting education, and other child welfare services. Designed to prevent the break-up of a family and to reunite family members. Foster care assistance places children under age 21, whose parents are unable to care for them, in temporary or permanent homes, and sponsors programs for foster families. Includes other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Involves presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of children who are HIV-positive about risks and complications, caregiving needs, and developmental and emotional needs of children.

**Client** (See **infected client** or **affected client**)

**Client advocacy** The provision of advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and medical treatment follow-ups, as case management does.

**Combination therapy** Two or more drugs or treatments used together to achieve optimum results against HIV infection and/or AIDS. For more information on treatment guidelines, visit <http://www.aidsinfo.nih.gov/guidelines>.

**Co-morbidity** A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.

**Confidential** Information such as name, gender, age, etc., that is collected on the client, and the client is reassured that no identifying information will be shared or passed on to anyone.

**Consortium/HIV Care Consortium**

An association of one or more public, and one or more nonprofit private, health care, and support service providers, people with HIV/AIDS, and community-based organizations operating within areas determined by the State to be most affected by HIV disease. The consortium agrees to use Title II grant assistance to plan, develop, and deliver (directly or through agreement with others) comprehensive outpatient health and support services for individuals with HIV disease. Agencies comprising the consortium are required to have a record of service to populations and sub-populations with HIV.

**Continuum of care** An approach that helps communities plan for, and provide, a full range of emergency and longterm service resources to address the various needs of PLWHA.

**Day or respite care for adults**

Community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of an adult client.

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**DCBP** *Division of Community-Based Programs*—The division within HRSA’s HIV/AIDS Bureau that is responsible for administering Title III, Title IV, and the HIV/AIDS Dental Reimbursement Program.

**Developmental assessment/early intervention services**

The provision of professional early intervention by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. Involves assessment of an infant’s or child’s developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. Includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provides information about access to Head Start services, appropriate educational setting for HIVaffected clients and education/assistance to schools.

**Dispensing of pharmaceuticals**

The provision of prescription drugs to prolong life or prevent deterioration of health.

**DSP** *Division of Science and Policy*—The division within HRSA’s HIV/AIDS Bureau which serves as the principal source of program data collection and evaluation, the development of innovative models of HIV care, and the focal point for coordination of program performance activities and development of policy guidance.

**DSS** *Division of Service Systems*—The division within HRSA’s HIV/AIDS Bureau that is responsible for administering Title I and Title II including the AIDS Drug Assistance Program (ADAP).

**DTTA** *Division of Training and Technical Assistance*—The division within HRSA’s HIV/AIDS Bureau that is responsible for administering the AIDS Education and Training Centers (AETC) Program and technical assistance and training activities of the HIV/AIDS Bureau.

**Dual therapy** The use of two antiretroviral drugs at one time to reduce the amount of detectable HIV.

**Early intervention** (See **HIV/EIS**—*HIV/Early Intervention Services/Primary Care*)

**EIS for Titles I and II** *Early intervention services for Titles I and II* are a combination of services that include outreach, HIV counseling, testing, referral and provision of outpatient medical care and supportive services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care.

**Eligibility criteria** The standards set by a State ADAP, usually through an advisory committee, to determine who receives access to ADAP services. Financial eligibility is usually determined as a percentage of the Federal Poverty Level (FPL), such as 200% FPL. Medical eligibility is most often a positive HIV diagnosis. Eligibility criteria vary among ADAPs.

**EMA** *Eligible Metropolitan Area*—The geographic area eligible to receive Title I CARE Act funds.

The boundaries of the eligible metropolitan area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the CDC. Some EMAs include just one city and others are composed of several cities and/or counties. Some EMAs extend across more than one State.

**Emergency financial assistance**

The provision of short-term payment for essential utilities and for medication assistance when other resources are not available.

**Epidemic** A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

**Exposure category** (See **risk factor**)

**Faith-based organization**

An organization that is owned and operated by a religiously affiliated entity, such as a Catholic hospital.

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**Family centered** A model in which systems of care under Ryan White Title IV are designed to address the needs of PLWHA and affected family members as a unit, by providing or arranging for a full range of

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services. The family structures may range from the traditional, biological family unit to nontraditional family units with partners, significant others, and unrelated caregivers.

**Family members** Includes children, partners, biological parents, adoptive parents, foster parents, grandparents, other caregivers, and siblings (who may or may not be living with HIV).

**Fiscal intermediary services**

Reimbursements received or collected on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts.

**Food bank/home delivered meals**

The provision of actual food, meals, or nutritional supplements. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

**FTE *Full-time equivalent***—A standard measurement of full-time staff (either paid or volunteer), which is based on a 35 to 40 hour work week. It is calculated by taking the sum of all hours worked by staff and dividing by 35 to 40, depending on how your organization defines full-time employment. For example, 2 staff members who work 20 hours each per week represent 1 FTE, assuming full-time employment is defined as 40 hours per week.

**Grantee of record** The official Ryan White CARE Act grantee that receives Federal funding directly from the Federal government (HRSA). This agency may be the same as the provider agency or may be the agency through which the provider agency is subcontracted.

**HAART *Highly active antiretroviral therapy***—An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels.

**HAB *HIV/AIDS Bureau***— The Bureau within the Health Resources and Services Administration (HRSA) of the DHHS that is responsible for administering the Ryan White CARE Act. Within HAB, the Division of Service Systems administers Title I, Title II, and the AIDS Drug Assistance Program (ADAP); the Division of Community-Based Programs administers Title III, Title IV, and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Centers (AETC) Program. The Bureau's Division of Science and Policy administers the SPNS Program, HIV/AIDS evaluation studies, and the CARE Act Data Report.

**Health education/risk reduction**

The provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling, to help clients with HIV improve their health status.

**Hemophilia/coagulation disorder**

Individuals with delayed clotting of the blood.

**Heterosexual contact** Individuals who report specific heterosexual contact with an individual with, or at increased risk

for, HIV infection (e.g., an injection drug user).

**High-risk insurance pool**

A State health insurance program that provides coverage for individuals who are denied coverage due to a pre-existing condition or who have health conditions that would normally prevent them from purchasing coverage in the private market.

**HIP *Health Insurance Program***—a program of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

**Hispanic or Latino/a** An individual of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

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**HIV counseling and testing**

The delivery of HIV counseling to an individual. Counseling includes pretest and posttest counseling activities (e.g., offering the individual the HIV antibody test, as appropriate; services discussing the benefits of testing, including the medical benefits of diagnosing HIV disease in the early stages and of receiving early intervention primary care; reviewing the provisions of laws relating to confidentiality, including information regarding any disclosures that may be authorized under applicable law, and information regarding the availability of anonymous counseling and testing; and discussing the significance of the results, including the potential for developing HIV disease). Testing refers to antibody tests administered by health professionals to ascertain and confirm the presence of HIV infection (includes ELISA and Western Blot). Counseling and testing *does not* include tests to measure the extent of the deficiency in the immune system because these tests are fundamental components of comprehensive primary care. This service category also excludes mental health counseling/therapy, substance abuse counseling/treatment, and psychosocial support services. These services are listed separately.

**HIV disease** Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

**HIV/AIDS status** The outcome of the client's HIV test result, which includes (1) HIV-positive not AIDS—client has tested positive for and been diagnosed with HIV, but has not advanced to AIDS; (2) HIV positive AIDS status unknown—client has tested positive for and been diagnosed with HIV, but it is unknown whether or not the client has advanced to AIDS; (3) CDC-defined AIDS—client has advanced to and been diagnosed with CDC-defined AIDS; (4) HIV-negative (affected)—client is HIV-negative and is an affected individual of an HIV-positive partner or family member; and (5) unknown—HIV/AIDS status of the client is unknown and not documented.

**HIV/EIS HIV/Early Intervention Services/Primary Care**—A program that encompasses the care supported by the Title III legislation and is made available by the grantee organization and its subcontractors. Subcontractors render care to clients referred to them by the grantee organization, and are reimbursed for their services, or otherwise have a remunerative relationship with the grantee for the referred service.

**Home health: Paraprofessional care**

The provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes.

**Home health: professional care**

The provision of services in the home by licensed health care workers such as nurses.

**Home health: specialized care**

The provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.

**Hospital or university-based clinic**

Includes ambulatory/outpatient care/outpatient medical care departments or clinics, emergency rooms, rehabilitation facilities (physical, occupational, speech), hospice programs, substance abuse treatment programs, STD clinics, AIDS clinics, and inpatient case management service programs.

**Household** All people who occupy a house, an apartment, a mobile home, a group of rooms, or a single room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of unrelated people who share living arrangements.

**Household income** The sum of money received in the previous calendar year by all household members 15 years old and over, including household members not related to the householder, people living alone, and others in non-family households.

**Housing assistance** This assistance is limited to short-term or emergency financial assistance to support temporary

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and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of CARE Act funds for short-term or emergency housing must be linked to medical and/or healthcare or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

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**Housing or housing related services**

*Housing related services* includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed.

**HRSA Health Resources and Services Administration**—The DHHS agency that is responsible for directing national health programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA is also responsible for administering the Ryan White CARE Act.

**IDU Injection drug user**—Individuals who report use of drugs intravenously or through skinpopping.

**Inactive client** A client whose status is inactive (as defined by your agency), which includes many possible reasons (e.g., client moved or is lost to follow-up).

**Indeterminate client** A child under the age of 2 whose HIV status is not yet determined, but was born to an HIV infected mother.

**Infected client** An individual who is HIV-positive who receives at least one Ryan White CARE Act-eligible service during the reporting period.

**Inpatient setting** This includes hospitals, emergency rooms and departments, and residential facilities where clients typically receive food and lodging as well as treatments.

**Institution** This includes residential, health care, and correctional facilities. Residential facility includes supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses.

**LTBI** Latent Treatment of Mycobacterium tuberculosis infection (LTBI) prevents the development of active disease and has been an essential component of tuberculosis (TB) control in the United States for several decades.

**Legal services** The provision of services to individuals with respect to powers of attorney, do not resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

**Local county or State health department**

Publicly funded health department administered by a local, county, or State government.

**MAI Minority AIDS Initiative**—A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. This initiative was enacted to address the disproportionate impact of the disease in such communities. It was formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

**Medicaid** A jointly funded, Federal-State health insurance program for certain low-income and needy people.

**Medicare** A health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

**MSM Men who have sex with men**—Men who report sexual contact with other men (i.e., homosexual

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contact) and men who report sexual contact with both men and women (i.e., bisexual contact).  
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**Mental health services**

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

**Monotherapy** The use of only one antiretroviral drug to reduce the amount of detectable HIV.

**More than one race** An individual who identifies with more than one racial category.

**Mother with/at risk for HIV infection (perinatal transmission)**

Transmission of disease from mother to child during pregnancy.

**Native Hawaiian or Other Pacific Islander**

An individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**New clients** Individuals who received services from a provider for the first time ever during this reporting period. Individuals who returned for care after an extended absence are not considered to be new unless past records of their care are not available.

**Non-permanent** Includes individuals who are homeless, as well as transient or in transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for sleeping. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program.

**Nutrition counseling/medical nutrition therapy**

The provision of nutrition education and/or counseling by a licensed registered dietitian outside of a primary care visit. Nutrition counseling/medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

**OI *Opportunistic infection***—An infection or cancer that occurs in individuals with weak immune systems due to AIDS, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus are all examples of opportunistic infections.

**OMB *Office of Management and Budget***—The office within the executive branch of the Federal Government, which prepares the President's annual budget, develops the Federal Government's fiscal program, oversees administration of the budget, and reviews Government regulations.

**Oral health care** Includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

**Other community based service organization**

Includes non-hospital-based organizations, AIDS service and volunteer organizations, private non-profit social service and mental health organizations, hospice programs (home and residential), home health care agencies, rehabilitation programs, substance abuse treatment programs, case management agencies, and mental health care providers.

**Outpatient setting** A hospital, clinic, medical office, or other place where clients receive health care services, but do not stay overnight.

**Outreach services** Programs that have as their principal purpose identification of people with HIV disease so that

they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with

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quantified program reporting that will accommodate local effectiveness evaluation.  
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**Outside the EIS program**

A referral made to a provider that (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Title III grantee or its parent organization.

**Partner Notification** A service provided by a clinician in your program to notify the partner of a client of possible exposure to HIV. (Check State and local laws for specific requirements.) It is not the number of individuals who tested positive for HIV antibodies and offered partners' names for notification, nor is it the number of individuals who came to your program because of a referral by a partner notification service.

**Permanency planning**

The provision of services to help clients/families make decisions about the placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

**Permanent housing** Includes apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited.

**PHSA** *Public Health Service Act.*

**Planning or evaluation**

The systematic collection of information about the characteristics, activities, and outcomes of services or programs to assess the extent to which objectives have been achieved, needed improvements have been identified, and/or decisions about future programming have been made.

**PLWHA coalition** *People living with HIV/AIDS coalition*—Organizations of people living with HIV/AIDS that provide support services to individuals and families infected with and/or affected by HIV and AIDS.

**Primary health care service**

Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client who is HIV-positive. Examples include medical, subspecialty care, dental, nutrition, mental health or substance abuse treatment, and pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; and counseling and testing.

**Private health insurance**

Health insurance plans such as Blue Cross/Shield, Kaiser Permanente, Aetna, etc.

**Private, for-profit ownership**

The organization is owned and operated by a private entity, even though the organization may receive government funding. A privately owned hospital is an example of a private, for-profit organization.

**Private, nonprofit (not faith-based)**

The organization is owned and operated by a private, not-for-profit, non-religious-based entity, such as a non-profit health clinic.

**Prophylaxis** Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has been brought under control (secondary prophylaxis).

**Provider agency/service provider**

The agency that provides direct services to clients (and their families) that are funded by the Ryan White CARE Act. Services may be funded through one or more Federal Ryan White CARE Act grants, or through subcontract(s) with official Ryan White CARE Act grantees. A provider may also be a grantee such as in Titles III and IV.

**Psychosocial support services**

The provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, play, and other rehabilitation therapies), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance

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abuse, or nutrition counseling/medical nutrition therapy that are provided to clients, family and household members, and/or other caregivers and focused on HIV-related problems.

**Public/Federal ownership**

The organization is funded and operated by the Federal Government. An example is a Federal agency.

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**Public/local ownership**

The organization is funded and operated by a local government entity. An example is a city health department.

**Public/State ownership**

The organization is funded and operated by a State government entity. An example is a State health department.

**Publicly funded community health center**

Includes community health centers, migrant health centers, rural health centers, and homeless health care centers.

**Publicly funded community mental health center**

A community-based agency, funded by local, state, or Federal funds, that provides mental health services to low income people.

**Quality management** A systematic process with identified leadership, accountability, and dedicated resources that

uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs should also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change. The process is continuous and should fit within the framework of other program quality assurance and quality improvement activities, such as JCAHO and Medicaid. Data collected as part of this process should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized.

**Referral for health care/supportive services**

The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.

**Referral to clinical research**

The provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research involves studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an IRB that initially approves and periodically reviews the research.

**Referrals for health services**

The act of directing a client who is HIV-positive to a health service not available within an EIS program. For the purposes of Title III data reporting, the process of making a referral is independent of the health service provided, and does not require evidence that the client actually received the service for which he or she was referred. However, if the service that the client is being referred for is paid for by the EIS program, then the cost of providing referral services should be reported. Title III funds can be used to pay for the costs associated with making the referral, as well as to pay for the services for which the client was referred. The referrals reported by Title III programs should be referrals for health services provided outside of the EIS program. Case management and other referrals for social or support services should not be reported in the *Referrals* section, nor should they be factored into the cost of providing referral services. Examples of health services for which clients may be referred outside of the EIS program include primary health care or specialty health services, any diagnostic health services

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such as radiology, lab tests, mental health evaluations, biopsies, and so forth.

**Rehabilitation services**

Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

**Reporting period** A calendar year, January 1 through December 31 of the reporting year. The reporting period may be shorter than a year if a provider agency did not receive CARE Act Title funding for an entire calendar year.

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**Reporting scope** Code 01 is the reporting scope for providers reporting ELIGIBLE services. Under the ELIGIBLE reporting scope, clients receiving any service eligible for Ryan White Title I, II, III, or IV funding are included in the report even if the service was not paid for with Ryan White Title I, II, III, or IV funds. This reporting scope is preferred by HRSA.

Code 02 is the reporting scope for providers reporting FUNDED clients. Under the FUNDED scope, only clients receiving services paid for exclusively with Ryan White I, II, III, or IV funds are included in the report. Typically, this is a subset of the eligible reporting scope. Providers using the funded-only reporting scope must have an adequate mechanism for tracking clients and services by funding stream and have secured prior approval from their grantee in consultation with HRSA.

**Residential or in home hospice care**

Hospice services provided through home-based hospice care, including nursing care, counseling, physician services, and palliative therapeutics to clients in the terminal stages of illness in their home setting. Services provided to clients in the terminal stages of illness in a residential setting, including non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal clients include: room, board, nursing care, counseling, physician services, and palliative therapeutics.

**Retrovirus** A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.

**Risk factor or risk behavior/exposure category**

Behavior or other factor that places an individual at risk for disease. For HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work.

**Section 330 of PHS A** Supports the development and operation of community health centers that provide preventive and primary health care services, supplemental health and support services, and environmental health services to medically underserved areas/populations.

**Self-pay** A client pays out of pocket for the majority of his or her health care costs.

**Solo/group private medical practice**

Includes all health and health-related private non-profit practitioners and practice groups.

**SPNS** *Special Projects of National Significance*—A health services demonstration, research, and evaluation program funded under Part F of the CARE Act. SPNS projects are awarded competitively.

**STI** *Sexually transmitted infection*—Infections spread by the transfer of organisms from person to person during sexual contact.

**Substance abuse treatment center**

An agency that focuses on the delivery of substance abuse treatment services.

**Substance abuse services—outpatient**

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The provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal or illegal drugs) provided in an outpatient setting rendered by a physician or under the supervision of a physician, or other qualified personnel.

**Substance abuse services—residential**

The provision of treatment to address substance abuse (including alcohol and/or legal and illegal drugs) problems provided in an inpatient health service setting (short term).

**Target population** A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

**Taxpayer ID #** The unique nine-digit number issued to an organization or agency by the Internal Revenue Service for use in connection with filing requirements. This may be the same as your Employer Identification Number (EIN).

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**TB skin test (PPD Mantoux)**

The abbreviation for purified protein derivative (PPD), a substance used in intradermal testing for tuberculosis.

**Technical assistance or TA**

The identification of need for and delivery of practical program and technical support to the CARE Act community. TA should assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating CARE Act supported planning and primary care service delivery systems.

**Title I** The part of the Ryan White CARE Act that provides direct financial assistance to designated EMAs that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related: (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals and families with HIV disease; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, when medically appropriate, from inpatient facilities.

**Title II** The part of the Ryan White CARE Act that authorizes the distribution of Federal funds to States and Territories to improve the quality, availability, and organization of health care and support services for individuals with HIV disease and their families. The CARE Act emphasizes that such care and support is part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated. The funds are distributed among States and Territories based, in part, on the number of AIDS cases in each State (or Territory) as a proportion of the number of AIDS cases reported in the entire United States.

**Title III** The part of the Ryan White CARE Act that provides support for early intervention services, including preventive, diagnostic, and therapeutic services for HIV/AIDS clients. This support includes a continuum of comprehensive primary health care, referrals for specialty care, counseling and testing, outreach, case management, and eligibility assistance.

**Title IV** The part of the Ryan White CARE Act that supports coordinated services and access to research for women, infants, children, and youth with HIV disease and their affected family members.

**Title IV Adolescent Initiative**

A separate grant under the Title IV program that is aimed at identifying adolescents who are HIV-positive and enrolling them in care.

**Transgender** An individual who exhibits the appearance and behavioral characteristics of the opposite sex.

**Total client-months** A calculation obtained by adding together the number of months that a premium, deductible, or co-pay was made for each unduplicated client. (e.g., If an agency pays the premiums for Client A's insurance for 12 months and Client B's insurance for 8 months, the total client-months equals 20 months.)

**Transmission category**

A grouping of disease exposure and infection routes. In relation to HIV disease, exposure groupings include injection drug use, men who have sex with men, heterosexual contact,

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perinatal transmission, etc.

**Transportation services**

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

**Treatment adherence services**

Provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

**Unduplicated client count**

An accounting of clients in which a single individual is counted only once. For providers with multiple sites, a client is only counted once, even if he or she receives services at more than one of the providers' sites.

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**URN** *Unique record number*—A nine-digit encrypted record number following HRSA's URN specifications that distinguishes the client from all other clients and that is the same for the client across all provider settings. The URN is constructed using the first letter of the first name, the third letter of the first name (if blank use middle initial, if no middle initial use '9'), first letter of the last name, third letter of the last name (if blank, use '9'), month of birth, day of birth, and gender code. This string is then encrypted using a HRSA-supplied algorithm that can be incorporated into the provider's data collection system.

**VA facility** Any facility funded through the Veterans Administration.

**Viral load test** A test that measures the quantity of HIV RNA in the blood. Results are expressed as the number of copies per milliliter of blood plasma. This test is employed as a predictor of disease progression.

**White (not Hispanic)** An individual having origins in any of the original peoples of Europe, the Middle East, or North Africa, but not of Hispanic ethnicity.

Maricopa County Health Care Mandates  
Ryan White Part A Program  
CAREWare Data Entry and Financial Reporting Procedure

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# Maricopa County Health Care Mandates

## Ryan White Part A Program

### CAREWare Data Entry and Financial Reporting Procedure

CAREWare is a data collection database designed for annual CADR reporting which also can be used as a financial and shared eligibility database. This document serves as the procedure document for data entry into the CAREWare system along with reporting features that are to be used for monthly financial reporting.

## Client Demographics

The screenshot shows the 'Client Information' form for a client named John. The form is divided into several sections:

- Client Information:** Includes fields for First Name (John), Middle Name, Last Name (client), Date of Birth (11/11/1980), Gender (Male), Client URN (JHCIT111801U), and Encrypted URN (pmASewo8i).
- Ethnicity:** Radio buttons for Hispanic, Non-Hispanic (selected), and Unknown.
- Race:** Checkboxes for White (checked), Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and Other.
- Client ID:** Fields for Client ID (By Provider), Address (111 Anytown), City (Phoenix), State (Arizona), Zip Code (85001), County (Maricopa), and Phone Number.
- HIV Status:** A dropdown menu set to 'HIV-positive (AIDS status unknown)', HIV+ Date (10/4/2005), and AIDS Date.
- HIV Risk Factors:** Checkboxes for Male who has sex with male(s), Heterosexual contact, Injuncting Drug Use, Perinatal Transmission, Hemophilia/coagulation disorder, Undetermined/unknown, Risk not reported or identified, and Receipt of transfusion of blood, blood components, or tissue.

### Important Data entry requirements:

First, Middle and Last Name – The name entered here must be the clients' legal name. This ensures against duplicate client records. If a client goes by a nickname, you may enter that in the Memo field.

Client Id – This is a field that is not shared between providers, it is a place to record a client id that matches to an internal system (I.e., POS, Medical Billing, Dental Billing, etc...)

Address, City, State – These fields need to be the client mailing address. If they are eligible due to another address, the eligibility address must be entered in the Memo field.

County – This needs to match the county that the eligibility address is based in.

Ethnicity/Race – You must select one of each category for the client otherwise the client will show up with missing data. (Hispanic selection in the Ethnicity field does not require an entry under race).

HIV Status / HIV Date – Select the proper HIV Status and the date of diagnosis

AIDS Date – Enter the date of diagnosis

RISK Factors – Please select all that apply for the client.

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**Client Information**  
 client, John      Change Log   Client Report   Delete Client   Find List   New Search   Close

Demographics   Services   Annual Review   Encounters   Referrals   HIV C&T   Relations   Custom Tab 1   Custom Tab 2   Custom Tab 3   Custom Subform

Year: 2006   Vital Status: Alive   Deceased Date:   Enrl Status: Active   Enrl Date: 8/29/2006   Case Closed:

Add/Edit Service Details

Date:	Service Name:	Contract:	Units:	Price:	Total:
9/26/2006	Dental Ins	RW Title 1	1	\$25.00	\$25.00

Amount Received   Save   Cancel

Date:	Service Name:	Contract:	Units:	Total:	Received:	Provider:
9/26/2006	Dental Ins	RW Title 1	1	\$25.00	\$0.00	ORAL Health Ad...

Service Sharing      New Service   Edit Service   Delete Service

Vital Status – change this to the appropriate status on a client

Enrl Status – This is the enrollment status for your agency, change this to the appropriate status on a client.

Enrl Date – Enter the date the client enrolled at your agency

Case Closed Date – Enter the date when an enrl status has been marked as closed

Enter the first service in order to enter the appropriate Annual Review data

**Client Information**  
 client, John      Change Log   Client Report   Delete Client   Find List   New Search   Close

Demographics   Services   Annual Review   Encounters   Referrals   Relations   Custom Tab 1   Custom Tab 2   Custom Tab 3   Custom Subform

Annual Year: 2006

Annual   Custom Annual   Quarter 1 (Jan. - Mar.)   Quarter 2 (Apr. - Jun.)   Quarter 3 (Jul. - Sep.)   Quarter 4 (Oct. - Dec.)

Primary Insurance: Medicaid	Household Income: \$10,000.00	<b>Title III</b> Referred outside of EIS: Experimental referral within EIS: Was client counseled about HIV transmission risks? Who counseled about transmission risks?
Primary HIV Medical Care: Publicly-funded clinic or health	Household Size: 1	
Housing/Living Arrangement: Non-permanently housed	Poverty Level: 102.00%	

Primary Insurance – Select from the list

Primary HIV Medical Care – Select from the list

MCDPH – Title I

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Ryan White Part A Program

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Housing/Living Arrangement – Select from the list

Household Income - This is the annual household income for the client

Household Size – The number of people in the household

Poverty Level is calculated for you based upon the information entered for the household

SPECIAL NOTES:

1. If your intake forms do not ask all the proper questions to complete this data, you will need to change them to do so. By not answering any of these required fields will cause reports to contain incomplete data.
2. Never change valid information to unknown/unreported. This data is shared between agencies so although you may not have received the answer to the question does not mean that another provider did not. As you get the questions answered by a client you may remove/change the status from unknown/unreported to the information you received.

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 Ryan White Part A Program  
 CAREWare Data Entry and Financial Reporting Procedure

## Service Entry

Services are entered for every service provided by an employee or subcontractor that represents your agency. The Title I administrative office will assist with the setup of services and contracts at the beginning of each contract year. In addition to services funded by Title I, each agency is required to report any valid Title I services regardless of funding source on the annual CADR report. So you will have a variety of services and contracts setup for data entry.

The screenshot shows the 'Client Information' window for a client named John. The interface includes several tabs: Demographics, Services, Annual Review, Encounters, Referrals, HIV C&T, Relations, Custom Tab 1, Custom Tab 2, Custom Tab 3, and Custom Subform. The 'Services' tab is active, displaying a table for 'Add/Edit Service Details'. The table has columns for Date, Service Name, Contract, Units, Price, Total, Received, and Provider. One entry is visible for the date 9/26/2006, service name 'Dental Ins', contract 'RW Title I', units '1', total '\$25.00', received '\$0.00', and provider 'GRAL Health Ad...'. Below the table are buttons for 'New Service', 'Edit Service', and 'Delete Service'. At the top right of the window are buttons for 'Change Log', 'Client Report', 'Delete Client', 'Find List', 'New Search', and 'Close'.

### Entering Services:

1. Look up client and verify they are eligible
2. Go to the service tab
  - a. Select New Service
    - i. Enter the Date, service provided, contract (funding source), # of units, service billable total and amount received (co-pay).
    - ii. Custom service fields are also available to have data entered, if your agency has that setup, complete them as well.
  - b. Save

### SPECIAL NOTE:

Service data entry is directly related to the amount your agency is going to bill to Title I. These entries must be complete and accurate.

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 CAREWare Data Entry and Financial Reporting Procedure

## Financial Report

**RW CAREWare 4.0 - Financial Report**

**Date Scope:**  
 Domains: ORAL Health Address Refresh

**Date Selection:**  
 Year: [2006] From: [8/1/2006] Through: [8/30/2006]

Funding Source	RW Funded?
Not Currently Funded	No
<b>RW Title I</b>	<b>Yes</b>
RW Title II	Yes
RW Title III	Yes
RW Title IV	Yes
Title IV Youth	Yes
Unspecified	No

Include Subservice Detail  Include Provider Information

From the reports menu select financial report. Highlight the Title I funding source and enter the from and through dates (typically one month). Check the box to include sub service detail.

### SPECIAL NOTE:

This is the key report that must be submitted as your billing report. Effective January 2007 service entries this report must balance for billing to be approved.

## Supplemental Reports

**Custom Reports**

**View/Edit**

**Data Scope:**  
 Show Shared Service Records  
 Show Shared Clinical Records

**Filter by Report Type:** [ ]

**Date Span:**  
 From: [8/1/2006] Through: [8/31/2006]

**Clinical Review Year:** [2006]

Show New Clients Only  Show Specifications  Sum Numeric Fields

Report Name:	Report Type:	Custom/Crosstab:	
Race/Ethnicity	Service	Crosstab	<input type="button" value="Run Report"/>
County	Service	Crosstab	<input type="button" value="New Report"/>
Gender	Service	Crosstab	<input type="button" value="Delete Report"/>
Risk Factor	Service	Crosstab	<input type="button" value="Edit Report"/>
Age Group	Service	Crosstab	<input type="button" value="Copy Report"/>
			<input type="button" value="Close"/>

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Supplemental reports will need run and attached to the financial report as supplemental reports for the reporting period. (Race/Ethnicity, County, Gender/Age, Risk Factors).

Highlight the report, change the from and through date and select run report.

Do this for all five reports.

ALL reports are added as an example

**Financial Report**

Friday, September 01, 2006 through Saturday, September 30, 2006

**Report Criteria**

Provider(s): ORAL Health Address Refresh  
Funding Source: RW Title I  
Group By Providers: True  
Include subservice detail: True

**ORAL Health Address Refresh**

Phone:  
Address:

	Clients:	Units:	Total:	Amount Received:	Not Received:
Oral Health Care					
Dental Ins	1	1	\$25.00	\$0.00	\$25.00
Oral Health Care Totals:	1	1	\$25.00	\$0.00	\$25.00
Provider Total	1	1	\$25.00	\$0.00	\$25.00
ReportTotal	1	1	\$25.00	\$0.00	\$25.00

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County (County by Srv Category)

Data Scope: ORAL Health Address Refresh

County by Srv Category

County:	Row Total:	Percent:	Oral Health Care:	Other support services:
Maricopa	4	100.0	2	2
Total:	4	100.0	2	2

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Gender (Gender by Srv Category)

Data Scope: ORAL Health Address Refresh

Gender by Srv Category

Gender:	Row Total:	Percent:	Oral Health Care:	Other support services:
Female	1	25.0	1	0
Male	3	75.0	1	2
Total:	4	100.0	2	2

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Race/Ethnicity (Race/Ethnicity by Srv Category)

Data Scope: ORAL Health Address Refresh

Race/Ethnicity by Srv Category

Race/Ethnicity:	Row Total:	Percent:	Oral Health Care:	Other support services:
Asian	1	25.0	1	0
Black or African-American	1	25.0	0	1
Hispanic	1	25.0	0	1
White (non-Hispanic)	1	25.0	1	0
Total:	4	100.0	2	2

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Risk Factor (HIV Risk Factor by Srv Category)

Data Scope: ORAL Health Address Refresh

HIV Risk Factor by Srv Category

HIV Risk Factor:	Row Total:	Percent:	Oral Health Care:	Other support services:
Not Specified	4	100.0	2	2
Total:	4	100.0	2	2

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Age Group (AgeGroup by Srv Category)

Data Scope: ORAL Health Address Refresh

AgeGroup by Srv Category

AgeGroup:	Row Total:	Percent:	Oral Health Care:	Other support services:
25 - 44	4	100.0	2	2
Total:	4	100.0	2	2

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Maricopa County Health Care Mandates  
Ryan White Title I Subpart A Program  
CAREWare and VPN Authorization Policies and Procedures

The following information has been outlined to identify the process, forms and policies used for authorization to access CAREWare maintained by the Ryan White Subpart A office.

## Authorization Requirements and Procedure

1. Each user that needs access to CAREWare must be assigned a VPN card and user id along with a CAREWare user id.
2. Complete VPN Request form and User Agreement and fax to the Ryan White Title I Subpart A office at 602-506-6300.
3. Ryan White Title I Subpart A office will process the request to Information Technology for completion of process.
  - a. Notification of Completed request within 72 hours
    - i. MCDPH – IT will email regarding the VPN authorization and policies
    - ii. MCHCM – Admin Office will deliver VPN card device and provide the user with a CAREWare user id and initial password.
4. Software installation and setup is a responsibility of each provider and some assistance may be provided through the Title I office, but most assistance is done through the MCDPH – IT department at 602-506-4357.

### Contact Information:

Dyle Sanderson	Administrative Assistant	602-506-6822
Carmen Batista	Data Management Assistant	602-506-1293
Julie Young	CAREWare Consultant	602-424-1700
Maricopa County	IT Department Help Desk	602-506-4357



# ActivCard & Remote Access Request Registration Form

NOTE: To avoid delay in processing, please complete form in its entirety

STEP 1 - REMOTE ACCESS REQUEST INFORMATION	
DATE:	REQUEST TYPE: <input type="checkbox"/> New Account <input type="checkbox"/> Account Re-Registration <input type="checkbox"/> ActivCard Transfer <input type="checkbox"/> Replacement Card (Previous ActivCard lost, stolen, damaged)
If this is a request to transfer responsibility of an ActivCard to another Client, please provide the name of the former Client and the serial number (S/N #) of the ActivCard being transferred.	
FORMER CLIENT:	Is this request for a vendor (If "No", please skip Step 3): <input type="checkbox"/> Yes <input type="checkbox"/> No  TYPE OF INTERNET ACCESS AVAILABLE: <input type="checkbox"/> High Speed, Broadband, T1, DSL, etc. <input type="checkbox"/> Dial-Up
ACTIVCARD S/N#:	

STEP 2 - CLIENT INFORMATION		
<i>"Client" denotes the specific individual responsible for the use of the ActivCard issued and for whom the remote access account will be created.</i>		
CLIENT'S LAST NAME:	CLIENT'S FIRST NAME:	** DBIT Employee ID #:
CLIENT'S HOME ADDRESS:	CLIENT'S PHONE:	** DEPARTMENT NAME:
CLIENT'S SUPERVISOR'S NAME (PLEASE PRINT):	CLIENT'S SUPERVISOR'S SIGNATURE:	

STEP 3 - VENDOR INFORMATION			
<i>This step needs to be completed if request is for a vendor. If this request is for a regular county employee, go to Step 4.</i>			
VENDOR/COMPANY NAME:	VENDOR CONTACT (For Employment Verification):		VENDOR PHONE (For Employment Verification):
VENDOR/COMPANY ADDRESS:	CITY:	STATE:	ZIP:
COUNTY DEPARTMENT SUPERVISOR'S VENDOR:	COUNTY DEPARTMENT CONTACT:	COUNTY DEPARTMENT CONTACT'S PHONE:	
COUNTY DEPARTMENT CONTACT'S SIGNATURE:			

**STEP 4 - PLEASE FAX, INTEROFFICE MAIL OR DELIVER FORM (PAGE 1 ONLY) TO THE COUNTY DEPARTMENT TELECOM COORDINATOR**

STEP 5 - AUTHORIZATION REQUIRED		
<i>This section needs to be completed by both the County Department Telecom Coordinator and County Department POLAN Manager.</i>		
ZONE ACCESS REQUEST: <input type="checkbox"/> Zone 2 (Secured, IT Security Officer Approval Required) <input type="checkbox"/> Zone 2 (Regular County Network)	BILLING ADDRESS (for telecom approved charges):	LOW CARD (necessary for printer billing):
TELECOM COORDINATOR'S NAME (PLEASE PRINT):	POLAN MANAGER'S NAME (PLEASE PRINT):	
TELECOM COORDINATOR'S SIGNATURE:	POLAN MANAGER'S SIGNATURE:	

**STEP 6 - PLEASE FAX, INTEROFFICE MAIL OR DELIVER FORM (PAGE 1 ONLY) TO: DCIO'S CUSTOMER SUPPORT CENTER - 381 S. 4<sup>TH</sup> AVE, 2<sup>ND</sup> FLOOR, PHOENIX, AZ 85003  
PHONE #: (602)506-4357 FAX #: (602)506-1111**

THIS PORTION TO BE FILLED OUT BY THE OCIO'S CUSTOMER SUPPORT CENTER		
Network Security Officer's Signature (if Required) _____ (Darrell Mills)	ActivCard Serial # _____	Assigned ActivPak Username _____
POLAN Manager/Tools or Telecom Coordinator Notified _____	Date / Time Notified _____	Method of Notification (Phone, Email, in Person, etc) _____
ACTIVCARD PICKED UP BY: Full Name (PLEASE PRINT) _____	Signature _____	Date _____



## Remote Access & ActivCard Procedures For Ryan White Program (Public Health)

NOTE: The Public Health department has purchased 100 ActivCards in collaboration with the Ryan White Program. All ActivCards have been initialized in ActivPak by the OCIO Customer Support Center. There will be a designated custodian for the ActivCards with Ryan White. The designated custodian of the ActivCards will have in his/her possession a hard copy and digital copy of both the Remote Access & ActivCard Registration Form and the instructions to download, install, configure and use the Nortel Contivity VPN Client (which also contains instructions on setting up users' ActivCards).

### SECTION I – Public Health - Ryan White Program

- 1) A client requires an ActivCard to access Maricopa County resources from a remote location.
- 2) Client makes a request to the designated custodian for a Remote Access Account and ActivCard.
- 3) The designated custodian will need to fill out a Remote Access & ActivCard Registration Form for the requesting client.
  - a. If requesting client IS NOT a County employee, then the designated custodian will need to fill out STEP 1 completely. On STEP 2, the designated custodian only needs to fill out the fields that DO NOT have the double asterisks (\*\*). Then fill out STEP 3 completely (designated custodian will be the "County Department Contact". Signature is required to proceed with the request.
  - b. If requesting client IS a County employee, the designated custodian will need to fill out STEP 1 and STEP 2 completely. Signature is required to proceed with request.
- 4) The designated custodian will need to write down the serial number to the ActivCard that will be provided to the requesting client (there is a portion near the bottom of the form that is allotted for the serial number).
- 5) The designated custodian will then need to fax, deliver, or interoffice mail the Remote Access & ActivCard Registration Form to the Public Health PC/LAN or Telecom Coordinator.

### SECTION II – Public Health PC/LAN

- 6) Public Health PC/LAN receives the requesting client's Remote Access & ActivCard Registration Form.
- 7) PC/LAN Tech needs to complete STEP 5 of the Remote Access & ActivCard Registration Form. All necessary signatures are required to proceed with request.
- 8) Form needs to be faxed to the OCIO Customer Support Center @ 602-506-1111.

### SECTION III – OCIO Customer Support Center

- 9) OCIO Customer Support Center receives the completed Remote Access & ActivCard Registration Form.
- 10) A remote access account will be created in ActivPak for the requesting client and the serial number that was provided will be associated with the client's new account. No start-up fee will be required for these accounts as they have already been paid for as a whole.
- 11) OCIO Customer Support Center will add new client to the RAS/VPN spreadsheet, documenting which card they will be utilizing.
- 12) OCIO Customer Support Center will contact the designated custodian and requesting client by email informing them that the requesting client's account has been created. A separate email will be sent to client with a security code for the client to reference in the event they are requesting service from the OCIO Customer Support Center.

**Maricopa County Department of Public Health**  
Ryan White Title I Program  
User Agreement

Agency: \_\_\_\_\_  
User: \_\_\_\_\_

I have received a copy of and agree to comply with the "Maricopa County Acceptable Use For Approved Vendor and Non-County Entity Remote Access Agreement"; and the Maricopa County Policy: "Acceptable Use of County Technology Resources" (#A2609). I understand that my privileges to access CAREWare will be revoked if I violate the provisions of either of these documents.

I understand that my access to the Maricopa County network is offered to me solely to provide me access to the CAREWare centralized database for reporting of client level demographics and service data as required under the Ryan White Title I contract between our agency and the Maricopa County Department of Public Health (MCDPH).

If my Activcard is lost or stolen, I understand that it is my responsibility to notify my direct manager and the Maricopa County IT support. I also understand that my agency may incur replacement charges and understand that I may become responsible for those charges.

I further understand that this Activcard and CAREWare access is for my use only. I agree not to share the passwords with anyone. I agree not to allow any other person to have access under my passwords. I agree to notify my direct supervisor immediately if I become aware that another person has access to my password or has gained unauthorized access to the Maricopa County network.

I agree that my obligations under this Agreement continue indefinitely.

I understand and agree that in the event I breach this agreement, my privileges under this agreement shall be revoked, and that I may be subject to penalties or liabilities under state or federal law or regulations

I will need the following CAREWare access:

- Data Entry                       View Only
- Reporting                         Contract/Service Management
- Agency database administration

\_\_\_\_\_  
User Signature

\_\_\_\_\_  
Date

By signing below, the User's supervisor agrees that the above mentioned CAREWare access is required by the user and agrees to monitor the user's adherence to the terms and conditions of the User Agreement.

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

## MARICOPA COUNTY ACCEPTABLE USE FOR APPROVED VENDOR AND NON-COUNTY ENTITY REMOTE ACCESS AGREEMENT

### A. Purpose

The purpose of this Agreement is to ensure that approved vendors and non-County entities that are granted remote access privileges to the County network use this privilege to support Maricopa County business strategies, individual department goals, and the efficient and effective delivery of services to Maricopa County citizens.

### B. Acceptable Use

Maricopa County computers, Remote Access connections and the IT infrastructure are intended for Maricopa County business purposes only and are to be used solely to carry out the responsibilities associated with performance of County employment or to satisfy specific deliverables as defined in County contracts. Improper use of County-provided resources may result in 1.) suspension of remote access privileges, 2.) permanent removal from the County network, or 3.) other disciplinary action up to and including immediate termination of contract status and initiation of performance penalties. Each individual entity employee granted Remote Access connections will be provided with a personalized Smart Card that may not be shared with any other person. If it is determined that a personalized Smart Card is shared with other individuals, the associated remote access account will be terminated and a formal notification will be sent to the vendor or non-County entity.

### C. Non-Disclosure and Confidentiality

Any information obtained by approved County vendors or non-County entities in the course of doing business with Maricopa County is potentially proprietary and/or confidential. This statement sets forth the County's requirements of the contractor with respect to such information.

The approved County vendor or non-County entity shall establish and maintain procedures and controls that are adequate to assure that no information contained in its records and/or obtained from the County or from others carrying out functions under the contract shall be used by or disclosed by it, its agents, officers, or employees, except as required to efficiently perform duties under the contract. If, at any time during the duration of the contract, the County determines that the procedures and controls in place are not adequate to ensure security, the County vendor or non-County entity shall institute any additional measure requested by the County within 15 days of the written request to do so.

The approved vendor or non-county entity agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the contractor as needed for the performance of duties under the contract, unless otherwise agreed to in writing.

I have read and agree with these conditions as a requirement of doing business with the County, and represent that I am authorized to bind my company or non-county entity to this agreement.

<b>Maricopa County Policy</b> Acceptable Use of County Technology Resources		<b>Number:</b> A2609 Revision: 2
<b>Category:</b> Information Technology – Information Systems		<b>Issued:</b> March 1998
<b>Initiated by:</b> Office of the CIO	<b>Approved by:</b> David Smith	<b>Revised:</b> March 2003

## A. Purpose

The purpose of this policy is to establish general privileges, responsibilities and restrictions in the use of County Technology Resources by County Employees so that the value of these resources is maximized. This policy supports and permits use of County Technology Resources that is consistent with the law, Maricopa County business strategies, individual department goals, contracted deliverables, and the efficient and effective delivery of services to Maricopa County citizens.

## B. Definitions

**Acceptable Use:** a use of County Computing Resources that is authorized and meets County policies.

**Authorized Use:** a use of County Computing Resources that is (1) performed according to those designated duties listed within an employee's job description or as assigned by an employee's supervisor or as necessary to carry out the daily duties of the job; or (2) required by a non-employee working for a vendor to satisfy the services contracted by the County; or (3) required by a nonemployee working for another outside organization under an Inter- Governmental Agreement (IGA) to satisfy the duties or services in the agreement.

**Authorized Users:** all individuals approved to use County Technology Resources. These include County employees (including temporary employees), non-employees providing services or products to the County (e.g. suppliers on contract) and/or non-employees who are given access to County data (e.g. suppliers on contract or outside organizations with IGA's).

**County Technology Resource (County Computing Resource):** any computing device, peripheral, software, information technology (IT) infrastructure, electronic data or related consumable (e.g. paper, disk space, central processor time, network bandwidth) owned or controlled by the County.

**Department Head:** the Elected Official, Presiding Judge, or Appointed Department Director serving as the responsible party for conducting business on behalf of the County.

**IT Infrastructure:** in the context of this policy, includes local and wide area networks (LAN and WAN), communications equipment, hardware (including FAX and telephones), communications software (including the Internet, Intranet, and bulletin board access software), and VPN and/or RAS capabilities for remote access and data distribution.

**Improper Use:** use of County Computing Resources for illegal, inappropriate, obscene, political, or personal gain purposes. Illegal activity is defined as a violation of local, state, and/or federal laws. Inappropriate use is defined as a violation of the intended use of the IT Infrastructure and County Computing Resources and/or purpose and goal. Obscene activity is defined as a violation of generally accepted social standards for use of a publicly owned and operated communications vehicle.

**Network:** a System of interconnected County Technology Resources designed to facilitate the sharing of devices and information among local and remote electronic systems used by authorized users.

<b>Maricopa County Policy</b> <b>Acceptable Use of County Technology Resources</b>	<b>Number: A2609</b> <b>Revision: 2</b>
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### C. Policy

Maricopa County Technology Resources are intended to be used for Maricopa County business purposes and are to be used to carry out the responsibilities associated with performance of County employment, County awarded contracts, or approved IGAs. Limited use of County Computing Resources for personal needs is permitted as long as such use is consistent with established County and department policy, and does not inhibit either governmental or administrative use.

Authorized users shall not use County Computing Resources for illegal, inappropriate, or obscene purposes, or in support of such activities. Use of County Technology Resources for political or personal gain is also prohibited.

The County may restrict the use of specific County Computing Resources through additional policies and standards. Individual departments within the County may further restrict the use of their County Computing Resources through their own supplemental department policies, standards, guidelines and procedures.

All use of County Technology Resources for electronic communication must present Maricopa County in a manner that preserves the County's good reputation and high standards of professionalism. Any electronic communication that constitutes a significant representation of Maricopa County to the Public, must be approved by the appropriate County Department Head or their designee. Consequently, any electronic communication discovered on a County site that is deemed inappropriate and/or has not been approved will be disconnected, with any incurred charges billed to the owning department. Alternatively, the owning department's web site may be disconnected from the County site until compliance is achieved.

Distribution and retention of any information accessed through County Computing Resources must follow County policy, Public Record Laws, and all state and federal regulatory requirements.

Improper use of County Technology Resources or any violation of this policy may result in disciplinary action up to and including termination of employment or contract status. Unacceptable usage is just cause for taking disciplinary action, suspension or reduction of computer privileges, revoking networking privileges, initiating legal action (civil or criminal), or notifying the appropriate authorities for further action.

The County shall have software and systems in place that monitor and record computer usage. Every computer site visited, including on the Internet/Intranet or email system, must be traced back to the originator. The County is able and reserves the right to monitor all traffic on the network, including but not limited to Internet/Intranet and email use, at any time, without prior notice or warning to the user. Anyone using County Computing Resources has no expectation of privacy in the use of these tools or any content therein.

Examples of Unacceptable Use: (The following provides some examples of, improper uses of County Computing Resources. Improper use of County Computing Resources is not limited to these examples.)

- Pursues illegal activities such as anti-trust or libel/slander.
- Violates copyrights (institutional or individual) or other contracts (license agreements). (e.g. downloading or copying of data or software or music that is not authorized or licensed).

<b>Maricopa County Policy</b> <b>Acceptable Use of County Technology Resources</b>	<b>Number: A2609</b> <b>Revision: 2</b>
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- Knowingly, or with willful disregard, initiates activities that disrupt or degrade network or system performance, or that crashes the network or other systems or that wastefully uses the finite County Computing Resources.
- Uses the County Computing Resources for fraudulent purposes.
- Performs gambling activities or other illegal schemes (e.g. pyramid, chain letters, etc.).
- Steals intellectual property, data or County Computing Resources.
- Misrepresents another user's identification (forges or acts as), or gains or seeks to gain nonauthorized access to another user's account/data or the passwords of other users, or vandalizes another user's data.
- Views, retrieves, saves, or prints text or images of a sexual nature or containing sexual innuendo (e.g. accessing adult oriented sites or information via the Internet/Intranet).
- Invades systems, accounts, and networks to obtain non-authorized access to and/or to do damage (hacking). This includes non-authorized scans, probes, or system entries.
- Intentionally intercepts and modifies the content of a message or file originating from or belonging to another person or computer with the intent to deceive or further pursue other illegal or improper activities.
- Knowingly or with willful disregard propagates destructive programs into County Computing Resources (e.g., worms, viruses, parasites, trojan horses, malicious code, email bombs, etc.).
- Uses County Computing Resources to conduct commercial or private business transactions, or supports a commercial/private business other than County business (e.g. using fax machines or telephones to further an employee's commercial/private business endeavors).
- Promotes fundraising or advertising of non-County organizations that have not been pre-approved.
- Generates or possesses material that is considered harassing, obscene, profane, intimidating or threatening, defamatory to a person or class of persons, or otherwise inappropriate or unlawful including such material that is intended only as a joke or for amusement purposes.
- Discloses protected County data (confidential, private, or best interest) via County Computing Resources without proper authority.
- Fails to comply with the instructions from appropriate County staff to discontinue activities that threaten the operation or integrity of County Computing Resources, or are deemed inappropriate, or otherwise violate this policy.

#### **D. Authority and Responsibilities:**

##### All Authorized Users:

- Are responsible for understanding and adhering to this policy.
- Should understand that any login to or access of any County Computing Resources constitutes their acknowledgement and acceptance of all County IT related policies.
- Must sign and submit an Acceptable Use Acknowledgement Form.

<b>Maricopa County Policy</b> <b>Acceptable Use of County Technology Resources</b>	<b>Number: A2609</b> <b>Revision: 2</b>
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- Must declare their identity and declare their affiliation with Maricopa County whenever County Computing Resources are used.
- Should understand that using County-provided equipment and software has no expectation of privacy in the use of these tools or any content therein.
- Are required to keep all electronic communications professional and follow established policies regarding workplace professionalism.
- Are responsible to protect and secure their County Computing Resources from non-authorized or improper use.
- Are responsible for following and adhering to the "use" restrictions of any external organization that they access or interface with.
- Who encounter or receive any material that violates this policy must immediately report the incident to the employee's supervisor and notify the sender that such communication is prohibited under County policy.
- Believing that any of their accounts have been tampered with in any way, are responsible for contacting their PC/LAN Manager or designee via the most expedient means possible.

#### The County (Department Heads):

- Shall monitor departmental use of its own County Computing Resources, at any time, without prior notice or warning to any user of its County Computing Resources.
- May investigate excessive network traffic or bandwidth usage (high browser use or message volume) for improper use of Maricopa County Technology Resources.
- May request access to email, Internet/Intranet and/or other County Technology Resource usage information for their organization at any time to ensure compliance with this policy (request must be made by Elected Officials, Presiding Judge, or Appointed Department Directors).
- Are responsible for identifying the authorized users of County Technology Resources.
- Are responsible to ensure compliance with this policy.
- Are responsible for initiating the approved County "Acceptable Use" banner for all their entry points into County Computing Resources (see approved County Acceptable Use Banner that includes a link to this policy – A2609).
- Are responsible for defining approved agency business and network utilization practices.
- Are responsible for providing acceptable use training to their employees.
- Shall notify the Office of the Chief Information Officer (OCIO), Internal Audit (IA), and the Network Security Officer (NSO) of any suspected violation of this policy upon discovery.
- Shall initiate the appropriate disciplinary action to respond to violations of this policy.

#### The Office of the Chief Information Officer:

- Will coordinate requests for technology usage information that involves enterprise servers or enterprise application services or non-employees.
- Will facilitate, if appropriate, the utilization of external resources including civil or criminal investigators to examine suspected violations (unless the department has its own email system).
- Will review this policy on an annual basis with IA and NSO.

#### The Network Security Officer:

- Will coordinate with all departments on the development of their own internal policies, standards, guidelines and procedures for acceptable use.
- Will coordinate with all County IT departments to insure that they have software and systems in place that can monitor, record and report computer usage.
- Will develop standards, guidelines and procedures to support this policy.
- Will develop training and orientation materials for all employees, suppliers, and other parties who use County Technology Resources.
- Will report to executive management on acceptable use.

<b>Maricopa County Policy</b> Acceptable Use of County Technology Resources	<b>Number: A2609</b> Revision: 2
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**Internal Audit:**

- Will evaluate departmental policies, standards, guidelines and procedures on acceptable use.
- Will establish criteria and procedures for auditing acceptable use.
- Will perform periodic annual audits on acceptable use.

**E. Related Documents:**

- Refer to Procedure – N/A
- Refer to Standard – N/A
- Refer to Guideline – N/A



Maricopa County Health Care Mandates  
Ryan White Comprehensive AIDS Resource Emergency CARE Act, Title I  
Monthly Fiscal and Program Monitoring Report

**Contractor:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Program Category:** \_\_\_\_\_

**Contract Number:** \_\_\_\_\_ **Contract Amount:** \_\_\_\_\_

**Reporting Month:** \_\_\_\_\_ **Billing Amount:** \_\_\_\_\_  
(Month/Year)

**Prepared by:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

One (1) signed original of this report must be filled out completely and submitted within 15 days after the end of the reporting month to:

Part A Program Reports  
Maricopa County Health Care Mandates  
Ryan White Title I Program  
4041 North Central Avenue, Suite 1400  
Phoenix, Arizona 85012

The undersigned hereby certifies to the Maricopa County Health Care Mandates that the following includes a true and correct statement of the amount due; that the following amount is due; that the following is a true and correct list of all subcontractors who have employed laborers and/or used materials and/or supplies for work performed; and that the following is a true and correct statement of service delivery and program activity. The undersigned has read the foregoing statement and knows the content thereof; the same is true to his/her own knowledge.

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Approved:** \_\_\_\_\_ **Not Approved:** \_\_\_\_\_ **Reason:** \_\_\_\_\_ **By:** \_\_\_\_\_

## **RYAN WHITE CARE SERVICES PROGRAM NARRATIVE REPORT FORMAT**

The program narrative is to address goals and objectives relating to Part A-funded services **only**. The report must address the following topics:

### **Program Accomplishments and Achievements**

Provide details. Relate narrative to goals and objectives as articulated in the contract work statement. It should also focus more heavily on those activities relating to direct client services rather than on lesser goals such as staff training, establishing linkage agreements, occupying new space, installing a new telephone system, etc.

Provide statistical back-up. A statement indicating "increased behavioral health referrals" lacks sufficient detail. Rather, the report should specify, "Behavioral health referrals have increased by 25% in the last quarter. The agency has been averaging 25 referrals per month for the last 3 months, up from an average of 20 referrals per month previously."

Elaborate on client participation in the program. If, for example, the program runs support groups, indicate the number of individuals attending the group each week.

*Do not report on overall agency performance and/or administrative activities. Grant writing and/or other fundraising activities; Bidder's Conferences; or Contract meetings are not suitable topics for inclusion in this report.*

### **Barriers and Obstacles to Meeting Program Goals/Objectives**

Be specific. Describe in detail any problems the program is experiencing in meeting service delivery targets.

### **Plan for Overcoming Obstacles**

A corrective action plan to remedy barriers must be developed. The plan is to be time specific, listing deadlines for implementation.

### **Technical Assistance Needs**

Identify any special training and/or assistance which facilitate the program's ability to meet stated goals and objectives.

### **Relationship to Other AIDS Services Programs**

In instances where a program is funded by multiple revenue streams (i.e., HOPWA, private funds) please address how service provision of the Title I component of the program relates to those activities funded by the other sources.

Similarly, if you have entered into a collaborative agreement with another agency to deliver services, please comment on the successes and/or obstacles encountered as a result of the collaboration.

### **Plans for Upcoming Reporting Period**

Discuss goals and objectives and problems anticipated any time in the near and/or distant future.

### **Addendum**

Attach copies of significant correspondence, brochures, advertisements, posters, linkage agreements, subcontracts, forms, newly-developed policies and procedures, specifically relating to your Part A-funded program during the reporting period.

Maricopa County Health Care Mandates  
Ryan White Part A Program  
CAREWare Financial and Supplemental Billing Reports

## Financial Reporting Notes

You are required to report all client level data in the Central CAREWare database implemented and maintained by the Ryan White Part A program managed under Maricopa County Health Care Mandates.

1. I am not sure how to go about balancing to CAREware
  - Contact Julie Young to get technical assistance
  - Get feedback from your internal financial person to assist
2. What do we do if unknown/unreported categories show on the crosstab reports?
  - Use the custom reports to create a report to find those clients and correct them.
  - Contact Julie Young if you need help creating a custom report
  - Determine if those are valid and then make sure you discuss this in the narrative portion of the billing packet.
  - Unknown/unreported data will not be acceptable for fields that determine eligibility, if you did not collect this data those activities are not eligible for reimbursement.
3. What will cause our billing packet to be rejected and not processed for payment?
  - If the financial report that is run within the Title I office does not match to the report you submitted
  - If you do not include all the appropriate documents in the billing packet
  - If you have unknown/unreported categories and have no explanation for it in your narrative report

Maricopa County Health Care Mandates  
 Ryan White Part A Program  
 CAREWare Financial and Supplemental Billing Reports

## Financial Report

**SPECIAL NOTE:**

This is the key report that must be submitted as your billing report. Effective January 2007 service entries in this report must balance for billing to be approved.

The total for the service category needs to match the total listed under billing amount on the Cover page.

**Financial Report**

Friday, September 01, 2006 through Saturday, September 30, 2006

**Report Criteria**

Provider(s): ORAL Health Address Refresh  
 Funding Source: RW Title I  
 Group By Providers: True  
 Include subservice detail: True

**ORAL Health Address Refresh**

Phone:  
Address:

	Clients:	Units:	Total:	Amount Received:	Not Received:
Oral Health Care					
Dental Ins	1	1	\$25.00	\$0.00	\$25.00
<b>Oral Health Care Totals:</b>	<b>1</b>	<b>1</b>	<b>\$25.00</b>	<b>\$0.00</b>	<b>\$25.00</b>
<b>Provider Total</b>	<b>1</b>	<b>1</b>	<b>\$25.00</b>	<b>\$0.00</b>	<b>\$25.00</b>
<b>ReportTotal</b>	<b>1</b>	<b>1</b>	<b>\$25.00</b>	<b>\$0.00</b>	<b>\$25.00</b>

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Maricopa County Health Care Mandates  
 Ryan White Part A Program  
 CAREWare Financial and Supplemental Billing Reports

## Supplemental Reports

Supplemental reports will need run and attached to the financial report as supplemental reports for the reporting period. (Race/Ethnicity, County, Gender/Age, Risk Factors).

ALL reports are added as an example

**Financial Report**

Friday, September 01, 2006 through Saturday, September 30, 2006

**Report Criteria**

Provider(s): ORAL Health Address Refresh  
 Funding Source: RW Title I  
 Group By Providers: True  
 Include subservice detail: True

**ORAL Health Address Refresh**

Phone:  
 Address:

	Clients:	Units:	Total:	Amount Received:	Not Received:
Oral Health Care					
Dental Ins	1	1	\$25.00	\$0.00	\$25.00
<b>Oral Health Care Totals:</b>	<b>1</b>	<b>1</b>	<b>\$25.00</b>	<b>\$0.00</b>	<b>\$25.00</b>
<b>Provider Total</b>	<b>1</b>	<b>1</b>	<b>\$25.00</b>	<b>\$0.00</b>	<b>\$25.00</b>
<b>ReportTotal</b>	<b>1</b>	<b>1</b>	<b>\$25.00</b>	<b>\$0.00</b>	<b>\$25.00</b>

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Maricopa County Health Care Mandates  
Ryan White Part A Program  
CAREWare Financial and Supplemental Billing Reports

County (County by Srv Category)

Data Scope: ORAL Health Address Refresh

County by Srv Category

County:	Row Total:	Percent:	Oral Health Care:	Other support services:
Maricopa	4	100.0	2	2
Total:	4	100.0	2	2

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Maricopa County Health Care Mandates  
Ryan White Part A Program  
CAREWare Financial and Supplemental Billing Reports

Gender (Gender by Srv Category)

Data Scope: ORAL Health Address Refresh

Gender by Srv Category

Gender:	Row Total:	Percent:	Oral Health Care:	Other support services:
Female	1	25.0	1	0
Male	3	75.0	1	2
Total:	4	100.0	2	2

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Maricopa County Health Care Mandates  
 Ryan White Part A Program  
 CAREWare Financial and Supplemental Billing Reports

**Race/Ethnicity (Race/Ethnicity by Srv Category)**

Data Scope: ORAL Health Address Refresh

**Race/Ethnicity by Srv Category**

Race/Ethnicity:	Row Total:	Percent:	Oral Health Care:	Other support services:
Asian	1	25.0	1	0
Black or African-American	1	25.0	0	1
Hispanic	1	25.0	0	1
White (non-Hispanic)	1	25.0	1	0
Total:	4	100.0	2	2

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Maricopa County Health Care Mandates  
Ryan White Part A Program  
CAREWare Financial and Supplemental Billing Reports

Risk Factor (HIV Risk Factor by Srv Category)

Data Scope: ORAL Health Address Refresh

HIV Risk Factor by Srv Category

HIV Risk Factor:	Row Total:	Percent:	Oral Health Care:	Other support services:
Not Specified	4	100.0	2	2
Total:	4	100.0	2	2

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Maricopa County Health Care Mandates  
Ryan White Part A Program  
CAREWare Financial and Supplemental Billing Reports

Age Group (AgeGroup by Srv Category)

Data Scope: ORAL Health Address Refresh

AgeGroup by Srv Category

AgeGroup:	Row Total:	Percent:	Oral Health Care:	Other support services:
25 - 44	4	100.0	2	2
Total:	4	100.0	2	2

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# **Ryan White Title I Program**

## **Quality Management Plan**

**2007/2008**

### **I. Mission Statement**

*To promote continuing improvement of service provided to Ryan White Title I program clients by:*

*Developing and strengthening our partnerships between providers, clients, funders, and the Department of Health Care Mandates.*

*Measuring and evaluating, the efficiency, effectiveness, and quality of health care and supportive services delivered to clients with the intent of improving overall clinical outcomes, support services, and healthcare network coordination.*

### **II. Scope of Services**

The services provided by XXX provider for Title I clients included the following: (list and describe services)

XXX provider is a comprehensive community based organization that also provides services for clients, etc. (describe all services).

### **III. HRSA/HAB Quality Management Expectations**

The CARE Act places major emphasis on enhancing the quality of care for people living with HIV (PLWH). The complexity of HIV care-and the Act's commitment of equal access to quality care for all PLWH-requires systematic efforts to ensure that CARE Act services are delivered effectively.

***Purpose*** – According to the Quality Management Technical Assistance Manual, the overall purpose of a CARE Act quality management program is to ensure that:

- Services adhere to PHS guidelines and established clinical practices
- Program improvement includes supportive services linked to access and adherence to medical care.
- Demographic, clinical and utilization data are used to evaluate and address characteristics of the local epidemic.

***A quality management program should have the following characteristics:***

- A systematic process with identified leadership, accountability, and dedicated resources.
- Use of data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks.
- Focus on linkages, efficiencies, and agency and client expectations in addressing outcome improvement.
- Continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement (QI) activities (i.e. JCAHO, Medicaid, and other HRSA programs).
- Data collected is used to feedback into the process to assure that goals are accomplished and they are concurrent with improved outcomes.

## **IV. Structure of the Title I Quality Management Program**

### **A. Authority/Organization/Responsibility**

The XYZ Board of XXX Provider has ultimate accountability for the quality of care and services provided to its customers, clients, and patients.

(Describe agency organizational structure)

(Describe committees or structure that reviews the quality of services; include leadership, membership, frequency of meetings, and reporting mechanisms)

### **B. Title I Provider Quality Management Roles and Responsibilities**

- Participate in quality management activities conducted by the Title I Quality Management Program in accordance with contractual requirements and the Quality Management Plan.
- Provide services in accordance with the EMA's Standards of Care.
- Develops and implements an agency-specific quality management plan for its Title I-funded services.
- Conducts quality improvement projects at the agency level.
- Reports quality management activities to the Title I Quality Management Program
- Requests and receives technical assistance, training and support, as indicated, from the Title I Quality Management Program

## **V. Data Collection**

The Quality Management Program requires participation in the regular collection, analysis and reporting of quality management data. The data includes, but is not limited to:

Client Records  
Clinical Databases  
Demographic Databases  
Billing records  
Client/staff interviews  
Client/staff surveys  
Utilization patterns

(Add any other sources)

## **VI. Reporting of Data**

Annual reports from participation in cross-cutting QI projects will be reported to the Title I quality management office utilizing the PDCA model. As QM findings identify an opportunity to improve services, providers will submit the results of QI projects to the Title I office. Data collected from standards of care outcome measures will be reported per the QM report schedule. Aggregated service category results of QM program monitoring will be reported to the Title I planning council and the Ad hoc Advisory QM committee.

## **VII. Consumer Satisfaction Survey**

An annual consumer satisfaction survey is conducted for all funded Title I service categories according to the provider consumer satisfaction administration survey. All clients that request follow-up upon completing the consumer satisfaction form will be contacted by XXX provider. Clients will be given the option to mail responses to the Title I QM program or drop surveys in the on-site consumer survey boxes. Aggregated results will be reviewed for opportunities to improve services.

## **VIII. Confidentiality**

The activities of the Quality Management Program are legally protected. All copies of committee minutes, reports, worksheets and other data are stored in a manner ensuring strict confidentiality. All QM activities should be handled according to agency confidentiality policies and QM documents solely utilized by authorized individuals.

### **IX. QM Activities/Goals 2007/2008**

1. Participate in service specific standard of care reviews and annual universal standards review. Implement all elements identified as needing improvement per the standards of care action plan.
2. Report quality management outcome measures per QM office schedule.
3. Participate in cross-cutting QI projects.
4. Report any QI projects identified as opportunities to improve services utilizing the PDCA model.
5. Participate in Quality Management Ad Hoc Advisory Committee as requested.
6. Develop vendor-specific QM plan.
7. Conduct an annual consumer satisfaction survey.

(Specific goals as warranted)

Signature \_\_\_\_\_  
Date \_\_\_\_\_

## **Provider Quality Management Schedule: Bi-annual reports**

**DUE: March 15, 2007 and September 15, 2007**

*March 2007 – Sept-Feb*

*/September 2007 – March -Aug*

- All outreach reports
- PCH – Mental Health – Nueropsych testing utlization
- Phoenix Shanti – GAF/Treatment Goals
- McDowell/South Park/South Central/PCH – Viral Loads/HIVQUAL data annually
- Body Positive – Nutrition – Supplement measure/quality of life survey for alternative complementary services/support group surveys
- JFCS – GAF/Treatment Goals
- Office of Oral Health – Dental Insurance Re-enrollment
- HIV Law Project – Legal Services Utilization/no show rates/economic value
- CPLC – GAF/Treatment Goals
- McDowell Clinic – Mental/Substance Abuse- GAF/Treatment Goals
- Food Box Checks – Food Storage and Food Sanitation
- Case Management Outcomes
- Transportation Outcomes
- Home Health Outcomes

Ryan White Planning Council/MCDPH Ryan White Title I Services  
Quality Management  
CULTURAL COMPETENCY

Current Policy under Construction

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MARICOPA COUNTY HEALTH CARE MANDATES  
RYAN WHITE TITLE I SUBPART A PROGRAM  
UNIVERSAL STANDARDS OF CARE

**Code of Ethics**

1. All Ryan White Title I Services will be provided to eligible and qualified clients without discrimination on the basis of HIV infection, race, creed, color, age, sex, gender, marital or parental status, sexual orientation, gender orientation, religion, ancestry, national origin, physical or mental disability (including substance abuse), immigrant status, political affiliation or belief, ex-offender status, unfavorable military discharge, membership in activist organization, or any basis prohibited by law.
2. All Ryan White Title I Services will serve the best interests of the client emphasizing confidentiality, respect for the client's rights and personal dignity, and enhancement of the client's humanity and self-esteem.
3. All Ryan White Title I Service Providers will maintain a grievance procedure which provides for the objective review of client grievances. All Ryan White Title I eligible and qualifying clients will be routinely informed about and assisted in utilizing the grievance procedure and shall not be discriminated against for doing so.

**Verification of Eligibility**

1. All Service Providers will verify and document the eligibility and qualification for services, under Title I of the Ryan White CARE Act, of individuals seeking services, in a manner consistent with HRSA guidelines as described in the Maricopa County Department of Public Health Policy Manual.
2. All Service Providers will document verification of HIV-positive status in a manner consistent with HRSA guidelines as described in the Maricopa County Department of Public Health Policy Manual.
3. All Service Providers will document verification of each client residing within Maricopa and Pinal Counties, Arizona in a manner consistent with HRSA guidelines as described in the Maricopa County Department of Public Health Policy Manual.

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**Confidentiality of Client Information**

1. All Ryan White Title I Service Providers will protect client confidentiality in accordance with state and federal laws.
2. All Ryan White Title I Service Providers will provide the agency's volunteer and paid staff an orientation/training on Client Confidentiality.
3. All Ryan White Title I Clients will be educated on their right to confidentiality and will be provided with a document, for their completion, that expressly describes the circumstances under which their client information can be released and to whom.

**Cultural Competency**

1. All Ryan White Title I Service Providers will provide appropriate services and referrals in an equitable and non-judgmental manner to all clients.
2. All Ryan White Title I Service Providers will provide reasonable accommodation to foreign language and/or sign language services for all clients.
3. All Ryan White Title I Service Providers will take into account and be responsive to cultural differences with the provision of direct client services.
4. All Ryan White Title I Service Providers will provide appropriate cultural competency/sensitivity training to all direct service staff.

**Continuity of HIV Service Delivery**

1. All Ryan White Title I Service Providers will document referral relationships with other Ryan White, and non-Ryan White, HIV/AIDS health and social services available within the EMA.
2. All Ryan White Title I Service Providers will establish and maintain a written referral process for all clients needing services outside of the Providers' agency.

**Client Satisfaction**

1. All Ryan White Title I Service Providers will compile and report client satisfaction data, consistent with the Quality Management program.
2. All Ryan White Title I Service Providers will develop an improvement process, as needed, based on the outcome of the Client Satisfaction Survey.

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**Client Rights and Responsibilities**

1. All Ryan White Title I Service Providers will provide all Ryan White Title I Clients a copy of the Statement of Consumer Rights and Responsibilities contained herein.
2. All Ryan White Title I Service Providers will take the necessary actions to ensure that services are provided in accordance with the Statement of Consumer Rights and Responsibilities and that each client fully understands his/her rights and responsibilities.

**Statement of Consumer Rights and Responsibilities**

All Ryan White Title I Service Providers will provide all Ryan White Title I clients with a copy of their Statement of Consumer Rights and Responsibilities, which will include the following elements:

**Consumer Rights**

- **Respect, courtesy and privacy:** The consumer has the right to be treated at all times with respect and courtesy within a setting that provides the highest degree of privacy possible.
- **Freedom from discrimination:** The consumer has the right to freedom from discrimination related to age, ethnicity, national origin, gender, disability, religion, sexual orientation, gender orientation, values and beliefs, marital status, medical condition, or any other arbitrary reasons.
- **Access to HIV/AIDS service information:** The consumer has the right to full access to information from the health care providers about current FDA approved or other proven HIV/AIDS treatments. The consumer has the right to full access to information from all service providers about HIV-related social and support services.

**Identity and provider credentials:** The consumer has the right to know the identities, titles, specialties, and affiliations of all service providers, as well as anyone else, involved in the consumer's care.

The consumer has the right to know about the service provider's rules and regulations that are pertinent to the care or type of care the consumer receives.

Any biases or conflict of interest the service provider may have will be disclosed. Consumers must be advised of the risk and benefits of any proposed treatment considered to be experimental in nature.

- **Culturally sensitive provision of information:** The consumer has the right to have information provided in a way that is easily understood and sensitive to each consumer's background, culture, and orientation.

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- **Care plan:** The consumer has the right to be involved in and make decisions about their plan of care prior to the start of and during the course of service. Consumers have the right to renegotiate the care plan at any time.
- **Self determination:** The consumer has the right to access all Title I services, provided that the service is currently available and all program guidelines, and eligibility requirements, have been met.
- **Declining services:** The consumer has the right to refuse to participate in any service. The consumer may change his or her mind after refusing service without affecting ongoing care.
- **Access to financial information:** The consumer has the right to receive an explanation of any fees related to services received, and to obtain a copy of the criteria used to determine eligibility for services.
- **A consumer grievance procedure:** The consumer has the right to voice complaints and suggest changes without interference, pressure, or reprisal.

The consumer will be informed of the service provider's grievance process for problem resolution. The consumer has the right to receive a response to a grievance in a timely manner.

- **Confidentiality:** The consumer has the right to confidentiality per federal and state guidelines.
- **Access to records:** The consumer may have access to treatment records as allowed by federal and state guidelines. The consumer will be provided with copies of their records as allowed by law, at a fair cost and within the timeline established by each service provider to furnish these documents.
- **Referral and continuity of care:** The consumer has the right to continuity of care whenever possible. The consumer has the right to appropriate referrals, based on eligibility and availability, to another HIV service provider.

### Consumer Responsibilities

- **Respect and courtesy:** The consumer has the responsibility of treating all services providers with respect and courtesy.
- **Correct and complete information:** The consumer has the responsibility to provide correct and complete information to the service provider about their health status.

The consumer has the responsibility to provide immediate notification of any and all changes in residency, employment, insurance and/or financial status.

The consumer has the responsibility to disclose the availability or use of other payment sources, treatment medications, and health or social service providers.

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The consumer has the responsibility of collecting and furnishing to the service provider any and all documentation necessary for the purposes of determining eligibility for Ryan White Services.

- **Seeking information about care:** The consumer has the responsibility for seeking facts and asking questions about the risks, benefits, and financial aspects of a service or treatment.
- **Care plan adherence:** The consumer has the responsibility of following the agreed upon care plan. The consumer is responsible for the results if they choose to act against professional advice or does not follow instructions of an agreed to treatment plan.
- **Scheduled appointments:** The consumer has the responsibility for keeping scheduled appointments. The consumer has the responsibility of canceling and/or rescheduling with the service provider when an appointment cannot be kept.
- **Communicating your financial needs:** The consumer has the responsibility for disclosing financial burdens related to their care plan prior to receiving health and/or social services. It is the responsibility of the consumer to provide accurate information about payment sources. The consumer is responsible for submitting requests for reimbursement forms to assure financial burdens may be adequately addressed by the service provider.
- **Rules and regulations of service providers:** The consumer has the responsibility for following the rules and regulations of the service providers.
- **Being respectful of others:** The consumer has the responsibility of being respectful of the rights, property, and confidentiality of others.
- **Voicing complaints:** The consumer has the responsibility for voicing individual complaints and requests for change in an appropriate and timely manner via the service provider's grievance procedures.

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**Case Management**

**Service Definition**

Provides a range of client-centered services that link clients with primary HIV medical care, psychosocial, and other services to insure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and a linkage that expedites discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic reevaluation and revision of the plan as necessary during the life of the client. Services may include client-specific advocacy. Following the assessment of individual need, advice and assistance in obtaining medical, social, community, legal, financial, benefits counseling and assistance, and other needed services is provided.

**Goals**

The goals of the Case Management service category are to:

- Facilitate access to primary medical care through a process of linkage to medical service and reduce barriers to care;
- Facilitate access to community services as a process of enabling linkage to medical care and other needed services; and
- Comply with the Planning Council's Universal Standards of Care.

STANDARD	MEASURE/EVIDENCE
<b>Client Level</b>	
1. <b>Educational Qualifications</b>	<ul style="list-style-type: none"> <li>▪ Case managers will have a bachelor's degree from an accredited college in a field related to case management such as social work, nursing, public health or other human services related field.</li> <li>▪ Comparable professional knowledge, skills, and abilities that documents 4 years of experience specific to case management may be substituted for the degree. Case management training may include psychosocial assessment of clients; interdisciplinary care coordination; monitoring of health and social service delivery to maximize efficiency/cost-effectiveness; knowledge of the resources available to target populations; development and utilization of client-centered care plans; data privacy and confidentiality.</li> </ul>

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STANDARD	MEASURE/EVIDENCE
<p>2. <b>Intake:</b> All clients are screened to determine the need for case management services and/or linkages into primary medical care or community services</p>	<p>Client's chart contains documentation of the intake within 10 working days of the first contact.</p>
<p>3. <b>Assessment:</b> Upon establishing need for services, client's assessment provides the foundation for service planning and delivery</p>	<ol style="list-style-type: none"> <li>1. Client chart will contain documentation of assessment within 10 working days of initial case management contact.</li> <li>2. Preferably, assessments will be conducted in the home setting however they may be conducted elsewhere based upon the client's preference.</li> <li>3. Client assessment will review at a minimum the following areas: <ul style="list-style-type: none"> <li>▪ medical;</li> <li>▪ treatment adherence;</li> <li>▪ dental;</li> <li>▪ nutritional;</li> <li>▪ mental health;</li> <li>▪ substance abuse;</li> <li>▪ financial;</li> <li>▪ educational;</li> <li>▪ social support;</li> <li>▪ legal needs;</li> <li>▪ transportation;</li> <li>▪ housing;</li> <li>▪ risk reduction;</li> <li>▪ cultural factors;</li> <li>▪ life skills; and</li> <li>▪ functional capabilities.</li> </ul> </li> </ol>
<p><b>Case Management Care Plan:</b> All clients must participate in the development of a care plan based on the findings of initial assessment.</p>	<ol style="list-style-type: none"> <li>1. Case Management care plan will be documented in the client chart within 10 days following comprehensive client assessment.</li> <li>2. Care plan will include client signature</li> <li>3. The care plan reflects short-term and long-term goals and all service referrals.</li> <li>4. Supervisor reviews initial care plan within 30 days to ensure all required record components are present and planned services are appropriate.</li> </ol>
<p><b>Identification of resources and referrals:</b> Based on assessment, case manager will identify applicable resources, inform client of those resources, provide appropriate referrals and/or encourage client to make the initial contact</p>	<ul style="list-style-type: none"> <li>▪ Documentation of applicable resources and referrals are in the client chart.</li> </ul>

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STANDARD	MEASURE/EVIDENCE
<p><b>Follow-up:</b> Client chart indicates contacts, activities and interventions to determine the efficacy of the care plan</p>	<ul style="list-style-type: none"> <li>▪ Client chart includes documentation of case management activities to provide referrals and/or to encourage client to make the initial contact for all existing and applicable services.</li> <li>▪ Client chart includes documentation of monthly contact or attempts to locate client</li> </ul>
<p><b>Reassessment:</b> All clients are reassessed at six month intervals for changes in service needs and care plan must be updated</p>	<ul style="list-style-type: none"> <li>▪ Client chart contains documentation of reassessment at six month intervals.</li> <li>▪ Reassessment reflects client progress in obtaining services needed and changes in client status.</li> <li>▪ Client chart documents that all client care plans were updated by case manager.</li> </ul>
<p><b>Case closure: Upon completion of care plan, death, client choice, or ineligibility, client's chart will be moved to inactive/closed status</b></p>	<ul style="list-style-type: none"> <li>▪ Client chart includes documentation of a closure note within ten working days of case closure/inactive status.</li> </ul>
<b>Vendor Level</b>	
<p>Agency follows established Phoenix EMA Ryan White Title I Standards of Care and agency-specific policies and procedures.</p>	<p>Agency has written policies and procedures that are consistent with most recent Case Management Standards of Care. A copy is available on-site.</p>
<b>System Level</b>	
OUTCOMES	MEASURES/EVIDENCE
<p>Improve clients' health by increasing access to primary medical care and the support services necessary to reduce barriers to care</p>	<ul style="list-style-type: none"> <li>▪ 90% of clients have documentation of access to primary medical care with 3 months of initial assessment</li> <li>▪ Treatment adherence will be discussed and documented in 80% of clients' charts</li> <li>▪ 100% of case management charts will contain a care plan</li> </ul>

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**Mental Health Services**

**Service Definition**

Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental-health professional who is licensed or authorized within the State, including psychiatrists, psychologists, clinical-nurse specialists, social workers, and counselors.

**Goals**

The goals of the Mental Health Services service category are to:

- Assist HIV-positive clients with reduction of symptoms related to mental health disorders thereby reducing barriers to medical care;
- Provide psychiatric evaluation and medication monitoring if indicated; and
- Comply with the State of Arizona requirements for the provision of behavioral health services, and the Planning Council’s Universal Standards of Care.

STANDARD	MEASURE/EVIDENCE
<b>Client Level</b>	
<p><b>1. Licensing</b></p> <ul style="list-style-type: none"> <li>○ As per ADHS guidelines A.A.C. Title 9 Chapter 20, professional staff will be licensed or supervised by a licensed behavioral health professional</li> <li>○ As per ADHS guidelines A.A.C. Title 9 Chapter 20, agencies will be licensed for behavioral health services</li> </ul>	<ol style="list-style-type: none"> <li>1. All staff are licensed and licenses are current</li> <li>2. All unlicensed staff are supervised by a licensed behavioral health professional</li> <li>3. Current license for agency is posted and current</li> </ol>
<p><b>2. Assessment</b></p> <ul style="list-style-type: none"> <li>○ Assessment will occur that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 20</li> </ul>	<p>Chart will include as appropriate an assessment within seven days after initiating or updating, which documents the following:</p> <ol style="list-style-type: none"> <li>1. Referral to a medical practitioner if indicated</li> <li>2. Presenting issue, substance abuse history, co-occurring disorder, medical condition and history, legal history, family history, behavioral health treatment history and signature of staff member conducting the assessment</li> <li>3. Initiation of assessment before treatment is started</li> <li>4. Approval of or provision of assessment by a licensed behavioral health professional</li> <li>5. Assessment must be updated every 12 months.</li> </ol>

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STANDARD	MEASURE/EVIDENCE
<p>3. <b>Treatment Plan</b>            A treatment plan must be completed that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 20</p>	<p>Treatment plan must include:</p> <ol style="list-style-type: none"> <li>1. client's presenting issue;</li> <li>2. identification of entities to provide all services;</li> <li>3. signature of client or guardian;</li> <li>4. signature and title of behavioral health professional and date completed;</li> <li>5. one or more treatment goals;</li> <li>6. one or more treatment methods and frequency of each treatment method;</li> <li>7. date the treatment plan shall be reviewed; and</li> <li>8. discharge planning, which includes education on relapse prevention.</li> </ol> <p>Initial treatment plan or Individual Service Plan must be:</p> <ol style="list-style-type: none"> <li>1. in place prior to any services being rendered;</li> <li>2. initiated within 30 days by behavioral health professional;</li> <li>3. completed with client participation; and</li> <li>4. based on assessment conducted.</li> </ol> <p>Individual Service Plan must be completed and documented no later than 90 days after client's first visit with a behavioral health professional.</p>
<p>4. Treatment is delivered per the individual's treatment plan</p>	<p>Treatment plan is reviewed:</p> <ol style="list-style-type: none"> <li>1. at least annually;</li> <li>2. when a goal is accomplished or changes;</li> <li>3. when additional information that affects the client's assessment is identified; and</li> <li>4. when a client has a significant change in condition or experiences an event that affects treatment.</li> </ol>
<p>5. Appropriate referrals and linkages to care will be provided</p>	<p>Necessary referrals are documented for one or more of the following:</p> <ol style="list-style-type: none"> <li>1. case management;</li> <li>2. psychiatric assessment;</li> <li>3. primary medical care;</li> <li>4. community support services; and</li> <li>5. substance abuse services.</li> </ol>

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STANDARD	MEASURE/EVIDENCE
<p><b>6. Discharge</b> Discharge from Mental Health Services occurs that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 20</p>	<ol style="list-style-type: none"> <li>1. Clients are discharged according to agency discharge criteria when treatment goals are achieved or when treatment needs are not consistent with agency services.</li> <li>2. Discharge summary must: <ul style="list-style-type: none"> <li>▪ be signed by a behavioral health professional;</li> <li>▪ include client's presenting issue and other behavioral health issues identified in treatment plan;</li> <li>▪ include summary of the treatment provided to the client;</li> <li>▪ include progress in meeting treatment goals; and</li> <li>▪ include referrals as needed.</li> </ul> </li> <li>3. Clients who are involuntarily discharged have a right to submit a grievance.</li> </ol>
<b>Vendor Level</b>	
Agency follows policies.	Agency has policies describing: <ol style="list-style-type: none"> <li>1. how to conduct an assessment;</li> <li>2. discharge criteria; and</li> <li>3. grievance procedures.</li> </ol>
<b>System Level</b>	
OUTCOMES	MEASURES/EVIDENCE
Improve clients' health by decreasing symptoms of mental health disorder thereby reducing barriers to medical care	<ol style="list-style-type: none"> <li>1. Upon completion of mental health treatment, 90% of treatment goals are addressed and 50% are met</li> <li>2. Clients' average GAF scores improve by 5% within 6 months or upon discharge</li> <li>3. 100% of clients receive an assessment prior to implementing the treatment plan</li> <li>4. 100% of clients have a completed treatment plan within 90 days from the clients' first visit</li> <li>5. 100% of treatment plans address primary medical care needs and make appropriate referrals as needed</li> </ol>

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**Primary HIV Medical Care**

**Service Definition**

Provision of professional, diagnostic, and therapeutic services rendered by a physician, physician’s assistant, clinical nurse specialist, nurse practitioner or registered nurse in an outpatient, community-based, and/or office-based setting. This includes diagnostic testing, early intervention, 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 and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care. Primary HIV Medical Care includes the provision of care that is consistent with Public Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

**Goals**

The goals of the Primary HIV Medical Care service category are to:

- Provide eligible clients with quality health care and strive for improved life by slowing or preventing disease progression and reducing mortality rates as a result of HIV-disease through medical care that follows the standards of the PHS guidelines;
- Compliance with the State of Arizona requirements for the provision of primary medical care, and the Planning Council’s Universal Standards of Care; and
- Understand and address the co-morbid issues that many HIV-positive individuals have and consider psychosocial issues that impact the client’s life when developing and implementing treatment plans.

STANDARD	MEASURE/EVIDENCE
<b>Client Level</b>	
1. Baseline medical evaluation will be performed by a medical provider within 3 visits and will include documentation of medical and social history. The baseline medical evaluation will be conducted within 90 days.	Chart indicates that the baseline medical evaluation was conducted within three visits not to exceed 90 days from the first visit with the medical provider.
2. The baseline medical evaluation will follow the PHS guidelines	The baseline evaluation may include but is not limited to the following and will be documented in client chart: <ul style="list-style-type: none"> <li>○ HIV antibody testing (if laboratory confirmation not available)</li> <li>○ CD4 cell count</li> <li>○ Plasma HIV RNA</li> <li>○ Complete blood count, chemistry profile, transaminase levels, BUN and creatinine, urinalysis, RPR or VDRL, tuberculin skin test (unless a history of prior tuberculosis or positive skin test), <i>Toxoplasma gondii</i> IgG, hepatitis A, B, and C serologies, and PAP smear in women.</li> <li>○ Fasting blood glucose and serum lipids if considered at risk for cardiovascular disease and for baseline evaluation prior to initiation of combination antiretroviral therapy.</li> </ul>

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STANDARD	MEASURE/EVIDENCE
3. Social history will include thorough documentation of HIV-specific information and will follow the PHS guidelines.	Client social history will include: <ul style="list-style-type: none"> <li>○ Assessment of substance abuse, economic factors, social support, mental illness, and co-morbidities</li> <li>○ Client queried regarding utilization of case management service. Case manager's name and agency documented if applicable</li> </ul>
4. Medical history will include thorough documentation of HIV-specific information	Client history will include: <ul style="list-style-type: none"> <li>○ HIV status</li> <li>○ Pregnancy history</li> <li>○ Allergies</li> <li>○ History of surgeries or procedures</li> <li>○ Current and past medications</li> <li>○ Mental health/substance use history</li> <li>○ Treatment history</li> <li>○ Past medical conditions</li> <li>○ Recommended Immunization Schedules for Adults, Adolescents, and Pediatrics from CDC</li> </ul>
5. All clients will be assessed for treatment adherence issues and, as appropriate, provided with education and follow-up	<ul style="list-style-type: none"> <li>○ Assessment is documented</li> <li>○ Client education and follow-up are documented if treatment adherence issues are identified</li> </ul>
6. Appropriate referrals and linkages to care will be provided	<ul style="list-style-type: none"> <li>○ Specialty care referrals are documented</li> <li>○ Referrals made to case management/social work are documented</li> <li>○ Referrals made to substance abuse treatment/mental health services are documented</li> </ul>
7. Pediatric-specific treatment will follow PHS pediatric guidelines and include age-appropriate developmental evaluation and ongoing growth assessments	<ul style="list-style-type: none"> <li>○ Current PHS pediatric guidelines and a policy requiring their utilization will be onsite</li> <li>○ Age-appropriate developmental evaluation is documented</li> <li>○ Ongoing growth assessments are documented</li> <li>○ Appropriate referrals to nutritional counseling are documented</li> <li>○ Appropriate referrals to mental health services are documented</li> <li>○ Patients are assessed and receive vaccinations as per current Recommended Immunization Schedules for Pediatrics from CDC</li> </ul>

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STANDARD	MEASURE/EVIDENCE
<p>8. Medical treatment for all patients will include the following and be documented in client chart</p>	<p>Patients will be offered:</p> <ul style="list-style-type: none"> <li>○ A CD4 test at least every 3-6 months</li> <li>○ A viral load test at least every 3-4 months</li> <li>○ HCV status for all patients is documented and updated annually if initial HCV is negative</li> <li>○ Patients without a history of previous TB treatment or positive PPD test result have a PPD placed and results read and documented annually</li> <li>○ An annual syphilis serology</li> <li>○ Female patients 18 years or older and sexually active female patients 13-18 years PAP smears every six months for the first year, then if negative annually thereafter</li> <li>○ Patients with CD4 &lt;200 will be offered appropriate PCP prophylaxis</li> <li>○ Patients with CD4 &lt;50 will be offered appropriate MAC prophylaxis</li> <li>○ Patients are assessed and will be offered vaccinations as per current Recommended Immunization Schedules for Adults, Adolescents, and Pediatrics from CDC</li> <li>○ Antiretroviral therapy is initiated per the PHS Guidelines:               <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <ul style="list-style-type: none"> <li>➤ Antiretroviral therapy is recommended for all patients with history of an AIDS-defining illness or severe symptoms of HIV infection regardless of CD4 T cell count</li> <li>➤ Antiretroviral therapy is also recommended for asymptomatic patients with &lt;200 CD4 T cells/mm<sup>3</sup></li> <li>➤ Asymptomatic patients with CD4 T cell counts of 201-350 cells/mm<sup>3</sup> should be offered treatment</li> <li>➤ For asymptomatic patients with CD4 T cell counts of &gt;350 cells/mm<sup>3</sup> and plasma HIV RNA &gt; 100,000 copies/μL most experienced clinicians defer therapy but some clinicians may consider initiating treatment</li> <li>➤ Therapy should be deferred for patients with CD4 T cell counts of &gt;350 cells/mm<sup>3</sup> and plasma HIV RNA &lt;100,000 copies/μL</li> </ul> </div> </li> </ul>

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Vendor Level	
9. Adult and Pediatric HIV care will follow current PHS guidelines	Current PHS guidelines and/or a policy requiring utilization of guidelines will be onsite
10. Medical provider credentials are appropriate for treating HIV/AIDS	<ul style="list-style-type: none"> <li>○ All licensed medical providers must show evidence of:</li> <li>○ HIV Specialist Certification or 20 hours of HIV-related CMEs per year, plus</li> <li>○ On-going, active medical management of 20 or more HIV clients</li> <li>○ Pediatric providers will have training and experience in the medical care of children with HIV</li> </ul>
11. Appropriate access to care will be provided	<ul style="list-style-type: none"> <li>○ A 24-hour schedule, capability or policy exists based upon Medicaid guidelines</li> <li>○ A triage policy or capability exists</li> <li>○ An urgent care policy, capability or same-day service exists</li> <li>○ An acute care policy or capability exists</li> <li>○ Physician has admitting privileges to hospital(s) per credentialing file</li> </ul>
System Level	
OUTCOMES	MEASURES/EVIDENCE
12. Improve patient care outcomes	<ul style="list-style-type: none"> <li>○ 50% of clients tested will have viral loads below the level of detection</li> <li>○ 75% of clients tested will have CD4 counts that identify them as not having a severely compromised immune status based on current PHS guidelines</li> <li>○ 80% of women/sexually active adolescents will receive PAP smears annually</li> <li>○ 80% of clients will be screened for active viral hepatitis C and hepatitis B</li> <li>○ 80% of adult clients will be screened for syphilis at least annually</li> <li>○ 80% of clients will be screened for tuberculosis at least annually if indicated</li> </ul>

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**Glossary**

- Adolescents ..... PLWH/A 13-18 years old
- AIDS ..... Acquired Immune Deficiency Syndrome, the late stage of illness triggered by infection with human immunodeficiency virus (HIV).
- Antiretroviral ..... a substance that stops or suppresses the activity of a retrovirus such as HIV.
- Asymptomatic ..... without signs or symptoms of disease or illness.
- Baseline ..... a reference point against which later measurements can be compared, (e.g., baseline CD4 count). Baselines are usually determined at the start of a treatment regimen, therapy or clinical trial.
- CD4 ..... one of two protein structures on the surface of a human cell that allows HIV to attach, enter and thus infect the cell. CD4 molecules are present on CD4 cells.
- CD4 Cell ..... a type of T-lymphocyte involved in protecting the human body against viral, fungal and protozoal infections.
- CD4 Cell Count ..... the most commonly used surrogate marker for assessing the state of the immune system. It measures the number of T-cells in a sample of blood. As the CD4 cell count declines, the risk of developing opportunistic infections increases. The normal CD4 cell count is 500 to 1500 per cubic millimeter of blood. CD4 cell counts should be rechecked at least every six to twelve months if CD4 counts are greater than 500/ mm<sup>3</sup>. If one's count is lower, testing every three months is advised.
- CDC ..... Centers for Disease Control and Prevention
- CMEs ..... Continuing Medical Education credits
- DNA ..... Deoxyribonucleic Acid, genetic material of all cellular organisms and most viruses.
- HAV ..... Hepatitis A
- HBV ..... Hepatitis B
- HCV ..... Hepatitis C
- HIV ..... Human Immunodeficiency Virus, the retrovirus recognized as the cause of AIDS. HIV may work with unidentified cofactors to cause AIDS.
- MAC ..... mycobacterium avium complex, a serious opportunistic infection caused by two similar bacteria found in soil and dust particles. In AIDS, MAC can spread through the bloodstream to infect lymph nodes, bone marrow, liver, spleen, spinal fluid, lungs and intestinal tract. MAC is usually found in people with CD4 counts below 100. Typical symptoms of MAC include night sweats, weight loss, fever, diarrhea and enlarged spleen.
- Opportunistic Infections (OI) .. conditions such as PCP, MAC or CMV that are caused by microbes which would not usually cause disease in persons with healthy immune systems. OIs occur especially or exclusively in persons with weak immune systems due to AIDS, cancer or immunosuppressive drugs.
- PAP Smear ..... microscopic examination of the surface cells of the cervix, usually conducted on scrapings from the cervical opening.

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- PCP .....pneumocystis carinii pneumonia, an infection caused the presence of pneumocystis carinii, (which is either a protozoa or fungus: it displays characteristics of both) in the body. This microbe grows rapidly in people with AIDS, and is most often detected in the lungs, but can also occur elsewhere in the body, especially skin, eyes, spleen, liver, or heart.
- PHS .....Public Health Service
- PLWH/A .....Person(s) living with HIV/AIDS
- Prophylaxis.....a treatment intended to preserve health and prevent the spread of disease or recurrence of symptoms in an existing infection that has been brought under control.
- Retrovirus.....a type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version, which becomes ingrained in the cell as part of its genetic material.
- RNA.....Ribonucleic acid, genetic material of certain viruses (RNA viruses) and, in cellular organisms, the molecule that directs the middle steps of protein production.
- STD .....Sexually-transmitted disease
- TB.....Tuberculosis
- T-cell.....T-lymphocyte, white blood cell that matures in the thymus that participates in cell-mediated immune reaction. CD4 and CD8 cells are both examples of T-lymphocytes.
- Viral Load .....the amount of HIV RNA per unit of blood. It serves an indicator of virus concentration and reproduction rate.
- Youth.....PLWH/A 13-24 years old

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**Substance Abuse Services**

**Service Definition**

Provision of treatment and/or counseling to address substance abuse issues (including alcohol, legal and illegal drugs), provided in an outpatient or residential health service setting.

**Goals**

The goals of the Substance Abuse Services service category are to:

- Assist HIV-positive clients with cessation of substance abuse thereby reducing barriers to medical care;
- Provide psychiatric evaluation and medication monitoring if indicated; and
- Comply with the State of Arizona requirements for the provision of Substance Abuse Services, and the Planning Council’s Universal Standards of Care.

STANDARD	MEASURE/EVIDENCE
<b>Client Level</b>	
<p><b>1. Licensing</b></p> <ul style="list-style-type: none"> <li>○ As per ADHS guidelines A.A.C. Title 9 Chapter 20, professional staff will be licensed or supervised by a licensed behavioral health professional.</li> <li>○ As per ADHS guidelines A.A.C. Title 9 Chapter 20, agencies will be licensed for behavioral health services.</li> </ul>	<ol style="list-style-type: none"> <li>1. All staff are licensed and licenses are current.</li> <li>2. All unlicensed staff are supervised by a licensed behavioral health professional.</li> <li>3. Current license for agency is posted and current.</li> </ol>
<p><b>2. Assessment</b></p> <ul style="list-style-type: none"> <li>○ Assessment will occur that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 20</li> </ul>	<p>Chart will include as appropriate an assessment, within seven days after initiating or updating, which documents the following:</p> <ol style="list-style-type: none"> <li>1. Referral to a medical practitioner if indicated;</li> <li>2. Presenting issue, substance abuse history, co-occurring disorder, medical condition and history, legal history, family history, behavioral health treatment history and signature of staff member conducting the assessment;</li> <li>3. Initiation of assessment before treatment is started;</li> <li>4. Approval of or provision of assessment by a licensed behavioral health professional; and</li> <li>5. Assessment must be updated every 12 months.</li> </ol>

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STANDARD	MEASURE/EVIDENCE
<p>3. <b>Treatment Plan</b> A treatment plan must be completed that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 20</p>	<p>Treatment plan must include:</p> <ol style="list-style-type: none"> <li>1. client's presenting issue;</li> <li>2. identification of entities to provide all services;</li> <li>3. signature of client or guardian;</li> <li>4. signature and title of behavioral health professional and date completed;</li> <li>5. one or more treatment goals;</li> <li>6. one or more treatment methods and frequency of each treatment method;</li> <li>7. date the treatment plan shall be reviewed; and</li> <li>8. discharge planning which includes education on relapse prevention.</li> </ol> <p>Initial treatment plan or Individual Service Plan must be:</p> <ol style="list-style-type: none"> <li>1. in place prior to any services being rendered</li> <li>2. initiated within 30 days by behavioral health professional</li> <li>3. completed with client participation</li> <li>4. based on assessment conducted</li> </ol> <p>Individual Service Plan must be completed and documented no later than 90 days after client's first visit with a behavioral health professional.</p>
<p>4. Treatment is delivered per the individual's treatment plan</p>	<p>Treatment plan is reviewed:</p> <ol style="list-style-type: none"> <li>1. at least annually;</li> <li>2. when a goal is accomplished or changes;</li> <li>3. when additional information that affects the client's assessment is identified; and</li> <li>4. when a client has a significant change in condition or experiences an event that affects treatment.</li> </ol>
<p>5. Appropriate referrals and linkages to care will be provided</p>	<p>Necessary referrals are documented for one or more of the following:</p> <ol style="list-style-type: none"> <li>1. case management;</li> <li>2. psychiatric assessment;</li> <li>3. primary medical care; and</li> <li>4. community support services.</li> </ol>

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STANDARD	MEASURE/EVIDENCE
<p>6. <b>Discharge</b> Discharge from substance abuse treatment occurs that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 20</p>	<ol style="list-style-type: none"> <li>1. Clients are discharged according to agency discharge criteria when treatment goals are achieved or when treatment needs are not consistent with agency services</li> <li>2. Discharge summary must: <ul style="list-style-type: none"> <li>▪ be signed by a behavioral health professional;</li> <li>▪ include client's presenting issue and other behavioral health issues identified in treatment plan;</li> <li>▪ include summary of the treatment provided to the client;</li> <li>▪ include progress in meeting treatment goals; and</li> <li>▪ include referrals as needed.</li> </ul> </li> <li>3. Clients who are involuntarily discharged have a right to submit a grievance.</li> </ol>
<b>Vendor Level</b>	
<p>Agency follows policies.</p>	<p>Agency has policies describing:</p> <ol style="list-style-type: none"> <li>1. how to conduct an assessment;</li> <li>2. discharge criteria; and</li> <li>3. grievance procedures.</li> </ol>
<b>System Level</b>	
OUTCOMES	MEASURES/EVIDENCE
<p>Improve clients' health through reduction of barriers to medical care by decreasing substance abuse</p>	<ol style="list-style-type: none"> <li>1. Upon completion of substance abuse treatment 90% of treatment goals are addressed and 50% are met</li> <li>2. Clients' average GAF scores improve by 5% within 6 months or upon discharge</li> <li>3. 50% of clients report a reduction in substance use</li> <li>4. 100% of clients have a completed treatment plan within 90 days from the clients' first visit</li> <li>5. 100% of treatment plans address primary medical care needs and make appropriate referrals as needed</li> </ol>

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**Transportation**

**Service Definition**

Conveyance services provided to a client in order to access primary medical care or psychosocial support services. May be provided routinely or on an emergency basis.

**Goals**

The goals of the Transportation service category are to:

- Provide public transportation for clients to access primary medical care, psychosocial support service, HIV-related care, treatment and/or education; and
- Provide taxi services for clients who do not have access to other means of transportation and are incapable of taking public transportation to enable them to travel to primary medical care, HIV-related care, treatment and/or education.

STANDARD	MEASURE/EVIDENCE
<b>Client Level</b>	
1. Client eligibility for taxi utilization will be determined using the criteria that no other means of transportation are available and the client is incapable of taking public transportation	Client will be determined incapable of taking public transportation by chart documentation of the barrier to care, which may include one of the following: <ol style="list-style-type: none"> <li>1. Lack of availability of personal or public transport</li> <li>2. Traveling with children</li> <li>3. Safety reasons</li> <li>4. Extreme weather</li> <li>5. Documented health issues</li> </ol>
<b>Vendor Level</b>	
2. Transportation requests are authorized and/or coordinated by Case Management	<ol style="list-style-type: none"> <li>1. Case manager documents the authorization of access to transportation</li> <li>2. Response to a request for transportation will be documented and completed within 3 business days of client's request</li> <li>3. Case management will maintain a Taxi Log indicating client time/date requested, cab company provided, destination, and time/date service provided.</li> <li>4. Case management will maintain a Bus Pass Log of all bus passes sold and includes client signature.</li> </ol>
3. Contracted vendors for transportation provide timely services and respect clients' individual needs	<ol style="list-style-type: none"> <li>1. Clients' complaints are documented concerning on-time performance and customer service concerns</li> <li>2. Follow-up is documented by the service provider and the vendor</li> </ol>

Ryan White Planning Council/MCDPH Ryan White Title I Services  
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STANDARD	MEASURE/EVIDENCE
4. Transportation service agency maintains policies and procedures	Policies are available on site and must include: <ol style="list-style-type: none"> <li>1. The point of origin and return for transportation services must be within Maricopa or Pinal County</li> <li>2. Availability of transportation during after hours and weekends</li> <li>3. Contracted taxi companies serve individuals with disabilities</li> <li>4. Taxi drivers maintain a valid Arizona driver's license</li> <li>5. Transportation agencies are licensed for commercial transportation</li> <li>6. Transportation agencies maintain state-required insurance</li> </ol>
<b>System Level</b>	
OUTCOMES	MEASURES/EVIDENCE
5. Provide access to primary medical care and support services for eligible clients	<ul style="list-style-type: none"> <li>▪ 80% of eligible clients self-report decreased barriers to primary medical care due to availability of transportation services</li> </ul>

**Maricopa County Health Care Mandates**  
**Ryan White Part A Program**  
**Condition of Award – Budget-Workplan-Audit**

Maricopa County Health Care Mandates, Ryan White Part A Program, requires that all Contractors for Ryan White Part A Services to complete an electronic budget and work plan statement that identifies the time and effort for services provided along with fiscal monitoring that is used to determine effectiveness and appropriateness of services provided. If your agency is subject to a OMB-A-133 audit, a copy of such audit and correspondence regarding audit must be provided to the Part A office. Due dates are identified on the Conditions of Award cover.

**Maricopa County Health Care Mandates  
Ryan White Part A Program  
Condition of Award: Maintenance of Effort**

The Maricopa County Health Care Mandates, Ryan White Part A Program, has initiated the above Condition of Award as part of its continued effort to ensure an adequate continuum of care in the Phoenix EMA for persons living with HIV/AIDS.

Instructions: For each Service Category listed in column B, please indicate the amount of funding that your agency receives on an annual basis for services to persons living with HIV/AIDS in the appropriate columns (C - J).  
Column I - For amounts listed in column J (Other), please provide an indication of the funding source below.

	Ryan White Title I	Ryan White Title II	Ryan White Title III	Ryan White Title IV	AHCCCS	HOPWA	SAMHSA	Other
1	Primary HIV Medical Care							
2	Pharmaceuticals Title I							
3	Case Management							
4	Oral Health							
4a	Oral Health Emergency Client Assistance							
5	Pharmaceuticals Title II							
6	Mental Health Services							
7	Substance Abuse Services							
8	Transportation							
9	Alternative/Complimentary Services							
10	Food Bank/Meals/Nutritional Supplements							
11	Psychosocial Support Services							
12	Outreach Services							
13	Nutritional Counseling							

**Maricopa County Health Care Mandates  
 Ryan White Part A Program  
 Condition of Award: Maintenance of Effort**

Ryan White Title I	Ryan White Title II	Ryan White Title III	Ryan White Title IV	AHCCCS	HOPWA	SAMHSA	Other
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14	Emergency Financial Assistance							
15	Health Education/ Risk Reduction							
16	Home Health Care							
17	Legal Services							
18	Interpreting Services							
19	Emergency Housing Assistance							
20	Health Insurance							

**Maricopa County Health Care Mandates**  
**Ryan White Part A Program**  
**Condition of Award – Sliding Fee Scale**

Maricopa County Health Care Mandates, Ryan White Part A Program, requires that all Contractors for Ryan White Part A Services to establish a sliding fee scale that is consistent and equitable related to a client's financial status and ensures a cap on client charges.

Please describe the sliding fee scale used and how your agency monitors this system for consistent application of it to the client's served. Please provide a copy of your policy and procedure document, if applicable, for sliding fee scale collection and monitoring.

**Maricopa County Health Care Mandates  
Ryan White Part A Program  
Condition of Award – Sub Contracted Services**

Maricopa County Health Care Mandates, Ryan White Part A Program, requires that all Contractors for Ryan White Part A Services to provide documentation of all sub contracts utilized by their agency in performing services funded through the Part A Program.

Please utilize the following table to provide a complete list of all sub contracted services that you anticipate utilizing to provide the services under each contract with the Ryan White Part A Program.

Sub Contract – Name of Agency	Total Amount of Subcontract	Scope of Service

**Maricopa County Health Care Mandates  
Ryan White Part A Program  
Condition of Award – Technical Assistance Needs**

Maricopa County Health Care Mandates, Ryan White Part A Program, requires that all Contractors for Ryan White Part A Services to provide a list of the technical assistance your agency will need to performing services funded through the Part A Program.

Please utilize the following table to provide a complete list of the technical assistance that you require to provide the services under each contract with the Ryan White Part A Program.

Description of Technical Assistance	Desired Date to complete

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

Maricopa County Health Care Mandates, as Administrative Agent for the Federal Ryan White HIV/AIDS Treatment Modernization Act of 2006 – Part A grant, has created and revised the format for budget submissions for all providers providing services under the Part A grant.

The attached set of instructions will aid you in the completion of the Maricopa County Health Care Mandates, Ryan White Part A budget forms.

The forms are to be completed electronically and sent to: Dyle Sanderson at [dylesanderson@mail.maricopa.gov](mailto:dylesanderson@mail.maricopa.gov)

**Purpose:** In an ongoing effort to continuously improve the quality of services under Ryan White Part A grant, these forms will enable providers to efficiently create annualized management budgets that accurately record the budgeted costs of services to the community. These forms create a standard format to accurately provide reporting information required under administration of Part A funds. Every effort has been taken to ensure the forms are easy to complete.  
\*\*Please note cells colored yellow \_\_\_ are the fields that are available for data input.

**Objective:** To standardize the budget system utilized by providers of Ryan White Part A Funds that will:

- a. Accurately track and report Administrative Costs and Direct Service Costs separately.
- b. Minimize risk of exceeding the Administrative Cost Cap (10% of the aggregate award available for service).
- c. Minimize the real or perceived risk of arbitrary budget approval.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**INSTRUCTIONS**

**Cover Page**            **B05-CV-1**

Complete this page to enter the summary information for your organization and Ryan White Part A grant award.

\*A separate budget packet, including Cover Page, is required for each Ryan White Part A service you provide.

The Cover Page consists of the following:

<b>Name</b>	The official name of your organization
<b>FEIN</b>	Enter your federal employee identification number
<b>Address</b>	The address of your organization
<b>Authorized Contact</b>	The name of the person to be contacted and who approves financial decisions
<b>Telephone</b>	The telephone number of the Authorized contact
<b>Primary Contact</b>	The name of the person(s) to be contacted primarily (if different from above)
<b>Telephone</b>	The telephone number of the Primary Contact
<b>Email</b>	The email of the Primary Contact
<b>Fax</b>	The fax number where you can receive facsimile message/correspondence
<b>Service Category</b>	The service category of the submitted budget packet (see Services Category in your contract)
<b>Grant Year</b>	The beginning and ending grant year of your budget submission
<b>Amount</b>	Enter the amount of this contract

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Budget Summary**      **B05-SU-1**

This form summarizes all of the line items in the submitted budget packet for the service award listed on the Cover Page.

**Section I**      Summarizes the organizational information provided on the cover page. The information will automatically populate as the cover page is completed.

**Section II**      This section summarizes the budget information calculated in the submitted budget packet for this grant. *This form is required for all Ryan White Part A awards issued by Maricopa County Health Care Mandates.* This form reports the summary line item amounts allocated as Administrative Costs, Direct Service Cost, and total budget for the budget packet for this service's award.

Administrative costs relate to oversight and management of CARE Act funds and include such items as contracting, accounting, and data reporting.

1. Administrative Costs, defined in Section 2604(f)(3) defines allowable "subcontractor administrative activities" to include:
  - a. Usual and recognized overhead, including establishing indirect rates for agencies;
  - b. Management and oversight of specific programs funded under this title; and
  - c. Other types of program support such as quality assurance, quality control, and related activities.

Examples include: salaries and expenses of executive officers, personnel administration, accounting, the costs of operating and maintaining facilities, and depreciation or use allowances on building and equipment.

**The Administrative Costs Column, including indirect costs, cannot exceed 10% of the total award.**

**\*\*Indirect Cost – Providers claiming an indirect cost must submit their most current negotiated indirect cost rate issued by the appropriate federal agency.**

2. Direct Services allocations are for services that directly benefit Ryan White HIV+ clients such as staff, medicine and drugs, clinical supplies, etc.

**The final determination for cost allocations between Administrative Costs and Direct Service Costs resides with Maricopa County Health Care Mandates.**

The information will automatically populate as the budget packet is completed.

The ending GRANT BALANCE must equal zero (0) for the budget document to be accepted.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Personnel**      **B05-PE-1**

Complete this form to list ALL persons being paid a salary from the Ryan White Part A grant in this budget packet.

This form calculates the applied annual salary and applied annual benefits per individual FTE.

The Provider must determine if the position(s) listed are Administrative, Direct Service, or both.

\*The Provider must indicate how much of the time spent on Ryan White Part A activities are considered administrative. For example – a Case Management Supervisor may continue with a case load of their own, in this case, it must be determined how much of their time should be allocated to Administrative duties and amount of time allocated to Direct Service support.

The cells references in the form (#) requiring entry are:

<b>Section (A)</b>	Full Time Hours - This is used to determine the annual hours for full time staff. (Typically 2,080)
<b>Section (B)</b>	Benefits – Enter a brief name of all benefits included for staff and the percentage of gross salary associated with that benefit. (i.e., Social Security – (FICA) 6.75%)
<b>Position Title</b>	Enter the position title
<b>Last Name</b>	Enter the staff member's last name
<b>FTE</b>	Enter the FTE, or fraction of full time, this person will work on this Part A grant. (i.e., a person who spends ½ of full time hours on this grant would be .5 FTE)
<b>Rate</b>	Enter the position's hourly rate
<b>Job Status</b>	Determine whether a persons primary responsibilities on this grant will be for Direct Service activities or Administrative activities by entering A or D. *For a staff member who has both responsibilities enter A.
<b>Percent Applied</b>	Enter how much of the staff member's time is spent on Administrative duties. (i.e., a staff member can spend 90% of their time doing administrative duties and 10% performing Direct Services.)

The cells referenced in the form (#) that are calculated are: **F, G, J, K, L, M, N, O, P, Q**

These calculations are explained under each of the cell references.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Travel**                      **B05-TV-1**

All travel must directly benefit and be specific to the work supported by this grant.

Complete this form to budget any travel expenses associated with the services of the Ryan White Part A grant.

This form consists of two (2) sections – Mileage and Other Travel

**Mileage**                      This section establishes a budget amount, both Administrative and Direct Service, for mileage reimbursement in conjunction with providing services to the grant. The Provider is to determine the per mile rate they reimburse staff (Cell [E12]) Maricopa County Health Care Mandates has adapted a standard formula to apply all mileage reimbursement budgets.

The mileage budget form requires the following entries:

- Annual Miles**                      Enter the annual miles that are budgeted for one (1) FTE staff person. **Do not use partial FTEs, only the annual miles for 1 FTE.**
- Rate**                                      [Cell E16] Enter the current rate used by your organization to reimburse mileage requests.
- Description**                      Provide a detailed justification of the travel budget requested, both Administrative Cost and Direct Services.

Cell references: (D), (E), and (F) are calculated automatically.

**Other Allowable Travel:** In some cases, other travel may be allowed under the Ryan White Part A grant. Each item listed in this section must have a detailed and accurate budget justification attached – *Be specific about who will travel, where, when, and why the travel is necessary.* At this time, Maricopa County Health Care Mandates has determined costs included in this section are Administrative Costs.

*(Section III: Reporting Requirements, Chapter 2: Budget, Contracting, and Fiscal Reports – Grantees should limit the use of Part A funds for travel to HRSA-sponsored technical assistance and other grantee meetings identified. All travel for contractors must be local and directly related to the services provided under the specific contract. Budgeting for international travel is not allowed.)*

- Dates of Travel**                      Enter the dates the “other travel” is expected.
- Cost Line Item**                      Enter the estimated cost and description of the expense. \*This can include car rental, parking fees, etc.
- Description**                              Provide a detailed description of the justification, in relation to Ryan White Part A services as awarded in this grant.

Cell references: (D), (E), and (F) are calculated automatically.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Supplies**      **B05-SP-1**

Complete this form to create the supplies budget for the Ryan White Part A grant for this budget packet. Supplies can include general office supplies (pens, paper, etc.), program, and medical supplies.

**Section I    General Office Supplies**

Maricopa County Health Care Mandates has initiated a standard allocation model for general office supplies: ***(Administrative Allocation = Total Budget x Percent of administrative FTE to total FTE)***

The General Office Supplies section requires the following entries:

<b>Item</b>	Enter a brief reference for the item(s) budgeted. (i.e., pens, paper, etc.)
<b>Annual Budget</b>	Enter the annual budget allocated for general office supplies
<b>Narrative</b>	Briefly describe the need for these items in operations of this grant.

Administrative costs in this section are applied to the annual budget using the formula provided above.

**Section II    Program Supplies**

This chart can be used to identify and budget for program specific and/or medical supplies used in providing services. Programs supplies have been determined to be Direct Service Costs; however final determination resides with Maricopa County Health Care Mandates.

When completing this section, enter your data into the following sections:

<b>Description</b>	Enter a brief reference for item(s) budgeted. (i.e., medical supplies)
<b>Annual Budget</b>	Enter the annual budget allocated for the program supplies listed.
<b>Narrative</b>	Briefly describe the need for these items in the operations of this grant.

**Section III – Equipment less than \$1,000**

This section includes items such as fax machines, shredders, and other small equipment less than \$1,000. Per HRSA guidelines, computers and software are considered supplies – include all computers.

When completing this section, enter data into the following sections:

<b>Description</b>	Enter a brief reference for item(s) budgeted. (i.e., fax, shredder, printer)
<b>Allocated Amount</b>	Enter the amount allocated for this item.
<b>Narrative</b>	Briefly describe the need for these items in the operations of this grant.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Equipment**      **B05-EQ-1**

Complete this form to budget for equipment needed to support services under this Part A grant. Indicate the item budgeted, the total budgeted amount, and a detailed justification of the equipment to be purchased.

Enter the appropriate information in cells **(A)**, **(B)**, and **(E)**.

- Item Budgeted**      Enter a brief reference for the equipment requested.  
**Amount Budgeted**      Enter the estimated cost of the equipment requested.  
**Narrative**      Provide a brief narrative justification detailing the need for the equipment.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Contractual**      **B05-CT-1**

Complete this form to budget for consulting, contract labor, and/or subcontractors in conjunction with operating this Part A grant. For each section, indicate the name, licenses/qualification, hours budgeted, quoted rate, dates of service, and a detailed justification for why these services are necessary to provide services.

**Section I – Consulting:**

This section should be completed to reflect budgeted amounts for consulting work done in conjunction with grant operations. For each consultant listed, a narrative will be required indicating their licenses and/or qualifications in addition to the budget justification for the services provided.

The consulting section requires the following entries:

<b>Consultant</b>	Indicate the vendor/consultant name
<b>Hours Budgeted</b>	Enter the anticipated hours the consultant will bill for services.
<b>Quoted Rate</b>	Enter the rate per hour that the consultant will bill.
<b>Admin Budget %</b>	This section allows the provider to determine the administrative percentage rate the consultant will be budgeted for. <b>*Final determination of this resides with Maricopa County Health Care Mandates.</b>
<b>Dates of Service</b>	Enter the dates anticipated the consultant will be utilized for.
<b>Licenses/qualifications</b>	Enter the licenses and/or qualifications the consultant possesses that indicated proper credentials to perform services.
<b>Narrative</b>	Indicate the needs and reasons for using the consultant.

**Section II – Subcontracts**

This section should be used to identify and budget for any subcontracts utilized in the grant year.

Backup is required for each subcontract listed in this section. Acceptable documentation is a signed sub-contract agreement or Memorandum of Understanding. Maricopa County will enforce the 10% administrative cost cap per HRSA guidelines established for first-line entities receiving Part A funds.

This section requires entry into the fields similar to the entries for section I.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Program Support B05-SP-1**

Complete this form to budget for other support necessary to provide services under this Part A grant. This form applies the FTE ratio for the expenditures including telephone, postage, copying, and utilities.

**Section I – Telephone**

Complete this section to complete the budget for telephone expenses.

**Annual amount budgeted** Enter the annual budget for telephone expenses used in operations of this contract award. \*Please note the two sections for cell phones and direct lines.

**Narrative justification** Provide a justification for the telephone expenses allocated to this contract.

**Section II – Copy/Duplicating**

This section allows you to budget for copying and duplicating expenses. This includes program brochures that are allocated as direct service.

Enter the information in the following:

<b>Description</b>	Reference the printing/duplicating projects anticipated.
<b>Budget</b>	Enter the budgeted amount, annually or by project.
<b>Narrative Justification</b>	Briefly describe each printing/duplicating project and indicate its need for this grant.

**Section III and Section IV – Postage and Utilities**

Complete these two sections to budget for postage and utilities used in this contract. Utilities should be defined by the service type (i.e., electric, water, gas, etc.)

**Section V – Other Program Support**

Enter any other program support in this section. Be sure to include an accurate narrative justifying the expenses.

Section V requires the following entries:

<b>Description</b>	Enter a brief reference to identify the support requested in the budget.
<b>Budgeted Amount</b>	Enter the total amount budgeted for each line item described.
<b>Narrative</b>	Provide a brief narrative, justifying the expenses requested in this section.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Other Professional Services B05-PF-1**

Complete this form to budget for other professional administrative services: audit/accounting, insurance, rent/space, or other professional services. For each section, indicate the provider of service(s), the rate, a detailed description of the service provided, and the method of calculating the budget for this Part A grant.

**Section I – Audit/Accounting/Finance**

Complete this section if professional financial services are utilized.

<b>Vendor</b>	Enter the name of the person/organization that will be providing the service.
<b>Hours Budgeted</b>	Enter the anticipated hours the above listed vendor will bill for.
<b>Quoted Price</b>	Indicate the rate per hour the vendor will charge this contract.
<b>Dates of service</b>	Indicate the dates this service will be performed.
<b>Description</b>	Provide a brief description of the service to be provided by the vendor.
<b>Cost Method Used</b>	Detail the method used to determine the costs charged to this contract.
<b>Budget Justification</b>	Provide a narrative justifying the need for this service.

**Section II – Insurance**

Complete this section to budget for insurance expenses allocated to this contract.

<b>Insurance Type</b>	Indicate the type of insurance (i.e., liability, professional, etc.)
<b>Annual Premium</b>	Enter the annual premium charged for this insurance
<b>Percent to Grant</b>	Enter the percentage of the annual premium allocated to this grant.
<b>Dates of Service</b>	Enter the start and end dates of each policy listed.
<b>Description</b>	Briefly describe the insurance policy (i.e., coverage etc.)
<b>Cost Method Used</b>	Briefly describe the cost method used in determining the allocation amount to this grant.
<b>Narrative</b>	Provide a narrative, justifying the need for this insurance in relation to the operations of this grant.

To complete this section, enter the data into the cells similar to the data in Section I

**Section III – Rent/Space**

Complete this section for rent/space costs allocated for this contract. Space is considered by Maricopa County Health Care Mandates to be administrative.

<b>Provider</b>	Indicate the provider/vendor.
<b>Annual Rent</b>	Indicate the annual amount of rent/space for the <b>organization</b> .
<b>Percentage to grant</b>	Input the percentage of rent allocated to this contract.
<b>Description</b>	Enter a brief description.
<b>Cost method used</b>	Describe how the costs allocated to this contract were determined.
<b>Budget Justification</b>	Provide a justification for this expenditure.

**Section IV – Other Professional Service**

Complete this section for other professional services used in this contract not listed above.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

Complete this section by filling out the necessary information in the Yellow cells. This section allows providers to indicate the percentage requested as Administrative and Direct Service. \*Final determination resides with Maricopa County Health Care Mandates.

To complete this section, the following fields are required:

<b>Vendor</b>	Provide the name of the vendor that will provide the service.
<b>Hours Budgeted</b>	Indicate the number of hours this service will require.
<b>Quoted Price</b>	If known, or estimated, indicate the price charged per unit in hours budgeted.
<b>Admin Budget</b>	Indicate the percentage of this service allocated as administrative cost. Final determination of Administrative percentage resides with Maricopa County Health Care Mandates.
<b>Description</b>	Use this cell to reference the project or service.
<b>Cost Method Used</b>	Briefly describe the determination of allocated costs to this grant. Also describe the determination of the Administrative budget percentage.
<b>Narrative</b>	Provide a brief narrative, justifying the need for this expenditure in relation to the operations of this grant.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Schedule of Deliverables**

Complete this form to indicate the services to be performed in this contract. This sheet allows for planning and cost calculations for services to be provided under the scope of the contract. Providers may utilize this sheet to begin determining the costs of providing services to clients.

Complete the yellow sections in this worksheet only. The information entered will be linked to the Unit Cost Sheet.

- A. **Activity (From Work Statement)** – Utilize the Work Statement (separate document) to enter the activity this unit will relate to.
  - B. **Product/Unit Name** – Enter the name that identifies the unit provided as listed under the eligible services policies and procedure document for said service service category.
  - C. **Number of Units Proposed** – Enter the number of units you are proposing to provide for the contract year.
  - D. **Proposed Fee per Product/Deliverable** – This fee will automatically calculated based on the information provided in the Unit Cost Worksheet (following). This amount is based on direct and administrative budgets provided in the previous sections.
- Schedule of Deliverables** – Enter the monthly amount of units that will be provided. This section allows for planning and budgeting on monthly activity for this contract.
- E. **Total Payment per Objective/Activity** – This is an automatic calculation based on the Proposed Fee per Product/Deliverable and the annual number of units provided.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Unit Cost**

This worksheet defines the costs for services proposed in the contract. Each unit of service proposed in the Schedule of Deliverables worksheet must be defined and costs calculated based on the information you provide and the total budget from the prior worksheets.

Complete the Yellow sections only. This worksheet allows providers to determine direct labor involved with providing the services of the contract. Some costs cannot be defined as easily, and this sheet automatically calculates these costs to provide a reasonable cost of units of service provided.

**Unit Definition** – Provide the description as defined in the service specific policies and procedures eligible service.

**Position** – From the personnel worksheet, indicate the position(s) that provide direct services for this unit. For example, indicate that this unit will require a Case Manager. Use each row to indicate different positions/duties involved in providing this unit.

**Direct Service duties** – Provide a brief narrative of what this position will be responsible for when completing this unit. For example, indicate that this position will provide a face-to-face meeting with a client.

**Hourly Rate** – From the personnel worksheet, indicate this position(s) hourly rate. If there is more than one position in the budget for this duty, enter the average hourly rate for the position – not the person. For example, if there are 4 Case Manager positions listed at various rates; indicate the average hourly rate for those four positions.

**Hourly BNF** – This automatically calculates the hourly benefits based on the rate indicated in the Personnel worksheet.

**Total Salary and Benefits** – This is a calculation that sums the hourly rate and the hourly benefits. This is a total personnel cost for this line item.

**Direct Svc Time spent** – Enter the amount of time this position will spend to complete this unit. Do not indicate it is per 15 minutes! Enter the amount of time this position would spend on this specific task. For example, a typical face-to-face visit may be 30 minutes. Enter 30 in this line item.

**Other Direct Costs** – This section applies the budgeted numbers from the previous sections and allocates the costs to this unit based on the number of units provided and percent of time spent providing these services. For example, Travel cannot be necessarily allocated per mile per unit (sometimes a Case Manager might have to travel; sometimes it will be in the office). This section applies an average.

**Administrative Costs** – This section applies the budgeted amounts from the previous sections and allocates the costs to this unit based on the number of units provided and percent of time spent providing these services in a similar manner to the Other Direct Costs.

**Cost per Unit** – This calculation indicates a reasonable rate that will link into the Schedule of Deliverables and provide a planning model for the actual costs to provide different services in this contract.

**Maricopa County Health Care Mandates**  
Ryan White Part A – Budget Documentation Instructions

**Unit Cost Narrative –**

This sheet is optional for providers to use. This sheet will be utilized **IF** the provider feels the unit costs cannot or should not be calculated in the Unit Cost Worksheet. MCDPH has the final authority to approve or disapprove of any amounts requested manually in this section. If a Provider indicates the use of the manual calculation, it is imperative they provide strong justifications of the costs associated with providing the services indicated.

Complete the Yellow sections only.

**Unit Name** – Enter the name as defined in the service specific policies and procedures eligible service.

- A. **Definition** - Provide the description as defined in the service specific policies and procedures eligible service.
- B. **Unit Measurement** – Enter how the unit will be measured and recorded. For example, 1 unit = 1 hour of time.
- C. **Reimbursement Rate Requested** – Enter the amount you are asking to be reimbursed for providing this service. This must match the total below.

**Unit Cost** – This section will be utilized to indicate the various costs associated with providing this service. It is critical the costs associated with this service be reasonable and justified.

- A. **Description of Cost** – Indicate what cost will be incurred to complete this unit of service. (i.e., Staff time).
- B. **Cost** – Indicate the actual cost for one unit of this service. (i.e., 1 hour of staff time)
- C. **Narrative Justification** – Provide a brief narrative of how this cost is associated with providing this service.

**Maricopa County Department of Public Health,  
Ryan White Title I - Budget Documentation**

**NAME OF ORGANIZATION:** \_\_\_\_\_

Fed. Employee ID # \_\_\_\_\_  
(FEIN)

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

AUTHORIZED CONTACT \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

E-MAIL \_\_\_\_\_

PRIMARY CONTACT \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

EMAIL \_\_\_\_\_

**SERVICE CATEGORY** \_\_\_\_\_

GRANT PERIOD: \_\_\_\_\_  
Start Date End Date

AMOUNT \$ \_\_\_\_\_ -

# Maricopa County Health Care Mandates, Ryan White Part A - Budget Documentation

**NAME OF ORGANIZATION:** \_\_\_\_\_

Fed. Employee ID #  
(FEIN) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

AUTHORIZED  
CONTACT \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

E-MAIL \_\_\_\_\_

PRIMARY CONTACT \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

EMAIL \_\_\_\_\_

**SERVICE CATEGORY** \_\_\_\_\_

GRANT PERIOD: \_\_\_\_\_  
Start Date End Date

AMOUNT \$ \_\_\_\_\_ - \_\_\_\_\_

**Maricopa County Health Care Mandates,  
Ryan White Part A Grant,  
Administration Budget Summary - B05-SU-1**

**(Section I)**

Organization  
Service Category  
Grant Period

0	Contract Number
0	
January-00	Through January-00

(Enter Contract #)

Narrative of Grant:

(Enter the Planning Council Definition of this service.)

**(Section II)**

Budget Requested: \$ -

Operating Expenses			Administrative Budget	Direct Service Budget	Total Budget
Personnel:	Salaries	0 FTE	\$ -	\$ -	\$ -
Personnel:	Fringe/Benefits		-	-	-

Subtotal: Personnel

-	-	-
---	---	---

**Other Direct Costs**

Travel		-	-	-
Supplies		-	-	-
Equipment		-	-	-
Contractual		-	-	-
Program Support		-	-	-
Other Professional Services		-	-	-

Subtotal: Other Direct Costs

-	-	-
---	---	---

**Total Operating Expenses**

-	-	-
---	---	---

(Personnel and Other Direct Costs)

**Indirect Costs**

Indirect Rate	0%		
---------------	----	--	--

(Providers claiming an indirect cost must submit their most current negotiated indirect cost rate issued by the cognizant federal agency.)

<b>Total Costs of Grant</b>	(Percent of Total)	-	-	\$ -
-----------------------------	--------------------	---	---	------

(Total Operating Expenses plus Indirect Costs)

0%	0%
----	----

**GRANT BALANCE** (Grant Revenue less Total Costs of Grant)

\$ -

The Grant balance must equal zero

Finance Approval \_\_\_\_\_ Date: \_\_\_\_\_

Exec. Director Approval \_\_\_\_\_ Date: \_\_\_\_\_

Administrative Agent \_\_\_\_\_ Date: \_\_\_\_\_

Personnel All staff paid in full or part from this Ryan White Title I grant are to be listed in the following chart.

1 Staffing

(C)	(C-a)	(D)	(E)	Provider Entry		Auto Calculation									
				(F) = (A) * (E) * (D)	(H)	(G) = (F) * (B)	(I)	(J) = (F) * (I)	(K) = (G) * (J)	(L) = (F) * (J)	(M) = (G) * (K)	(N) = (G) * (L)	(O) = (G) * (M)		
Position Title	Last Name	FTE	Rate	Gross Applied to grant per FTE	Benefits Applied to grant per FTE	Job Status	Percent applied as Administrative	Gross Admin Salary	Gross Admin Benefits	Direct Service Salary	Direct Service Benefits				
1		0	0	-	-	A	100%	-	-	-	-				
2				-	-	A	0%	-	-	-	-				
3				-	-	0	0%	-	-	-	-				
4				-	-		0%	-	-	-	-				
5				-	-			-	-	-	-				
6				-	-			-	-	-	-				
7				-	-		0%	-	-	-	-				
<b>TOTAL</b>		0		-	-			-	-	-	-				
(Admin)		0 FTE		(N) = (D) * (I)			0%	(P) = (N) / ((N) + (O))							
(Direct Service)		0 FTE		(O) = (D) * (1-(I))			0%	(Q) = (O) / ((N) + (O))							

(A) Calculating Annual Salary

Annual Salary	0
---------------	---

(Rate x Annual Hours)

(B) Benefits

Benefits	Percent
	0.00%
	0.00%
<b>TOTAL</b>	<b>0.00%</b>

**Maricopa County Health Care Mandates Part A - Budget Document**  
Travel - B05-TV-1

**TRAVEL**

Travel can be budgeted for the cost of staff mileage and other travel associated with grant activities under Title I funds.

**1 Mileage** Mileage will be budgeted utilizing the standard calculation of annual miles for a full time staff person x the rate determined by your organization per mile x the number of FTE(s) budgeted to provide services under this grant.

	(A)	(B)	(C)	(D) = (B)*(C)*(A)	(E)	(F)	(G)
<b>Mileage 0 0</b>							
	FTE	Annual Miles Budgeted (Per 1 FTE)	Miles Applied to Grant	Budget \$0.00	Admin	Direct Svc	Description
1	0	0	0	\$ -	-	-	
2	0	0	0	\$ -	-	\$0.00	
<b>TOTAL</b>	0	0	0	\$ -	-	\$ -	

(Total Miles applied to this grant)

**(B) Note - Budget annual mileage for 1 FTE**

**2 Other Allowable Travel**

At this time, Maricopa County Health Care Mandates has determined that costs included in this section are Administrative Costs.

	(A)	(B)	(C)	(D) = (B)+(C)	(E) = (D)	(F)	(G)
<b>Other Allowable Travel 0 0</b>							
	Dates of Travel	Cost Line Item	Cost Line Item	Total Budget	Admin	Direct Service	Description
1		\$ -	\$ -	\$ -	-	-	
	Description						
2		\$ -	\$ -	\$ -	-	-	
	Description						
3		\$ -	\$ -	\$ -	-	-	
	Description						
				\$ -	-	-	

Admin      Direct Service      Total

**SUMMARY** (Travel)

-                      -                      -

**Maricopa County Health Care Mandates Part A - Budget Document**  
Supplies - B05-SUP-1

The supplies line item is used to budget funds for supplies used in the operations of the budget. This category can include general office supplies and program/medical supplies.

**General Office Supplies: includes pens, paper, toner, etc.** (Apply at FTE Ratio)

	(A)	(B)	(C) = (A) * (1 - (B))		(D) = (B) + (C)	(E)
General Office Supplies 0 0						
Item	Annual Budget	Admin 0%	Direct Service	Total	Narrative	
1	0	-	-	-		
2		-	-	-		
3		-	-	-		
4		-	-	-		
5		-	-	-		
<b>TOTAL</b>		-	-	<b>TOTAL</b>	\$	-

**2 Program Supplies** Program Supplies have been deemed Direct Service.

	(A)	(B)	(C)	(D) = (B)	(E)	(F)
Program Supplies 0 0						
Description	Annual Budget	Admin	Direct	Narrative		
1	0		-			
2			-			
3			-			
4			-			
5			-			
<b>TOTAL</b>		-	-	<b>TOTAL</b>	\$	-

**3 Equipment less than \$1,000 - includes computers, fax machines, shredders, and adding machines to be used in the operations of this grant.** (Apply at FTE Ratio)

	(A)	(B)	(C) = (A) * (1 - (B))		(D) = (B) + (C)	(E)
Equipment less than \$1,000 0 0						
Description	Allocated Budget	Admin 0%	Direct Service	Total	Narrative	
1	0	-	-	-		
2		-	-	-		
3		-	-	-		
4		-	-	-		
5		-	-	-		
<b>TOTAL</b>		-	-	<b>TOTAL</b>	\$	-

Summary

- -

**Maricopa Country Health Care Mandates Part A - Budget Document**  
**Equipment - B05-EQ-2**

The equipment line item is budgeted for equipment purchased or leased in conjunction with operations of the grant.

**Equipment greater than \$1,000**

1 Equipment greater than \$1,000 - Include large equipment necessary to be used in the operations of this grant. Please note that there are more requirements for approval.

(A)	(B)	(C)	(D) = (B * (1 - (C)))	(E) = (B) + (C)	(E)
<b>Equipment greater than \$1,000 0 0</b>					
Item Budgeted	Amount Budgeted	Admin 0%	Direct Service	Total	Narrative
1	0	-	-	-	
2		-	-	-	
3		-	-	-	
4		-	-	-	
5		-	-	-	
<b>TOTAL</b>		-	-	<b>TOTAL</b>	<b>\$ -</b>



**Maricopa Country Health Care Mandates Part A - Budget Document**  
**Other Program Support - B05-SP-1**

**Other Program Support**

**1 Telephone**

Telephone 0 0					
Description	Annual Amount Budgeted	Admin 0%	Direct Service	Total	Narrative Justification
1 Cell Phones	0	-	-	-	
2 Direct Line		-	-	-	
3		-	-	-	
TOTAL		-	-	TOTAL	\$ -

**2 Copy/Duplicating**

Copy/Duplicating 0 0					
Description	Budget	Admin 0%	Direct Service	Total	Narrative Justification
1 Program Brochures					
	0	-	-	-	
2 Other Copying/Duplicating					
	0	-	-	-	
	0	-	-	-	
	0	-	-	-	
TOTAL		-	-	TOTAL	\$ -

Budget Category 6 4

**3 Postage**

Postage 0 0					
Description	Amount Budgeted	Admin 0%	Direct Service	Total	Narrative Justification
1	0	-	-	-	
TOTAL		-	-	TOTAL	\$ -

**4 Utilities**

Utilities have been deemed 100% administrative. (Ruling 6.6.B05)

Utilities 0 0					
Description	Amount Budgeted	Admin 0%	Direct Service	Total	Narrative Justification
1	0	-	-	-	
		-	-	-	
		-	-	-	
		-	-	-	
TOTAL		-	-	TOTAL	\$ -

**4 Other Program Support**

Other Program Support 0 0					
Description	Budgeted Amount	Admin 0%	Direct Service	Total	Narrative
1	0	-	-	-	
	0	-	-	-	
	0	-	-	-	
	0	-	-	-	
TOTAL		-	-	TOTAL	\$ -

**Maricopa Country Health Care Mandates Part A - Budget Document**  
**Other Professional Services - B05-PF-1**

**1 Audit/Accounting/Finance**

Audit/Accounting/Finance 0 0							
Vendor	Hours Budgeted	Quoted Price*	Total Price	Dates of Service	Admin	Direct Service	Description
a	0	0	-		-		
Cost Method Used							
Budget Justification							
b			-		-		
Cost Method Used							
Budget Justification							
c					-		
Cost Method Used							
Budget Justification							
			TOTAL		-		\$ -

**2 Insurance**

Insurance 0 0							
Insurance Type	Annual Premium	Percent To grant	Total Grant	Dates of Service	Admin	Direct Service	Description
a	0	0%	-		-		
Cost Method Used							
Budget Justification							
b	0	0%	-		-		
Cost Method Used							
Budget Justification							
c		0%	-		-		
Cost Method Used							
Budget Justification							
			TOTAL		-		\$ -

**3 Rent/Space**

Rent/Space 0 0							
Provider	Annual Rent	Percent to Grant	Total Grant	Dates of Service	Admin	Direct Service	Description
a	0	0%	-		-		
Cost Method Used							
Budget Justification							
			TOTAL		-		\$ -

**4 Other Professional Service**

Other Professional Service 0 0							
Vendor	Hours Budgeted	Quoted Price*	Total Price	Admin Budget %	Admin	Direct Service	Description
a	0	0	-	0%	-	-	
Cost Method Used							
Budget Justification							
b			-		-	-	
Cost Method Used							
Budget Justification							
c					-	-	
Cost Method Used							
Budget Justification							
			TOTAL		-	-	\$ -



















**Instructions:** Use this worksheet to submit manual calculations of proposed reimbursement rates for services provided under this grant.  
 Complete one section for each unit of service proposed. (i.e, face-to-face visit)  
 It is the Provider's responsibility to adequately identify costs associated with this service.  
 Unallowable and/or unnecessary costs will be rejected by MCDPH.

Unit Name:

Definition:

(Briefly describe and define the unit of service that you are proposing)

Unit Measurement:

Reimbursement Rate Requested:  (enter the rate at which you are submitting to be reimbursed for this service.)

\* This number must match the total in the section below.

Unit Cost: (Use this section to justify the rate at which you are requesting to be reimbursed.)  
 (PER UNIT)

	Description of Cost	Cost	Narrative Justification
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Total -

Description of Cost Identify the cost associated with providing this cost.  
 (i.e., personnel and benefits utilized in providing one unit.)  
 Cost Input the amount PER UNIT  
 Narrative Justification Briefly describe how this cost was calculated, the reason for this cost, and any other information relevant to justify the cost.  
 any other information relevant to justify this cost.

Unit Name:

Definition:

(Briefly describe and define the unit of service that you are proposing)

Unit Measurement:

Reimbursement Rate Requested:  (enter the rate at which you are submitting to be reimbursed for this service.)

\* This number must match the total in the section below.

Unit Cost: (Use this section to justify the rate at which you are requesting to be reimbursed.)  
(PER UNIT)

	Description of Cost	Cost	Narrative Justification
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
	Total	-	

Description of Cost Identify the cost associated with providing this cost.  
(i.e., personnel and benefits utilized in providing one unit.)

Cost Input the amount PER UNIT

Narrative Justification Briefly describe how this cost was calculated, the reason for this cost, and any other information relevant to justify the cost.  
any other information relevant to justify this cost.

Unit Name:

Definition:

(Briefly describe and define the unit of service that you are proposing)

Unit Measurement:

Reimbursement Rate Requested:  (enter the rate at which you are submitting to be reimbursed for this service.)

\* This number must match the total in the section below.

Unit Cost: (Use this section to justify the rate at which you are requesting to be reimbursed.)  
(PER UNIT)

	Description of Cost	Cost	Narrative Justification
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
	Total	-	

Description of Cost Identify the cost associated with providing this cost.  
(i.e., personnel and benefits utilized in providing one unit.)

Cost Input the amount PER UNIT

Narrative Justification Briefly describe how this cost was calculated, the reason for this cost, and any other information relevant to justify the cost.  
any other information relevant to justify this cost.

Unit Name:

Definition:

(Briefly describe and define the unit of service that you are proposing)

Unit Measurement:

Reimbursement Rate Requested:  (enter the rate at which you are submitting to be reimbursed for this service.)

\* This number must match the total in the section below.

Unit Cost: (Use this section to justify the rate at which you are requesting to be reimbursed.)  
(PER UNIT)

	Description of Cost	Cost	Narrative Justification
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
	Total	-	

Description of Cost Identify the cost associated with providing this cost.  
(i.e., personnel and benefits utilized in providing one unit.)

Cost Input the amount PER UNIT

Narrative Justification Briefly describe how this cost was calculated, the reason for this cost, and any other information relevant to justify the cost.  
any other information relevant to justify this cost.

Unit Name:

Definition:

(Briefly describe and define the unit of service that you are proposing)

Unit Measurement:

Reimbursement Rate Requested:  (enter the rate at which you are submitting to be reimbursed for this service.)

\* This number must match the total in the section below.

Unit Cost: (Use this section to justify the rate at which you are requesting to be reimbursed.)  
(PER UNIT)

	Description of Cost	Cost	Narrative Justification
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
	Total	-	

Description of Cost Identify the cost associated with providing this cost.  
(i.e., personnel and benefits utilized in providing one unit.)

Cost Input the amount PER UNIT

Narrative Justification Briefly describe how this cost was calculated, the reason for this cost, and any other information relevant to justify the cost.  
any other information relevant to justify this cost.

Unit Name:

Definition:

(Briefly describe and define the unit of service that you are proposing)

Unit Measurement:

Reimbursement Rate Requested:

(enter the rate at which you are submitting to be reimbursed for this service.)

\* This number must match the total in the section below.

Unit Cost:

(Use this section to justify the rate at which you are requesting to be reimbursed.)

(PER UNIT)

	Description of Cost	Cost	Narrative Justification
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
	Total	-	

Description of Cost

Identify the cost associated with providing this cost. (i.e., personnel and benefits utilized in providing one unit.)

Cost

Input the amount PER UNIT

Narrative Justification

Briefly describe how this cost was calculated, the reason for this cost, and any other information relevant to justify the cost. any other information relevant to justify this cost.

Unit Name:

Definition:

(Briefly describe and define the unit of service that you are proposing)

Unit Measurement:

Reimbursement Rate Requested:

(enter the rate at which you are submitting to be reimbursed for this service.)

\* This number must match the total in the section below.

Unit Cost:

(Use this section to justify the rate at which you are requesting to be reimbursed.)

(PER UNIT)

	Description of Cost	Cost	Narrative Justification
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
	Total	-	

Description of Cost

Identify the cost associated with providing this cost.  
(i.e., personnel and benefits utilized in providing one unit.)

Cost

Input the amount PER UNIT

Narrative Justification

Briefly describe how this cost was calculated, the reason for this cost, and any other information relevant to justify the cost.  
any other information relevant to justify this cost.

Unit Name:

Definition:

(Briefly describe and define the unit of service that you are proposing)

Unit Measurement:

Reimbursement Rate Requested:

(enter the rate at which you are submitting to be reimbursed for this service.)

\* This number must match the total in the section below.

Unit Cost:

(Use this section to justify the rate at which you are requesting to be reimbursed.)

(PER UNIT)

	Description of Cost	Cost	Narrative Justification
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
	Total	-	

Description of Cost

Identify the cost associated with providing this cost. (i.e., personnel and benefits utilized in providing one unit.)

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**Maricopa County Health Care Mandates  
Ryan White Part A Program  
Phoenix, EMA  
FY 2007/2008**

(Agency Name) \_\_\_\_\_ FY 2007/2008 WORK PLAN FOR \_\_\_\_\_ (Service Category)

**Performance Measure FY 2006/2007**

- 1) Number of new clients =
- 2) Number of returning clients =
- 3) Face to Face visits =
- 4) =
- 5) =
- 6) % of compliance =
- 7) Total # unduplicated clients

Challenge:

Goal:

OBJECTIVES:	ACTIVITIES	IMPLEMENTATION PLAN/POSITIONS REQUIRED	HOW GOALS WILL BE MEASURED/ATTAINED/EVALUATION METHODS
<p><b>Objective 1:</b></p> <p><b>The project will:</b> (Define and describe the activities associated with the objectives and how they will achieve the goals and objectives as stated)</p>	<p><b>Implementation:</b></p> <p><b>Responsible staff:</b> (For each activity and measurement, indicate the staff responsible)</p>	<p><b>Narrative Measure Statement:</b> (provide a narrative of how the objective will be measured, evaluated, and maintained i.e., # of units reported in database)</p> <p><b>Service Unit Name:</b> (Provide the name of the service unit for this objective – may be more than one i.e., face to face, client intake, etc.,)</p> <p><b>Service Unit Description:</b> (Further describe Service Unit i.e., face to face = 15 minutes via in person contact)</p> <p><b>Units to be Provided:</b> (enter the annual service units budgeted)</p>	

OBJECTIVES:	ACTIVITIES	IMPLEMENTATION PLAN/POSITIONS REQUIRED	HOW GOALS WILL BE MEASURED/ATTAINED/EVALUATION METHOD
<p>Objective:</p>	<p>The project will:</p>	<p>Implementation:</p> <p>Responsible staff:</p>	<p>Narrative Measure Statement:</p> <p>Service Unit Name:</p> <p>Service Unit Description:</p> <p>Units to be Provided:</p>