

HIV COMMUNITY SERVICES PROGRAM

**Support Services: Policies,
Definitions and Guidance**

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SECTION 1: Program Policies

PROGRAM PRIORITIES

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

Core Medical Services	Support Services
<ul style="list-style-type: none"> • Outpatient/Ambulatory Medical Care • AIDS Drug Assistance Program * • AIDS Pharmaceutical Assistance • Early Intervention Services • Oral Health Care* • Health Insurance Premium and Cost Sharing Assistance • Home Health Care* • Home and Community Based Health Services • Hospice Service • Mental Health Services* • Medical Nutritional Therapy* • Medical Case Management Services* • Substance Abuse Services Outpatient* 	<ul style="list-style-type: none"> • Case Management Services (non-medical)* • Child Care Services • Pediatric Development Assessment • Emergency Financial Assistance* • Food Banks/Home Delivered Meals • Health Education/Risk-Reduction • Housing Services* • Legal Services • Linguistic Services* • Medical Transportation Services* • Outreach Services • Permanency Planning • Psychosocial Support Services* • Referral for Health Care/Supportive Services • Rehabilitation Services • Respite Care

	<ul style="list-style-type: none"> • Substance Abuse Services (Residential)* • Treatment Adherence Counseling
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*Services currently funded by the HIV Community Services program

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

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

CAREWARE

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

GENERAL PROGRAM REQUIREMENTS

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

8. The Ryan White Program is a needs-based program; clients with the highest needs receive the greatest amount of service. Additionally, clients are not required to participate in case management if they do not require any Ryan White Program services. The Ryan White Program is not a federal entitlement program.
9. Clients receiving only CAREAssist services are not required to be in case management unless specifically required by the CAREAssist program. However, clients receiving Oregon Housing Opportunities in Partnership (OHOP) housing assistance services must be enrolled in case management as a requirement of program eligibility.
10. Service expenditures are expected to meet the minimum assessed need for the client. If the HIV case manager is faced with authorizing a basic service/item versus a more costly service/item that serves the same purpose, the HIV case manager should select the basic service/item.
11. State Managed Services **not** allowed for reimbursement at the local level include: Medical Nutritional Therapy, Home Health Care, Mental Health Treatment/Therapy or Counseling and Substance Abuse Treatment.
12. Ryan White Program funds may not be used to pay for professional licensure or meet program licensure requirements.
13. HIV Case Managers must pre-authorize any payment for client services. In no case may funds be used to pay any client bill in arrears (“Past Due” notifications).
14. Ryan White Program funds cannot be used to support or qualify a client for access under Oregon’s Medical Marijuana Program.
15. Ryan White Program funds may not be used to pay for off-premise social or recreational activities (i.e. movies, vacations, gym membership, parties, or retreats).
16. Every Ryan White Part B Program must be in compliance with the State requirements for a Release of Information (as required under ORS 192.518-192.524) in which a client authorizes in writing the disclosure of certain information about his/her case to another party (including family members).
17. All support service payments must be directly linked to documented need. Authorizing support service payments for one service to offset the client-identified need, which is either a disallowed service or for which the client has reached the service category cap, is not allowed. In other words, cost-shifting client expenses to offset a disallowed or “maxed” out service is not allowed.
18. Ryan White Program funds cannot be used to provide services to persons incarcerated in a local, State or Federal correctional facility with the

exception of case management/care coordination for purposes of transition into the community.

19. Eligible clients can receive services regardless of immigration status.

20. Per HRSA policy, funds awarded under the Ryan White Part B Program may NOT be used for:

- Inpatient Hospital Services: Funds may not be used to assist with inpatient care.
- Clinical Trials: Funds may not be used to support the costs of operating clinical trials of investigational agents, treatments (to include administrative management or medical monitoring of patients) or the cost of transportation and travel for a client's participation.
- Pre-Exposure Prophylaxis: Funds may not be used to purchase antiretroviral medication for HIV negative people.
- Clothing: Purchase of clothing.
- Detox: Inpatient detoxification in a hospital setting (Detoxification offered in a separate licensed residential setting is allowed, including a separately-licensed detoxification facility within the walls of a hospital, see Substance Abuse Services).
- Funerals: Funeral, burial, cremation, or related expenses.
- Household Appliances: Household appliances.
- Mortgages: Payment of private mortgages.
- Needle Exchange: Syringe exchange programs.
- Pets: Pet foods, products or veterinary visits. (Expenses for licensed guide dogs are allowable, see Medical Emergency Financial Assistance: Health Aids.)
- Taxes: Paying local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Vehicle Maintenance: Direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees.
- Water Filtration: Installation of permanent systems of filtration of all water entering a private residence. (Water filtration/purification devices (either portable filter/pitcher combinations or filters attached to a single water tap) are allowable under Psychosocial Emergency Financial Assistance: Supplemental Food Assistance, in communities/areas where recurrent problems with water purity exist and are documented. Such

devices (including their replacement filter cartridges) purchased with Ryan White HIV/AIDS Program funds must meet National Sanitation Foundation standards for absolute cyst removal of particles less than one micron.)

CLIENT ELIGIBILITY

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

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

Verification of HIV Diagnosis

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

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

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

Verification of Identity

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

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

Verification of Residence

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

Residence may be verified for an individual by providing one Tier one document or two Tier 2 documents:

Tier 1 (one required)	Tier 2 (two required)
<ul style="list-style-type: none"> • Current CAREAssist Card or copy of the CAREAssist Eligibility Report 	<ul style="list-style-type: none"> • Current Oregon Voter Registration card

<ul style="list-style-type: none"> • Unexpired Oregon State driver license or Tribal ID • Unexpired Oregon State ID • Utility Bill (cell phone bills not accepted) • Lease, rental, mortgage or moorage agreement/document • Current property tax document • Residency Verification Form (for homeless clients or clients without documentation of residency) 	<ul style="list-style-type: none"> • Letter from lease holding roommate (must include the lease holder's name, address that matches the CAREAssist Application and/or HIV Community Services Intake Form, relationship to the client and the lease holder's phone number) • Copy of public assistance/benefits letter/documentation (SSI, SSDI, TANF, etc.) • Paystubs showing home address • Court Corrections Proof of Identity • Homeowner's association fee • Military/Veteran's Affairs documents • Oregon vehicle title or registration card • Any document issued by a financial institution that includes your residence address, such as, a bank statement, loan statement, student loan statement, dividend statement, credit card bill, mortgage document, closing paperwork, a statement for a retirement account, etc.; • Approved letter from Oregon State Hospital, homeless shelter, transitional service provider or halfway house • Letter on company letterhead from an employer certifying that the client lives at a non-business residence address owned by the business or corporation.
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Verification of Insurance

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

- CAREAssist (CAREAssist Card and a copy of the CAREAssist Eligibility Report)
- Qualified Health Plan (QHP)
- Medicare
 - Part A
 - Part B
 - Part D
 - Low Income Subsidy
 - Qualified Medicare Beneficiary
- Oregon Health Plan (Medicaid)
- Private
 - Purchased outside Health Exchange
 - Group Policy (employer or spouse/parent's employer)
 - COBRA
 - Dental Insurance
- Other Public
 - VA Benefits¹
 - Indian Health Services²
- No Insurance

Verification of Income

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

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

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

There are 5 steps to determining income eligibility.

Topic	Guidance
Step #1: Determine whether client is pre-qualified	If a client is active in CAREAssist, and CAREAssist has determined client's income is at or below 250% of the FPL, they are pre-qualified. To be pre-qualified, proof of current participation in the CAREAssist Program must be obtained during the original Intake and at every 6 month review.
Step #2: Determine family members	<p>A family is defined as a group of two or more persons related by birth, marriage, adoption, or a legally defined dependent relationship (see "Dependent Status Policy" below). Life partner, significant other, legally registered Domestic Partner, or roommate (with no children in common) is not counted as family for purposes of income verification.</p> <p>Please note CAREWare uses the term "household" for the family definition described above. Also, the family/household definition described here is not the same as the definition of household used by the OHOP program.</p>
Step #3: Determine allowable documentation	<p>All income, produced by all dependents, must be declared as part of the household income. The following are the most commonly presented types of documentation:</p> <ul style="list-style-type: none"> • Social Security award letter (current year) • Copy of Social Security check • Year-end 1099 form • W2 fax form from employer • Federal income tax return • Accounting paperwork (spread sheet, financial journal, account books, etc.) • Bank statements showing automatic deposits • Pay stubs (2 months current consecutive paystubs or earnings statements for ALL jobs) <p>See "Allowable Income Documentation" below for complete list of allowed income and verification documents.</p>
Step #4: Calculate Gross Income	<p>In most circumstances, gross income is used to determine eligibility. Gross Income is total income <u>BEFORE</u> any taxes or other withholdings are deducted.</p> <p>Net Income is also known as "take home" income, or income <u>AFTER</u> taxes and withholdings are deducted. Net income may only be used when:</p> <p>(i) A self-employed individual or the individual's family member files an Internal Revenue Service, Form 1040, Schedule C in which case the agency will allow a 50 percent deduction from gross receipts or sales; or</p> <p>(ii) An individual or individual's family member has income from</p>

	<p>rental real estate and provides a copy of the most recent year's IRS Form 1040 (Schedule E). In this case the agency may use the total rental real estate income, as reported on the Schedule E. If the Schedule E shows a loss, the applicant or applicant's family member shall be considered to have no income from this source.</p> <p>Because annual income will vary based upon whether or not the client is paid hourly, weekly, bi-weekly, or twice a month, see "Gross Monthly Income Determination" below for instructions on annualize.</p>
<p>Step #5: Identify the Federal Poverty Level</p>	<p>Determine an applicant's income by adding together all sources of family income, and dividing that number by the applicable FPL. The resultant sum is the applicant's percentage of the FPL. To qualify for Ryan White Medical/Supportive services, a client's gross income can be no more than 250% of the FPL. All clients can receive case management/care coordination services regardless of income.</p> <p><i>Please note: the CAREWare database will be updated after the poverty level changes take effect each year (March 1st); however, it can take some time to do so.</i></p>

Dependent Status Policy

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

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

approved by a U.S. Judicial proceeding. NO exceptions will be made to this requirement. Notarized copies of documents must be made available upon request to the program.

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

Allowable Income Documentation

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

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

- Affidavit of no income

Gross Monthly Income Determination

The following are program criteria for determining gross monthly income:

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

<ul style="list-style-type: none"> • <u>If in the same job since the beginning of the year:</u> 	<p>Refer to the year-to-date (YTD) total, then divide by the months, and percent of partial months, represented on the pay stub.</p>	<p>Example: Client X has a pay stub showing a pay date of June 15 and a YTD of \$10,000. Divide the YTD amount by 5.5 months: <i>\$10,000 divided by 5.5 months equals \$1,818.18 per month.</i></p>
<ul style="list-style-type: none"> • <u>If there is an hourly rate:</u> 	<p>Calculate both the monthly income based on the YTD amount listed on their pay stub, described above, <u>and</u> annualize the hourly rate to find the monthly income to the client's best advantage.</p>	<p>Example: Client X makes \$11 per hour. Calculate BOTH a YTD total AND multiply \$11 x 2080 work hours per year which equals an annual income of \$22,880. Then divide the annual income of \$22,880 by 12 months which equals \$1,906.67 per month.</p>
<ul style="list-style-type: none"> • <u>If the client has received a one-time, annual bonus:</u> 	<p>This should be included in the ANNUAL salary (not YTD). To determine monthly income of total, divide by 12 months. Proof of the one-time status of the bonus may</p>	

	be necessary.	
<ul style="list-style-type: none"> • <u>If the client is paid twice-a-month OR every-other-week:</u> 	Carefully check the pay stub to determine which factor to calculate when determining annual income – 24 pay periods per year for twice-a-month and 26 pay periods per year for every-other-week.	
<ul style="list-style-type: none"> • <u>If there is a discrepancy between the monthly rate based upon YTD and the monthly rate stated on the pay stub or by client:</u> 	The monthly rate based upon YTD is calculated by dividing the YTD amount on the pay stub by the number of months in the total pay period. If this monthly rate is different from the monthly rate stated on the pay stub or if the client stated a different pay rate, further investigation will be warranted. This usually indicates a change in client status. They may have experienced a reduction in hours, began working part-time or were laid off - if the YTD monthly is less than the stated monthly. They may have worked some extra overtime or had a special circumstance which is not going to continue - if the YTD monthly is more than the stated monthly.	

- **Seasonal work:** Annual income based on documented seasonal trending is used for clients who can prove seasonal employment. Seasonal employment often means income is generated during certain time periods, which may or may not be over the limit during that time period, but when annualized over 12 months is within limits. Again, the client’s ability to document their earning “trend” is important and can be verified by looking at the client’s previous year’s federal income tax return.
- **Self-employed clients:** The client’s ability to document their earning “trend” is important and can be verified by looking at the client’s previous year’s federal income tax return. A self-employed applicant or the applicant’s family member should provide a copy of the most recent year’s IRS Form 1040 (Schedule C) in which case the Authority may allow a 50 percent deduction from gross receipts or sales.

- **Change in income or where there are no trends in income:** Annual income shouldn't be used for clients who experience frequent changes in income. Within reason, the program attempts to "look forward" in income assessment. The current monthly income should be used to determine eligibility.
- **Rental income** Net rental income will be used when the client submits the most recent year's Schedule E. If net income on the Schedule E is a negative amount, CAREAssist will consider this as zero income from this source. Without a Schedule E, gross rental income will be used.

Deductions

- Do not take into account garnished wages, liens, child support payments and the monies garnished from monthly SSDI awards, to include reimbursement of previous Social Security overpayments.
- Gross income includes the amount that is deducted from Social Security checks for Medicare Part B.
- Food stamps are not considered income.

SIX MONTH ELIGIBILITY DETERMINATION

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

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

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

Verification of Residence

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

Verification of Income

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

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

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

Verification of Insurance

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

SECTION 2: Locally Managed Services

CASE MANAGEMENT/CARE COORDINATION (NON-MEDICAL)

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

Definition:

Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management/care coordination does not involve coordination and follow-up of medical treatments, as medical case management does.

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

Reporting Requirement:

Unit: 15 minutes

Report in CAREWare under:

County Based Service Model	Regional Service Model
NEF - Non-RN Intake/Eligibility Review	Intake/Eligibility Review (IC) - Annual
NAF - Non-RN Screening: Face-to-face	Eligibility Review (IC) - Semi-Annual
NRF - Non-RN Rescreening: Face-to-face	RN Triage (IC)
NIF - Non-RN Case Management: Face-to-face	CC Triage (IC)
NCC - Non-RN Case Conference	Intake Coordination General (IC)
NCP - Non-RN Care Plan	Screening (CC)
NTF - Non-RN Transfer & Discharge: Face-to-face	CC Travel Time (CC)
NIN - Non-RN Case Management: Non-Face-to-face	CC Care Plan (CC)
NTN - Non-RN Transfer & Discharge: Non-Face-to-face	CC Case Conference (CC)
Non-RN Travel Time	Care Coordination (CC)
	CC Acuity Change (CC)
	Transfer/Discharge (CC)
	Dental Case Management (Dental Only)

MEDICAL EMERGENCY FINANCIAL ASSISTANCE

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

DRUG REIMBURSEMENT

Definition:

Service to pay for emergency access to approved pharmaceuticals/medications (includes full pay or copay medication assistance). Medications include prescription drugs intended to prolong life, improve quality of life or prevent the deterioration of health.

Program Guidance:

The definition does not include medications that are dispensed or administered during the course of a regular medical visit, that are considered part of the services provided during that visit.

Prescription pharmaceuticals/medications listed on the state's ADAP/CAREAssist Drug Formulary may not be purchased with locally administered support service funds unless documentation can be provided that the client is not eligible for CAREAssist/Bridge Program/UPP, or extenuating circumstances apply. Documentation that the client is not eligible for CAREAssist must include, at a minimum: (1) a denial or

restricted letter from CAREAssist or (2) notation of the reason(s) the client is not eligible for CAREAssist in the progress notes in the client's file.

It is recommended that the case manager pursue pharmaceutical company patient assistance programs as an alternative to paying for HIV specific prescription medications with local Ryan White funds.

Reporting Requirement:

Unit: Prescription

Report in CAREWare under "Drug Reimbursement"

EYE CARE

Definition:

Services rendered by an Optometrist, Ophthalmologist or Optician.

Program Guidance:

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

Reporting Requirement:

Unit: Payment

Report in CAREWare under "Eye Care"

HEALTH AID

Definition:

An assisting device, which is beneficial to physical health. This may include medical devices (such as crutches, slings, certified guide dog expenses, etc.) and hearing aids. Notes: Denture replacement or realignment is covered under Oral Health Care.

Program Guidance:

Insurance must be billed if applicable.

Reporting Requirement:

Unit: Payment

Report in CAREWare under "Health Aid"

MEDICAL BENEFIT PAYMENT

Definition:

The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance in order to receive medical benefits under a health insurance program. This includes premium payments, copayments, and deductibles.

Program Guidance:

CAREAssist Cost Share Payments: Cost Share payments to CAREAssist are allowed under the following circumstances:

- Documented emergency only
- Onetime payment only
- One payment per client per fiscal year (July-June)

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

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

Reporting Requirement:

Unit: Payment

Report in CAREWare under “Medical Benefit Payment”

MEDICAL SERVICE

Definition:

Provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner, or other health care professional who is certified in his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include 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 PHS's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

Program Guidance:

Any service authorized under the category must coincide with an application/referral to CAREAssist. In Oregon it is rare that a person with HIV/AIDS will not qualify for health insurance/co-pay/deductible coverage through CAREAssist.

Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Usual providers of medical care are: physicians, advanced practice nurses (e.g., nurse practitioners, certified nurse midwives, and clinical nurse specialists), physician assistants, and specialists (e.g., OB/GYNs, immunologists, cardiologists, etc.).

Service includes payment for labs, radiology and medical equipment. Medical equipment (and supplies) may include diabetic supplies, respiratory equipment (CPAP, BiPAP), oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies.

Reporting Requirement:

Unit: Payment

Report in CAREWare under "Medical Service"

NON-PRESCRIPTION MEDICATIONS

Definition:

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

Program Guidance:

Use of non-prescription medications must be recommended by the client's primary care provider.

Reporting Requirement:

Unit: Medication

Report in CAREWare under "Non-prescription medication - EFA"

NUTRITIONAL SUPPORT (RN AUTHORIZED)

Definition:

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

Program Guidance:

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

Please see "Supplemental Food Assistance" for information on how to assist clients who are not determined to have a nutritional need for specific food products but that still need supplemental food assistance. Clients who qualify for food under EFA do not qualify for food assistance under Medical Nutritional Therapy.

Case managers may provide assistance to clients under either Medical Nutritional Therapy OR Supplemental Food Assistance as described in the client's most current Care Plan, but clients may not receive both at the same time.

For nutritional guidance: <http://www.aids-etc.org/aidsetc?page=etres-display&resource=etres-193>

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

Reporting Requirement:

Unit: Card or Voucher

Report in CAREWare under “Nutritional Food Voucher”

PSYCHOSOCIAL EMERGENCY FINANCIAL ASSISTANCE

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

OTHER- EFA

Definition:

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

Program Guidance:

No services are allowed under this category without prior authorization from the HIV Care and Treatment Program.

Reporting Requirement:

Unit: Payment

Report in CAREWare under “Other - EFA”

TRAVEL LODGING

Definition:

Includes lodging necessary when traveling to receive medical care.

Program Guidance:

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

Reporting Requirement:

Unit: Day

Report in CAREWare under “Travel Lodging”

SUPPLEMENTAL FOOD ASSISTANCE

Definition:

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

Program Guidance:

Documentation that clients have exhausted other food services prior to authorization (i.e. food banks, food stamps) must be in the client’s chart.

For clients who have been assessed by a RN to have a nutritional need for food assistance please refer to “Medical Nutritional Therapy, Food Voucher”. Case managers may provide assistance to clients under either Medical Nutritional Therapy OR Supplemental Food Assistance as described in the client’s most current Care Plan, but clients may not receive both at the same time.

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

Reporting Requirement:

Unit: Card or Voucher

Report in CAREWare under “Supplemental Food Assistance”

UTILITIES

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

- They qualify for the Ryan White Program, Part B program and are enrolled in active HIV case management;
- They have been assessed as having an emergency need;
- They provide current detailed documentation substantiating the amount of the subsidy for the particular utility requested;
- The utility bill is current; and
- The client's Care Plan includes goals that specifically address activities to assist the client in meeting their utility costs without emergency assistance from Ryan White Program funds.

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

Definition:

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

Program Guidance:

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

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

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

Reporting Requirement:

Unit: Payment

Report in CAREWare under “Utilities”

HOUSING SERVICES

Maximum Allowable (per Fiscal Year, July-June): \$1,000 per client per year total for all sub-services in this category.

The Oregon Housing Opportunities in Partnership (OHOP) program is a component of the HIV Care and Treatment Program, and OHOP regional Housing Coordinators are an important resource to clients with housing needs. Housing Coordinators facilitate in-depth client housing needs assessments and access to housing services provided directly through the OHOP program or through referral to other community-based housing providers.

In order to assure that Ryan White housing assistance funds are used as the funds of last resort, Case Managers must submit an OHOP Client Referral Packet for the OHOP program whenever chronic client housing needs are identified. Chronic housing needs are defined as: a person who needs ongoing supplemental housing assistance more than 2 weeks (14 days) in any fiscal year or a person whose needs are not met by the \$1000 service cap/per FY. Case managers submit this form in order to initiate ongoing consultation among the client, the Case Manager, and the local OHOP Housing Coordinator. Referral to the OHOP program does not preclude the use of Ryan White housing assistance. When clients have emergency housing needs, HIV Case Managers may assist clients with those housing needs immediately, and then initiate contact with the local OHOP Housing Coordinator as soon as possible following provision of emergency housing services.

Clients accessing OHOP must continue in HIV Case Management services. The intent of the OHOP program is that HIV Case Managers, OHOP Coordinators

and eligible clients will work together to develop and implement a client Housing Plan.

Local Ryan White-funded housing assistance includes the provision of short-term assistance to support temporary or transitional housing to enable an individual or family to gain or maintain medical care. Related housing services may be housing in medical treatment programs for chronically ill clients (e.g., assisted living facilities), specialized short-term housing, transitional housing and non-specialized housing for HIV-affected clients. This category includes access to short-term emergency housing for homeless people.

The necessity of housing services for purposes of medical care must be documented in the progress notes of all clients receiving local Ryan White-funded housing assistance. Additionally, at least one housing-related goal must be included in the client's Care Plan.

Ryan White Program Housing funds may not be distributed as direct cash payments to recipients for services. Additionally, Housing funds may not pay for: mortgage payments, recreational vehicles (RV), or any item that would increase the property value of the home (hot water heater, centralized heating and air conditioning, roof, vinyl siding, renovations, etc.).

Case Managers must pre-authorize any payment for client services. In no case may Ryan White Program funds be used to pay client bills in arrears.

RENT ASSISTANCE

Definition:

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

Program Guidance:

Use of Ryan White Program funds for short-term or emergency housing must be linked to medical and/or health care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment. Client's care plan must document the necessity for this service and must be linked to the client's ability to stay in medical care.

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

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

Reporting Requirement:

Unit: Week

Report in CAREWare under “Rent Assistance”

IMPORTANT: use the following matrix based on dollar amount of assistance versus full monthly rent amount to determine number of units to report:

<i>Assistance amount / Full monthly rent amount =</i>	<i>Units of Service</i>
<i>0.0 – 0.25</i>	<i>1 week</i>
<i>0.26 – 0.5</i>	<i>2 weeks</i>
<i>0.51 – 0.75</i>	<i>3 weeks</i>
<i>0.76 – 1.00</i>	<i>4 weeks</i>

For example: A client’s monthly rent amount is \$400. In order to gain or maintain access to HIV-related medical care or treatment, the client requires \$250 in rental assistance for the month. The assistance amount (\$250) divided by the full monthly rent amount (\$400) equals 0.63, so the Case Manager would record “3 weeks” as the unit of service.

Unit cost (“Price” in CAREWare) will be automatically calculated when you enter the total number of “Units” using the table above and the “Total” amount paid.

HOUSING-RELATED DEPOSITS

Definition:

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

Program Guidance:

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

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

Reporting Requirement:

Unit: Payment

Report in CAREWare under "Housing-Related Deposits
RESIDENTIAL FACILITY

Definition:

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

Program Guidance:

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

Reporting Requirement:

Unit: Day

Report in CAREWare under "Residential Facility"

TRANSITIONAL HOUSING

Definition:

Transitional short-term emergency housing such as motels or hotels for purposes of moving or assisting an individual or family into a long-term stable living situation. This service may also apply to short term or emergency housing required to gain or maintain access to medical care.

Program Guidance:

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

Reporting Requirement:

Unit: Day

Report in CAREWare under “Transitional Housing”

LINGUISTIC SERVICES

Linguistics services include interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support the delivery of Ryan White-eligible services.

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

Definition:

Provision of interpretation and translation services to include ASL (American Sign Language).

Program Guidance:

The intent of this service is to provide language for the purpose of assisting a client in understanding and accessing medical services. Ryan White

Program, Part B funded providers should identify translation services which are available to clients for all commonly spoken languages.

Reporting Requirement:

Unit: 15 Minutes

Report in CAREWare under “Translation Services”

MEDICAL CASE MANAGEMENT

Definition:

A range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized care plan; (3) coordination of services required to implement the care plan; (4) continuous client monitoring to assess the efficacy of the plan and adaptation of the care plan, at least every 6 months, as necessary during the enrollment of the client (. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Program Guidance:

Case management activities under this category are provided by a licensed Registered Nurse or Nurse Practitioner. The individual will be educated in the scientific basis of nursing under defined standards of education and whose activities are related to the diagnosis and treatment of human responses to actual or potential health problems.

Reporting Requirement:

Unit: 15 minutes

Report in CAREWare under:

County Based Service Model	Regional Service Model
REF - RN Intake/Eligibility Review	Assessment (RN)
RAF - RN Assessment: Face-to-face	Medical Case Management (RN)
RRF - RN Reassessment: Face-to-face	RN Acuity Change (RN)
RIF - RN Case Management: Face-to-face	RN Case Conference
RCC - RN Case Conference	RN Care Plan
RCP - RN Care Plan	Travel (RN)
RTF - RN Transfer & Discharge: Face-to-face	Transfer/Discharge (RN)
RIN - RN Case Management: Non-Face-to-face	Pharmacist General (<i>Pharmacist Only</i>)
RTN - RN Transfer & Discharge: Non-Face-to-face	Pharmacist Single Consult (<i>Pharmacist Only</i>)
RN Travel Time	Pharmacist Consultation (client contact) (<i>Pharmacist Only</i>)

MEDICAL TRANSPORTATION SERVICES

Travel Lodging appears under “Other-EFA”

Ryan White Programs are required to provide assurances that funded support services are directly linked to assisting clients to access and successfully remain in HIV treatment. Therefore, support service documentation showing this linkage is required and case managers must document, in the client’s file, the purpose of all transportation purchases. Transportation should not be authorized unless the client clearly identifies their need related to accessing a care provider, dentist, pharmacy, permanent stable housing, or a core medical service reflected in the client’s care plan.

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

Definition:

Medical transportation services are conveyance services provided, directly or through a voucher, to a client to enable him or her to access health care and support services, including access to OHA approved self-management trainings or education groups or during a housing search period for permanent stable housing.

May be provided routinely or on an emergency basis. Medical Transportation should be provided through:

- A contract(s) with a provider(s) of such services;
- Voucher or token systems;

- Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed).

PUBLIC TRANSPORTATION-SINGLE TRIP

Definition: See Above

Program Guidance: None

Reporting Requirement:

Unit: Trip

Report in CAREWare under “Public Transport-single trip”

PUBLIC TRANSPORTATION-MONTHLY PASS

Definition: See Above

Program Guidance:

Bus passes should be purchased under the local transit system’s disability rate wherever possible.

Reporting Requirement:

Unit: Month

Report in CAREWare under “Public Transportation-monthly pass”

GAS CARD

Definition: See Above

Program Guidance:

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

Reporting Requirement:

Unit: Card or Voucher

Report in CAREWare under “Gas Card”

TAXI FARE

Definition: See Above

Program Guidance: None

Reporting Requirement:

Unit: One-Way Trip

Report in CAREWare under “Taxi fare”

OTHER SPECIAL TRANSPORT SERVICES

Definition:

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

Program Guidance: None. **If being provided for a rental vehicle, vehicle must be insured.**

Reporting Requirement:

Unit: Payment

Report in CAREWare under “Other special transportation svcs.”

ORAL HEALTH CARE

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

Definition:

Diagnostic, preventative, and therapeutic services provided by a dental health care professional licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained dental assistants.

Program Guidance:

This service does include medications dispensed or administered during the course of the service visit. Denture replacement or realignment is covered in this category.

Cosmetic procedure and restorations are not allowable unless they are necessary to alter, restore or maintain occlusion (close mouth) or nutrition. Exceptions may be made with program authorization for infants, children and youth.

This service is not available to “affected” family members.

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

Reporting Requirement:

Unit: Visit

Report in CAREWare under “Dental Services”

PSYCHOSOCIAL SUPPORT SERVICES

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

Definition: Caregiver support

Program Guidance:

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

Reporting Requirement:

Unit: Payment

Report in CAREWare under “Psychosocial Services”

EXCEEDING SERVICE CAPS

Exceptions to the “Maximum Allowable” service caps can be made locally for clients who meet the following eligibility requirements:

- Client is actively enrolled in case management services.
- The service cap waiver will facilitate the client’s access to one of the core medical services listed in Section 1.
- The client has a current plan (Care Plan or documented in progress notes) to help the client meet the service need, without utilizing Ryan White funds, on an ongoing basis.
- The client has been assessed Acuity level 3 or 4 in the acuity life area that corresponds to the intended need. This eligibility requirement is waived for women, infants, children and youth.

Required Documentation

Download and complete the “Exceeding Service Cap Documentation” form from the program website at www.healthoregon.org/hiv. The form includes the following required information:

- Total amount that is being requested to be waived;
- Acuity level and date acuity worksheet was completed;
- The reason for the requested waiver;
- How the requested service funding will facilitate the client’s access to core medical services (to be completed by the RN Case Manager); and
- The signature of the RN Case Manager.

A copy of this completed form and any supporting documentation must be included in the client record.

SECTION 3: State Managed Services

See the [State Managed Services Policies and Procedures](#) and the State Managed Services [Funding Request Instructions](#) for the program polices and other information.

HOME HEALTH CARE

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

PROFESSIONAL/SPECIALIZED HOME HEALTH CARE

Definition:

The provision of services in the home by licensed health care workers, such as nurses, and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Program Guidance:

This service is not available to “affected” family members.

Reporting Requirement:

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

PARAPROFESSIONAL HOME HEALTH CARE

Definition:

Non-medical care provided in the home setting for persons living with HIV/AIDS whose home care needs are not adequately covered by other resources. Non-medical care involves assistance with daily life activities: home health aide and attendant care services.

Program Guidance: This category does not include inpatient hospital services or nursing home and other long term care facilities. This service is not available to “affected” family members.

Reporting Requirement:

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

MEDICAL NUTRITION THERAPY

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

Definition:

Medical Nutritional Therapy Services including nutritional supplements provided by a licensed registered dietician outside of a primary care visit. The provision of food may be provided pursuant to a physician's recommendation and nutritional plan developed by the dietician.

Program Guidance:

Clients must have a Nutrition Life Area Acuity of 2, 3 or 4 documented as part of their most recent Nurse Assessment to be eligible for this service. Additionally, a written physician recommendation is required prior to referral and must be documented in the client's case notes by a Medical Case Manager.

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

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

A copy of the most current Medical Nutrition Plan, developed by the licensed registered dietitian, must be included in the client's chart and there must be documentation of case conferencing between the Medical Case Manager and the licensed registered dietitian at a minimum of every 3 months during the time the client is receiving this service.

Summary of Minimum Documentation Requirements

- Nutritional Life Area Acuity of 2, 3 or 4
- Written physician recommendation
- Documentation of the referral by the Medical Case Manager
- Copy of the dietitian's Medical Nutrition Plan
- Documentation of case conference between the Medical Case Manager and the licensed registered dietitian at a minimum of every 3 months while the client is receiving the service

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

Reporting Requirement:

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

MENTAL HEALTH SERVICES

Definition:

Mental health services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

This service is not available to "affected" family members.

Program Guidance:

Services must be provided by a mental health professional licensed or authorized within the State, including psychiatrists, psychologists, clinical nurse specialists, social workers, and counselors.

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

Reporting Requirement:

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

ORAL HEALTH CARE

Definition:

Diagnostic, preventative, and therapeutic services provided by a dental health care professional licensed to provide health care, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained dental assistants.

Program Guidance:

This service also includes medications dispensed or administered during the course of the service visit (prescribed medications must be paid for by local funds and reported under “Drug Reimbursement”). Denture replacement or realignment is covered in this category.

Cosmetic procedure and restorations are not allowable unless they are necessary to alter, restore or maintain occlusion (close mouth) or nutrition. Exceptions may be made with program authorization for infants, children and youth.

This service is not available to “affected” family members.

When available, services available through dental insurance and Part F funded dental clinics should be used prior to SMS.

Recommended Maximum Allowable (per Fiscal Year, July-June): \$1000 per client per year. HIV Case Managers have the ability to request funds based on the client need (a dental services plan must be provided with the State Managed Services Program Request Form. See the State Managed Services Program Request Form Instructions for details.

Reporting Requirement:

Paid by State program. Local jurisdictions will not report this service in CAREWare unless using local Ryan White Part B funds (see Section 2).

SUBSTANCE ABUSE SERVICES

Maximum Allowable (per Fiscal Year, July-June): \$5000 per client per year total for both Substance Abuse: Outpatient Treatment and Substance Abuse: Residential Treatment.

OUTPATIENT THERAPY

Definition:

Substance abuse services (outpatient) are medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel. They include limited support of acupuncture services to HIV-positive clients provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists.

Program Guidance:

Funds may be used for outpatient drug and/or alcohol substance abuse treatment. Such services should be limited to:

- the pre-treatment program of recovery readiness;
- mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse;
- outpatient drug-free treatment and counseling;
- methadone treatment;
- neuro-psychiatric pharmaceuticals; and
- relapse prevention.

Funds may not be used for syringe exchange programs. This service is not available to family members.

Reporting Requirement:

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

RESIDENTIAL THERAPY

Definition:

Substance abuse services (residential) include treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term). . They include limited support of acupuncture services to HIV-positive clients provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists.

Program Guidance:

Funds may be used for outpatient drug or alcohol substance abuse treatment. Such services should be limited to:

- the pre-treatment program of recovery readiness;
- mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse;
- methadone treatment;
- neuro-psychiatric pharmaceuticals; and
- relapse prevention.

The following limitations apply to use of Ryan White Program Funds for residential services.

- Funds may not be used for inpatient detoxification in a hospital setting;
- However, if detoxification is offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of a hospital), Ryan White Program funds may be used for this activity;
- If the residential treatment facility 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.

This service is not available to “affected” family members.

Reporting Requirement:

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

ADHERENCE AIDS

Definition:

A number of treatment adherence aids are available by order, including pill organizers, planners, pill reminders, pill splitters, alarms, and electronic reminders delivered by SMS, phone or email.

Program Guidance:

Adherence aids may be ordered by completing the HIV Medication Adherence AIDS order form as found on the program [website](#). Order forms must be submitted and authorized by the Medical Case Manager. It is expected that the Medical Case Manager will assist the client in using aids as part of the client's care plan.

Reporting Requirement:

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

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

Program Priorities

The mission of the CAREAssist program is to improve the health of HIV+ Oregon residents by paying for insurance premiums and co-payments on prescriptions and medical services. CAREAssist is a program of the Pharmacy Services Division of the Oregon Health Authority and works in partnership with HIV Community Services. To that end, CAREAssist provides the following services:

1. Insurance premium payment on almost any health insurance plan, including employer based plans, private insurance, Medicare, Oregon Health Plan, Qualified Health Plans purchased in or outside of the exchange, and COBRA plans.
2. Copayments on medical services and prescriptions, including those not specific to HIV treatment. Payments will be made up to a maximum of \$6,350 per year per client.
3. For medications not covered by someone's insurance, CAREAssist will pay for the medication as long as it is included on the CAREAssist formulary. Most medications will be accessed at a CAREAssist in-network pharmacy, including a mail order pharmacy. Out of network pharmacies may be used for 1) clients who are mandated to use a specific pharmacy per their insurance coverage or 2) medications for acute conditions can be accessed at an out of network pharmacy.
4. Tobacco Cessation Supports. CAREAssist clients who are ready to quit tobacco can receive direct referral to the Oregon Quitline, Nicotine Replacement Therapy (patches, gum or lozenges) from the CAREAssist mail order pharmacy, or referral to other supports.
5. Medication Therapy management can be provided to eligible clients who are having difficulty adhering to medication regimens. MTM provides phone-based support to patients through direct adherence counseling with an HIV pharmacist who will work with the patient to fit their medication regimen into their life.

6. The Bridge program provides urgently needed HIV specific medical care and medications on the CAREAssist formulary for persons who are in the process of applying for health insurance.
7. The Uninsured Persons program provides access to HIV specific medical care and medications on the CAREAssist formulary to persons who are ineligible for health insurance until the next open enrollment period. See Appendix C for more information.
8. Clinical pharmacy consultation services are available for Part B clients statewide. An onsite clinical pharmacist, located at HIV Alliance, is available to provide a variety of services, including but not limited to: medication adherence counseling, patient and provider consultation, drug interaction checking, and patient advocacy with insurance and coordinated care organizations. The pharmacist can also provide recommendations on OTC (over-the-counter) products, management of side effects, and management of other chronic diseases. Contact the pharmacist at HIV Alliance or CAREAssist for additional information.
9. Dental Insurance: CAREAssist provides dental insurance through MODA. Any CAREAssist client may enroll as long as their primary insurance is not the Oregon Health Plan. Dual-eligible clients with Medicare and Medicaid are eligible for this benefit. Only preventative care and examinations are covered within the first six months of enrollment. Restorative fillings are covered after six months and more comprehensive care like root canals, crowns, bridges etc. are allowed after 12 months.

Client Eligibility

In order to be eligible, a person must:

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

Coordination with CAREAssist

Part B Case Managers are expected to work in partnership with the CAREAssist program to ensure client's maintenance of health insurance. See Appendix B for more information on the roles related to this partnership. Part B Case Managers are able to view current client eligibility review data online, including type of insurance and FPL through the [Client Eligibility Report](#).

Program Requirements

1. All CAREAssist clients are required to recertify their eligibility for the program every 6 months through a process called the Client Eligibility Review (CER). CERs are mailed to clients every 6 months and they have a month to return.
2. Clients must maintain health insurance in order to qualify for full benefits.

Additional Resources

Please see the [CAREAssist website](#) for more information, including forms, applications, contact information, and additional ADAP related resources.

APPENDIX A: RYAN WHITE FUNDED FOOD SERVICES QUICK GUIDE:³

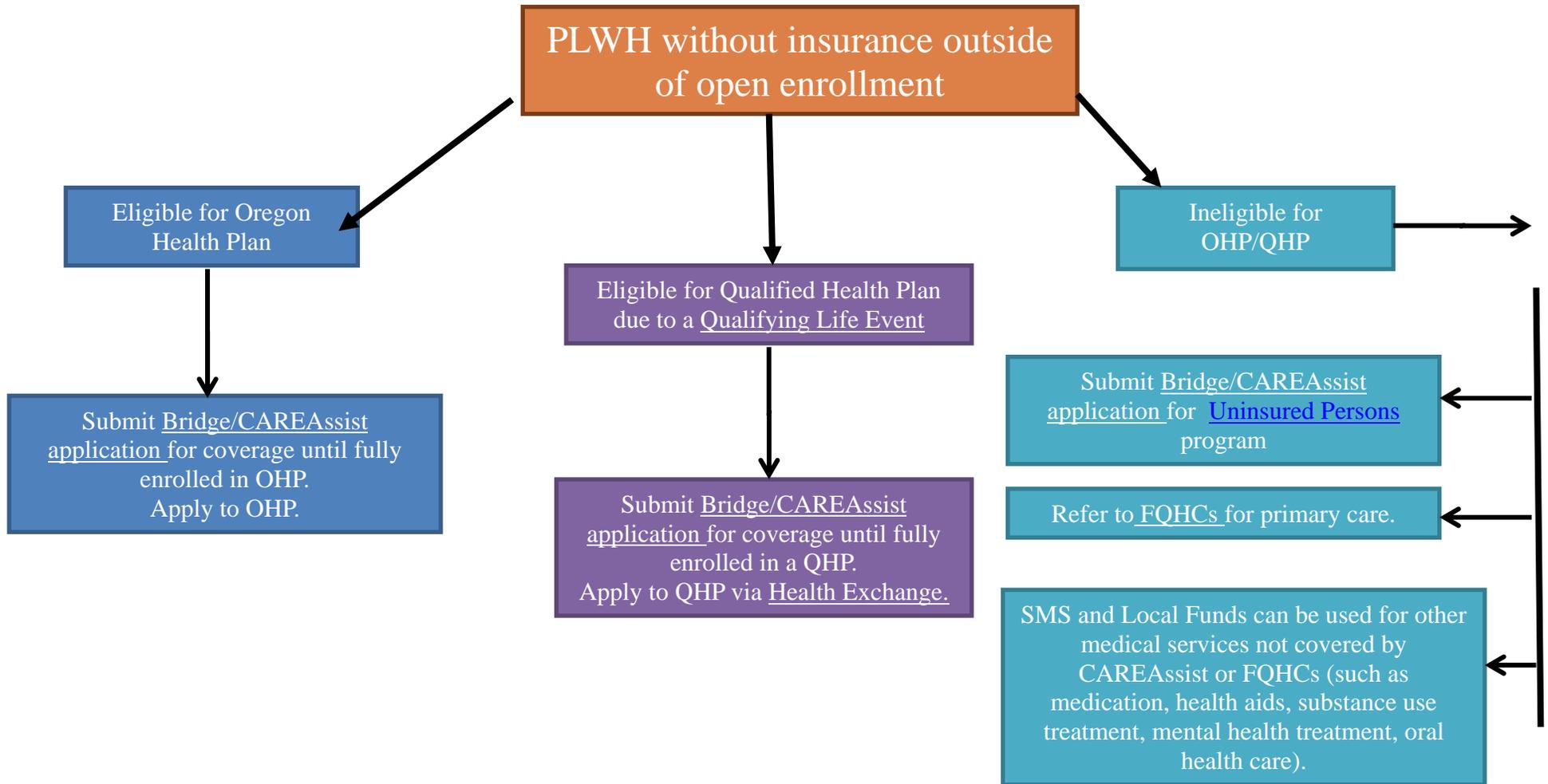
This guide is intended to clarify the use of food related assistance to ensure appropriate delivery and data entry of food services funded by Ryan White Program funds.

	Supplemental Food Assistance	Nutritional Support	Medical Nutritional Therapy
Definition Summary	A card or voucher that cannot be converted to cash, allowing a client to purchase food products necessary to maintain health.	A card or voucher that cannot be converted to cash, allowing a client to purchase food products and supplements (i.e. Vitamins Ensure) necessary to maintain health.	Medical Nutritional Therapy includes nutritional supplements (i.e. Vitamins, Ensure), nutritional counseling and the provision of food
Service Cap	This service is one of four sub-services under Psychosocial Emergency Financial Assistance. The total services cap for Psychosocial EFA is \$1000/per year, per client.	This service is one of seven sub-services under Medical Emergency Financial Assistance. The total services cap for Medical EFA is \$1500/per year, per client.	\$2500/per year, per client
Funding Source	Local Ryan White	Local Ryan White	State Managed Services- Requires submission of State Managed Services Application and receipt of authorization before beginning services.
Authorized By	Case Manager (RN or Psychosocial)	Medical Case Manager (RN)	Licensed Dietician
Documentation Required from HIV Medical Provider	No	RN's should document coordination with the client's physician when developing nutritional plans.	Yes- must be included in client chart <u>prior</u> to referral
Other Required Documentation	Documentation that client has exhausted other food services prior to authorization (i.e. food banks, food stamps) must be in the client's chart	Documentation of a current (within past 12 months) Nutritional Assessment and identification of nutritional needs and goals in the client's care plan must be provided in the client chart by the Medical Case Manager. Food/Supplements provided should be provided to a client with specific instructions for maintaining nutrition/overall health based on the Assessment.	A copy of the most current Medical Nutrition Plan, developed by the Dietician, must be included in the client's chart and there must be documentation of case conferencing between the Medical Case Manager & the Dietician at a minimum of every 3 months during the time the client is receiving this service.

³ Case managers may provide food assistance under EITHER Supplemental Food Assistance or Nutritional Support using local funds. Clients may not receive Supplemental Food Assistance in combination with any other food service. However, clients may receive Nutritional Support and Medical Nutritional Therapy at the same time.

CAREWare Data Entry	Supplemental Food Assistance Unit= Card or Voucher	Nutritional Food Voucher Unit= Card or Voucher	NA
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APPENDIX B: ACCESSING MEDICAL SERVICES OUTSIDE OF OPEN ENROLLMENT



- A Bridge Application is preferred if there is a medically *urgent* need for client to access medication, or client is going to experience an interruption in ARV treatment.
- The Uninsured Persons program provides access to the CAREAssist formulary and a limited number of medical services necessary for HIV care, until full coverage can be obtained.
- Open Enrollment occurs November 15th – February 15th of every year.