PALM BEACH COUNTY
HIV ELIMINATION SERVICES

RYAN WHITE PART A/MAI
PROGRAM MANUAL

Community Services Department
Board of County Commissioners Palm Beach County

Helping People Build Better Communities!

Revised March 1, 2025

Table of Contents

Section I: Overview of Ryan White Part A Program

Ch 1. Statement of Purpose

The Palm Beach County Ryan White HIV/AIDS Program (PBC RW Part A/MAI) has developed this Program Manual to ensure adherence to local and federal policies and standards. The Program Manual serves as a reference to support service delivery within the HIV Coordinated Services Network system of care, and is inclusive of program, fiscal, and service specific guidelines. The Program Manual is reviewed annually, with updates released prior to the beginning of the grant year (GY). Program Manual updates within the GY are communicated through PBC RW Part A/MAI clarification notices, and will be included in the Program Manual the following year.

Ch 2. Authority/Oversight

HRSA HAB Policy Clarification Notices
HRSA HAB Program Letters
HRSA HAB Universal, Program and Fiscal Monitoring Standards (2013)
HRSA Part A Manual (2023)
Palm Beach County Community Services Department (Recipient)
Palm Beach County HIV Care Council (local Planning Council)
Ryan White HIV/AIDS Treatment Extension Act

Referencing: Specific Authority 381.0011(13) FS.
Law Implemented 381.001(1), 381.003(1)(c), 381.0011 (5) FS, History-New1-23-07. Amended 10-27-08

Ch 3. Ryan White HIV/AIDS Program Part A/MAI (RW Part A/MAI) Description

The United States Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 to improve quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV. The legislation has been reauthorized four times since its inception, in 1996, 2000, 2006, and 2009. The Ryan White Treatment Extension Act expired on September 30, 2013, but funding has been extended through the appropriations bill. Federal funding delivers HIV/AIDS care to over 500,000 people each year nationally and approximately 3,500 persons in Palm Beach County. The RW Part A/MAI is the payer of last resort, with program clients receiving services when there are no other available sources of payment for care and treatment, public or private.

The Health Resources & Services Administration (HRSA) RW Part A/MAI provides core medical and support services to low-income persons with HIV/AIDS, based on availability, accessibility and funding of the program. As the Recipient of RW Part A/MAI funding, Palm Beach County Board of County Commissioners (BCC) designates administration of the program to the Community Services Department (CSD), in concert with Palm Beach County HIV CARE Council (HIV CARE Council).

The Ryan White HIV/AIDS Treatment Extension Act of 2009 guiding principles include:

- Revise care systems to meet emerging needs. The Ryan White programs through local planning and decision making with broad community involvement, determine how to best meet the HIV/AIDS care needs. Programs assess the demographics of new HIV/AIDS cases and revise care systems to ensure capacity to meet the needs of emerging communities and populations. Populations traditionally underserved, including persons living with HIV (PWH) who know their HIV status but are not in care, are a priority. Outreach and Early Intervention Services (EIS) work to ensure linkages are made to primary health and supportive services.
- Ensure access to quality HIV/AIDS care. Ryan White programs shall use quality management programs

to ensure that available treatments are accessible and delivered according to established HIV related treatment guidelines.

- Coordinate services with other health care delivery systems. The Ryan White program, as payer of last resort, may fill gaps in care. This occurs through the coordination across federal/state/local programs in order to maximize efficient use of resources, enhance systems of care, and ensure coverage of HIV/AIDS related services within managed care plans.
- Evaluate the impact of funds and make needed improvements. Federal policy and funding decisions are increasingly determined by outcomes. Documentation demonstrating the impact of Ryan White funds on improving access to quality care/treatment along with areas of continued need are a priority. Programs must have a quality assurance and evaluation mechanisms that assess the effects of Ryan White resources on health outcomes of clients.

Structure

The Palm Beach County Board of County Commissioners (BCC) is the Recipient of the Ryan White Part A & MAI funding from the U.S. Department of Health and Human Services (HHS), Health Resource Services Administration (HRSA), HIV/AIDS Bureau (HAB) as an Eligible Metropolitan Area (EMA). The BCC delegates grant management and administration to the Community Services Department (CSD), Ryan White HIV/AIDS Program (RWHAP). This responsibility includes managing and monitoring each project, program, sub-award, function, or activity supported by the grant award.

Recipient staff contact information:

Appendix A- PBC RW Part A/MAI Organizational Chart

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Jasmine Parrish MPH, BSN, RN
Quality Management Clinician
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Delray Beach, FL 33445
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Vacant
Health Equity Contracts/Grants Coordinator

Fiscal:

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Financial Analyst I
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Grant Compliance/Contract:

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Grant Compliance Specialist II
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West Palm beach, FL 33401

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Email: aballa@pbc.gov

The BCC appoints members of the Palm Beach County HIV CARE Council (HIV CARE Council). The HIV CARE Council is charged with planning for the HIV Coordinated Services Network. This includes priority setting, resource allocation, integrated/comprehensive planning, assessing unmet need, special studies as needed, and administrative assessment. The HIV CARE Council has several standing committees, displayed below. The HIV CARE Council information can be found at https://discover.pbcgov.org/carecouncil/Pages/default.aspx

The HIV CARE Council is a collaborative and balanced body made up of persons with HIV, members of affected communities, service providers, and community leaders whose legislative responsibilities shall be to plan, develop, monitor, evaluate and advocate for a medical and support services system for individuals and families affected by HIV/AIDS.

The current officials for 2025-2026 are:

CC Chair – Richardo Jackson
CC Vice Chair – Tad Fuller
CC Secretary – Kristen Harrington
CC Treasurer – Dr. Youssef Motti

The current committee chairs for 2025-2026 are:

Executive Chair – Richardo Jackson
Community Engagement Chair – Kristen Harrington
Planning Chair – Lysette Perez
Priorities & Allocations Chair – Dr. Youssef Motti
Quality Management & Evaluation (QMEC) Chair – Hector Bernandino
LGBTQ Health Equity Chair – Kim Rommell Enright
Housing Chair- Miguel Vasquez

For more information about the HIV CARE Council, contact the HIV CARE Council Coordinator, Neeta Mahani, by phone 561-355-4820 or by email nmahani@pbc.gov

Ch 4. PBC RW PART A/MAI Subrecipients (2025-2026)

AIDS Healthcare Foundation (AHF)

AIDS Pharmaceutical Assistance, Early Intervention Services, Medical Case Management, including Treatment Adherence, Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Emergency Financial Assistance/Emergency Medication, Food Bank/Home Delivered Meals, Food Bank/Nutritional Supplements, Medical Transportation, Non-Medical Case Management, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Mental Health Services; ***Part C funded services: Registered Nurse MCM, Linkage to Care, Outpatient Medical and Labs***

Location(s):
(1) 200 Congress Park Drive, Delray Beach, FL 33445
(2) 1411 North Flagler Drive, West Palm Beach, FL 33401

Phone(s):
(1) (561) 279-0991
(2) (561) 284-8182

Fax: (561) 279-0539

Program Contact: Kristen Harrington
Email: Kristen.Harrington@ahf.org
Phone: (561) 350-2196

Fiscal Contact: Karla Drummond
Email: Karla.Drummond@ahf.org
Phone: (954) 522-3132 EXT 53206

Quality Management Contact: Neil Walker
Email: Neil.Walker@ahf.org
Phone: (786) 457-9023

CAN Community Health

AIDS Pharmaceutical Assistance, Outpatient/Ambulatory Health Services; ***EHE Rapid Entry to Care (REC)***

Location(s): 201 N. Dixie Highway, Lake Worth, FL 33460
Phone: (561) 867-9991
Fax: (561) 484-5813

Program Contact: Hardeep Singh
Email: hsingh@cancommunityhealth.org
Phone: (786) 800-5631 x 19206

Fiscal Contact: Max Wilson
Email: mwilson@cancommunityhealth.org
Phone: (904) 234-4661

Quality Management Contact: Tim Emanzi
Email: temanzi@cancommunityhealth.org
Phone: (941) 300-4440 ext. 111954

Compass, Inc.

Early Intervention Services, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Mental Health Services, Emergency Financial Assistance, Medical Transportation, Non- Medical Case Management
Location(s): 201 N. Dixie Highway, Lake Worth, FL 33460
Phone: (561) 533-9699
Fax: (561) 318-6671

Program Contact: Raymond Cortes
Email: raymond@CompassLGBTQ.com
Phone: (561) 533-9699 ext. 4008

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Phone: (561) 533-9699 ext. 4038

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Raymond Cortes
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Phone: (561) 533-9699 ext. 4008

FoundCare, Inc.

Early Intervention Services, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Specialty Outpatient Medical Care, Food Bank/Home Delivered Meals, Medical Transportation, Non-Medical Case Management, Early Intervention Services (MAI), Medical Case Management (MAI), Non-Medical Case Management (MAI), Psychosocial Support Counseling (MAI); *EHE Rapid Entry to Care (REC)*
Call Center main phone number: 561-432-5849
Call Center main fax number: 561-432-9732
Care Coordination fax number: 561-283-0224
Location(s):

(1) 2330 S. Congress Avenue, Palm Springs, FL 33406
(2) 1901 South Congress Ave Suite 100 Boynton Beach, FL 33426
(3) 840 US Highway 1 North Palm Beach FL 33408
(4) 1500-A NW Ave. L, Belle Glade, FL 33430
(5) 5730 Corporate Way #100, West Palm Beach, FL 33407
(6) 5867 Okeechobee Blvd, West Palm Beach, FL 33417 (Yolette Bonnet Center)

(7) 5205 Greenwood Ave, Suite 150 West Palm Beach, FL 33407
(8) RIVIERA BEACH HEALTH CENTER COMING 2025
3501 Broadway Avenue, Riviera Beach FL 33404

Phone(s):
(1) (561) 472-2466 (Palm Springs)
(2) (561) 274-6400 (Boynton Beach)
(3) (561) 776-8300 (North Palm Beach)
(4) (561) 996-7059 (Belle Glade)
(5) (561) 863-7800 (Corporate Way)
(6) (561) 660-5468 (Okeechobee Blvd)
(7) (561) 848-8701 (Greenwood Ave)

Fax (es):
(1) (561) 304-0472 (Palm Springs)
(2) (561) 274-3912 (Boynton Beach)
(3) (561) 776-0727 (North Palm Beach)
(4) (561) 996-1567 (Belle Glade)
(5) (561) 840-0747 (Corporate Way)
(6) (561) 899-4867 (Okeechobee Blvd)
(7) (561) 848-9059 (Greenwood Ave)

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Phone: (561) 432-5849 ext.1085

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EHE Contact: Quinton Dames
Email: Qdames@foundcare.org
Phone: (561) 472-9160 ext. 1256
Cell phone: (561) 323-5845

Legal Aid Society of Palm Beach County

Legal Services, Non-Medical Case Management
Location(s): 423 Fern Street, Suite 200, West Palm Beach, FL 33401
Phone: (561) 655-8944
Fax: (561) 822-9827

Program Contact: Sandra Powery Moses
Email: smoses@legalaidpbc.org
Phone: Direct (561) 822-9821; Work Cell (561)383-1530

Fiscal Contact: Shane Ramsaroop
Email: sramsaroop@legalaidpbc.org
Phone: (561) 822-9765

Quality Management Contact: Marcy Classe
Email: mclasse@legalaidpbc.org
Phone: (561) 721-6096

Midway Specialty Care Center

Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Non-Medical Case Management, Medical Case Management, including Treatment Adherence

Location(s): (1) 2247 Palm Beach Lakes Blvd, Suite 209A, West Palm Beach, FL 33409
(2) 5507 South Congress Ave, Suite 150, Atlantis, FL 33462
Phone: (1) (561) 249-2279
(2) (561) 766-0590
Fax(es): (1) (561) 720-2970
(2) (561) 766-0591

Program Contact: Jiovanna Allen
Email: jallen@midwaycare.org
Phone: (407) 745-1171

Fiscal Contact: Kathyrn Hayden
Email: khayden@midwaycare.org
Phone: (772) 742-9276

Quality Management Contact: Tiffany Elias-Bender
Email: telias@midwaycare.org
Phone: (561) 200-3772

Monarch Health Services, Inc.

Early Intervention Services, Lab Diagnostic Testing, Non-Medical Case Management, Medical Case Management, including Treatment Adherence; *EHE Rapid Entry to Care (REC)*

Location(s):
(1) 2580 Metrocentre Blvd., Ste. 1, West Palm Beach, FL 33407
(2) 14000 S. Military Trail, Ste. 110, Delray Beach, FL 33445
Phone: (561) 523-4589
Fax: (561) 491-2602

Program Contact: Jeanice Petit-Frere
Email: jpetitfrere@monarchealth.org
Phone: (561)523-4589 ext 407

Fiscal Contact: Damion Baker
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Quality Management Contact: Jeanice Petit-Frere
Email: jpetitfrere@monarchealth.org
Phone: (561)523-4589 ext 407

The Poverello Center, Inc.
Food Bank/Home Delivered Meals
Location(s):
(1) Grocery and Gift Card Home Deliveries throughout Palm Beach County,
(2) Administrative Offices at 2056 N Dixie Hwy, Wilton Manors, FL 33305
Phone: (954) 361-9242
Intake: intake@poverello.org

Program Contact: James Stevenson or Emma Roca
Email: jstevenson@poverello.org or eroca@poverello.org

Fiscal Contact: Jose Castillo
Email: jcastillo@poverello.org

Quality Management Contact: Brad Barnes
Email: Bbarnes@poverello.org

Treasure Coast Health Council, Inc. d/b/a Health Council of Southeast Florida
Early Intervention Services, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Specialty Outpatient Medical Care, Medical Transportation, Non-Medical Case Management, Early Intervention Services (MAI), Medical Case Management (MAI), Non-Medical Case Management (MAI), Psychosocial Support Counseling (MAI)
Location(s): 600 Sand Tree Drive, Suite 101, Palm Beach Gardens, FL 33403
Mobile, community-based and virtual services available
Phone: (561) 844-4220
Fax: (561) 844-3310

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Appendix B- PBC HIV Elimination Services Matrix

Section II: Universal Guidelines-Program

Ch 1. Clinical Quality Management

Purpose

To establish clinical quality management standards for Subrecipients providing any service through PBC RW Part A/MAI.

Policy

Subrecipients shall participate in quality management activities, as required by the Recipient.

Procedure

Subrecipient shall designate a Quality Management representative.

The designated Quality Management representative shall

a) Participate in the Quality Improvement Workgroup led by the Recipient office
b) Participate in systems-level CQM activities when applicable
c) Lead Subrecipient-level quality improvement projects
d) Author Subrecipients quality management plan; and
e) Ensure accurate collection and reporting of Subrecipient data, including aggregate performance metrics by grant year quarter for each service category.

National Monitoring Standards

Quality Management		
Standard	**Performance Measure/Method**	**Provider/Subrecipient Responsibility**
To implement a CQM program, recipients need to have the necessary infrastructure, performance measurement, and quality improvement (QI) components in place. HAB PCN 15-02 clarifies the HRSA RWHAP expectations for CQM programs.	a) Documentation that the recipient has in place a CQM program that includes, at a minimum: • All components of infrastructure. • A performance measures portfolio that is reflective of RWHAP-funded services, local HIV epidemiology, and identified needs of people with HIV, including at least one measure for all RWHAP-funded service categories; and two measures for highly utilized and highly prioritized RWHAP-funded service categories. b) A process to regularly collect and analyze performance measure data (more frequently than data collection for reporting). c) QI activities based on clinical performance data. d) Implement QI activities using a defined approach or methodology. e) CQM expectations for Subrecipients and funded service categories. f) Review of the CQM program to ensure that both the recipient and providers are carrying out necessary CQM activities and reporting CQM performance data. g) Monitor Subrecipient compliance with	• Participate in quality management activities as contractually required and outlined in the recipient's CQM plan.; at a minimum: o Compliance with relevant service category definitions and EMA/TGA standards of care o Collection and reporting of data for use in measuring performance

	guidelines and the Part A program's approved service category definition for each funded service category.	
	h) Develop and monitor service standards to ensure that services are compliant with HHS treatment guidelines and the Part A program's approved service category definition for each funded service	

Ch 2. Access to Care

Purpose

To establish access to care standards for Subrecipients providing any service through PBC RW Part A/MAI.

Policy

Subrecipient shall ensure access to care standards are met.

Procedure

Subrecipient must demonstrate access to care standards are met through documentation/methods outlined in National Monitoring Standards.

National Monitoring Standards

Access to Care		
Standard	**Performance Measure/ Method**	**Provider/Subrecipient Responsibility**
H.2.a. Access to Care 1. Intergovernmental Agreements (IGAs) to be established and maintained with the CEOs of the political subdivisions in the EMA/TGA that provide HIV-related health services and account for no less than 10 percent of AIDS cases diagnosed in the EMA or TGA over the last five years. 2. Maintenance of appropriate referral relationships with entities considered key points of access to the healthcare system to facilitate EIS for individuals who have diagnosed HIV infection.	a) Documentation that IGAs are in place with the CEOs of the political subdivisions in the EMA/TGA that provide HIV-related health services and account for no less than 10 percent of AIDS cases diagnosed in the EMA or TGA over the last five years. b) Documentation of written referral relationships with entities considered key points of access to the healthcare system to facilitate EIS for individuals who have diagnosed HIV infection.	a) Provide documentation of a written referral and linkage agreements with key points of entry, and make these agreements available for review by the recipient upon request.
A.1. Structured and ongoing efforts to obtain input from people with HIV in the design and delivery of services.	a) Documentation of people with HIV participating in committees and contributing to public meetings minutes. b) Documentation of the existence of appropriate mechanism(s) for obtaining client input. c) Documentation of content, use, and confidentiality of client satisfaction surveys or focus groups conducted at least annually.	a) Maintain a file of materials documenting the consumer committee's membership and meeting attendance, including minutes. b) Regularly implement client satisfaction survey tools, focus groups, and/or public meetings, with analysis and use of results documented. c) Implement appropriate mechanism(s) for obtaining client input.

A.2. Provision of services regardless of an individual's ability to pay for the service.	a) Recipient and subrecipient billing and collection policies and procedures do not: • Deny services for non-payment. • Require full payment prior to service. • Include any other procedure that denies services for non-payment.	a) Ensure that billing, collections, copays, and schedule of charges and limitation of charges policies do not act as a barrier to receiving services, regardless of the client's ability to pay. b) Implement an appeals/grievance process and maintain a file of individuals who refused services with reasons for refusal specified; include in the file any complaints from clients, with documentation of complaint review and decision reached and/or response given if any.
A.3. Provision of services regardless of the current or past health condition of the individual to be served.	a) Maintain documentation of eligibility determination and provider policies to ensure that they do not: • Permit denial of services due to pre-existing conditions. • Permit denial of services due to non-HIV-related conditions (primary care). • Provide any other barrier to care due to a person's past or present health condition.	a) Maintain files of eligibility determination and clinical policies. b) Implement an appeals/grievance process and maintain a file of individuals refused services with reasons for refusal specified; include in the file any complaints from clients, with documentation of complaint review and decision reached and or/response given if any.
A.4. Provision of services in a setting accessible to individuals with HIV who are low-income and comply with the Americans with Disabilities Act (ADA) Barrier-Free Health Care Initiative.	a) Maintain policies and procedures that provide by referral or vouchers, transportation if the facility is not accessible to public transportation, and policies that facilitate access to care for low-income individuals. b) Maintain an environment that provides barrier-free access to healthcare, which includes provisions for mobility disabilities and communication disabilities.	a) Ensure that the facility is accessible by public transportation or provide transportation assistance. b) Ensure that the facility is compliant with the ADA Barrier-Free Health Care Initiative requirements.
A.5. Dissemination of information to low-income individuals regarding the availability of HIV-related services and how to access them.	a) Availability of informational materials about Subrecipient services and eligibility requirements such as: • Newsletters. • Brochures. • Posters. • Community bulletins. • Social media. • Webpages. • Any other types of promotional materials.	a) Maintain a file documenting Subrecipient activities for the promotion of HIV services to low-income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements.

Ch 3. Client Eligibility Determination

Purpose

To establish client eligibility determination standards for Subrecipients providing any service through PBC RW Part A/MAI.

Policy

The RWHAP legislation requires that individuals receiving services through RW Part A/MAI must:

a) Have a documented diagnosis of HIV;
b) Be low-income, defined as at or below 400% Federal Poverty Level (FPL); AND
c) Be a resident of Palm Beach County.

By statute, HRSA RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payment source. Subrecipients must make reasonable efforts to secure non- RWHAP funds for services, prior to utilizing PBC RW Part A/MAI - funded services. Subrecipients are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer- sponsored health insurance coverage and/or other private health insurance). PBC RW Part A/MAI is the payer of last resort and will provide services not covered, or partially covered, by public or private health insurance plans.

Additional caps/limitations for specific service categories may be implemented to meet program goals under principles of health equity. When setting priorities and allocating funds, the HIV CARE Council may optionally limit certain services more precisely. Further information can be found within each service category guideline and summarized on the Caps/Limitations Table (formerly known as the Eligibility Table)

HRSA Policy Clarification Notices: PCN#13-01, PCN#13-02, PCN#13-03, PCN#13-04, PCN#13-05, PCN#21-02

Procedures

Subrecipients providing PBC RW Part A/MAI services must certify and document client eligibility prior to, or simultaneously with, services being rendered. Subrecipients are required to make a determination of client eligibility/ineligibility within 24 hours of receiving all required documentation.

Initial Eligibility Certification Documentation

Required Eligibility Documentation

a) HIV diagnosis; AND
b) Palm Beach County residency; AND
c) Income at or below 400% FPL.

Required HIV Coordinated Services Network (CSN) Enrollment Documentation

- Authorization to Use and Disclose Protected Health Information
- Notice of Privacy Practices
- Client Rights and Responsibilities
- Grievance Policy
- Verification of enrollment and/or screening for other third-party insurance programs or payer sources

Required Client Profile Documentation

- Eligibility Assessment
- Notice of Eligibility Determination

Annual Eligibility Confirmation Documentation

Subrecipients must conduct timely eligibility confirmations to assess if the client's income and/or residency status has changed at least every twelve (12) months OR at any time when changes may affect a client's eligibility for services.

Required Eligibility Confirmation Documentation

- Palm Beach County residency
- Income at or below 400% FPL

Required Client Profile Documentation

- HIV Coordinated Services Network (CSN) consent form
- Verification of enrollment and/or screening for other third-party insurance programs or payer sources
- Eligibility Assessment
- Notice of Eligibility Determination

Rapid Eligibility Determination

For both initial and annual recertification procedures, eligibility determinations may be performed simultaneously with testing and treatment. Subrecipients assume the risk that PBC RW Part A/MAI funds utilized for clients ultimately determined to be ineligible will not be reimbursed by the Recipient, and Subrecipient must identify an alternate payment source for the services rendered. All funded service categories may be provided on a time-limited basis, not to exceed 30 days. Subrecipients may determine if and which services they are willing to provide to clients during this time-limited rapid eligibility determination period. All clients must be registered in the client database (Provide Enterprise) to establish the 30 day rapid eligibility period while an eligibility determination is being made.

Eligibility Status Notification

1. The applicant shall be provided written Notice of Eligibility (NOE) determination identifying the service categories for which they are eligible.
2. The applicant will be ineligible for all service categories not listed on the NOE and shall be provided reason for ineligibility.

Additional Information

1. Immigration status is irrelevant for the purpose of eligibility for RWHAP services. Immigration status should not be shared with immigration enforcement agencies.
2. RW Part A/MAI does not require documentation to be provided in-person nor be notarized.
3. Clients are required to report any changes that may affect eligibility. This includes changes to income, residency, or third-party insurance programs or payer sources.
4. Clients with access to local, state or federal programs that deliver the same type of services provided through RW Part A/MAI must utilize services through those programs since PBC RW Part A/MAI is payer of last resort. This requirement does not preclude an individual from receiving allowable services not provided or available by other local, state or federal programs, or pending a determination of eligibility from other local, state or federal programs.
5. PBC RW Part A/MAI eligibility shall only be determined by PBC RW Part A/MAI Recipient/Subrecipients. PBC RW Part A/MAI will allow an active, current (less than 12 months old) Notice of Eligibility from a RW HIV/AIDS Program Part A or Part B/ADAP within the state of Florida as acceptable source documentation for PBC RW Part A/MAI eligibility, so long as the NOE contains sufficient information from which an eligibility determination can be made (current address, income/household size/FPL, 3rd party payer source, etc.). If the information contained in the NOE is insufficient

(i.e. address outside of PBC), additional documentation must be provided.

Appendix C- PBC RW Part A/MAI Client Eligibility Determination Table

Appendix D- PBC RW Part A/MAI Allowable Eligibility Documentation List

Appendix E- PBC RWHAP Coordinated Services Network (CSN) Client Consent

National Monitoring Standards

Client Eligibility Determination		
Standard	**Performance Measure/Method**	**Provider/Subrecipient Responsibility**
B.1. Eligibility determination of clients as specified by the jurisdiction or AIDS Drug Assistance Program (ADAP): Eligibility determination of clients for RWHAP services within a predetermined timeframe.	a) Documentation of eligibility required by the jurisdiction or ADAP in client records, including the following: • A documented diagnosis of HIV, • Low-income status as defined by the recipient, and • Proof of residency within its service area, as defined by the recipient. b) Eligibility policy and procedures on file. c) Documentation that all staff involved in eligibility determination have participated in required training on appropriate policies and procedures. d) Subrecipient client data reports consistent with eligibility requirements specified by the recipient.	a) Develop and maintain client records that contain documentation as required by the recipient of a client's eligibility determination, including the following: • Completion of an eligibility determination as specified by the recipient. • Documentation of eligibility determination required in client records, with documentation as required by the recipient: - Initial proof of HIV diagnosis (required only once). - Low-income. - Proof of residence. - Proof of compliance with eligibility determination as defined by the jurisdiction or ADAP. b) Conduct periodic reviews based upon recipient policies and procedures to identify any potential changes that may affect eligibility, and require clients to report any such changes. c) Document compliance with eligibility determination as defined by the jurisdiction or ADAP. d) Document that all staff involved in eligibility determination and confirmation have participated in the required training.
C.2. Ensure military veterans with Department of Veterans Affairs (VA) benefits are deemed eligible for RWHAP services.	a) Documentation that eligibility determination policies and procedures do not classify VA health benefits as an insurance program or deny access to RWHAP services citing "payor of last resort."	a) Ensure that policies and procedures do not classify VA health benefits as an insurance program or cite the "payor of last resort" requirement to compel an otherwise eligible client who is a veteran to obtain services from the VA or refuse to provide services.

Ch 4. Suspending Client Relationships

Purpose

To establish guidelines for suspending client relationships with Subrecipients providing any service through PBC RW Part A/MAI.

Policy

Subrecipients are not required to provide PBC RW Part A/MAI services to prospective or current clients when doing so threatens the physical, mental, or emotional well-being of Subrecipient staff, the public, or the client themselves.

Procedure

A prospective or current PBC RW Part A/MAI client relationship with a Subrecipient may be suspended voluntarily, or involuntarily for violations of Subrecipient policies and procedures that govern code of conduct, rights and responsibilities, or for actions that are deemed threatening to the well-being of Subrecipient staff, the public, or the client themselves. Client behavior warranting suspension may include, but is not limited to, threats or acts of violence, verbal abuse and harassment, criminal activity, and destruction or theft of property.

Subrecipients are encouraged to assess if client behavior can be attributed to medical or mental health diagnoses, and attempt to provide appropriate services that may support a change in client behaviors when possible. Progressive interventions such as verbal warning, written warning, and counseling/education should be utilized and documented prior to suspending client relationships.

Client relationship suspensions may be for a defined period of time or indefinite, and must be documented in the client record. Client must be notified of suspension in writing; including information related to reason for suspension, length of time of suspension, procedures and conditions of re-establishing the relationship, resources/referrals to needed services from other service providers, and a copy of the Subrecipient grievance policy.

In all cases of client relationship suspensions, the Ryan White Program Manager must be notified by the Subrecipient via email and provided a copy of written client notification. Clients have the right to grieve the suspension in accordance with Subrecipient grievance policy and procedures.

Ch 5 Service Referrals

Purpose

To establish service referral standards for Subrecipients providing any service through PBC RW Part A/MAI.

Policy

Subrecipient shall obtain written referral and linkage agreements with key points of entry. Referrals shall be managed in the PBC RW Part A/MAI data management information system. Subrecipients shall acknowledge referrals regardless of current funding availability.

Procedure

All referrals must be processed and tracked through the PBC RW Part A/MAI client data management information system. For internal referrals to Ryan White Subrecipients, the agency and needed service must be selected. For external referrals outside the HIV CSN, select or enter the agency and service needed.

Regardless of funding availability for service, referral submissions are encouraged. Referral reports are used in planning, the priorities and allocations process, as well as grant applications to demonstrate unmet need.

Referrals created in the client data management system are open for 30 days. After 30 days, if there is no acknowledgement, a new referral must be submitted.

National Monitoring Standards

Service Referrals		
Standard	**Performance Measure/Method**	**Provider/Subrecipient Responsibility**
F.2. Referral Relationships with Key Points of Entry The requirement that Part A Subrecipients maintain appropriate referral relationships with entities that constitute key points of entry. Key points of entry defined in legislation: • Emergency rooms. • Substance use disorder and mental health treatment programs. • Detoxification centers. • Detention facilities. • Clinics regarding sexually transmitted disease. • Homeless shelters. • HIV disease counseling and testing sites. • Healthcare points of entry specified by eligible areas. • Federally Qualified Health Centers (FQHCs). • Entities, such as RWHAP Part B, Part C, Part D, and Part F recipients.	a) Documentation that written referral relationships exist between Part A Subrecipients and key points of entry.	a) Establish written referral relationships with specified points of entry. b) Document referrals from these points of entry.

Ch 6. Minority AIDS Initiative Services (MAI)

Purpose

To establish Minority AIDS Initiative service standards for Subrecipients providing any service through PBC RW Part A/MAI.

Policy

MAI funds are designated to reduce the HIV-related health disparities and improve the health outcomes for disproportionately impacted, HIV+ minority populations, such as Black/African Americans, Black Haitians, and Hispanics. MAI funding shall be used to address health disparities and health inequalities among minority communities. As instructed by HRSA, MAI funds are to be used to deliver services designed to address the unique barriers and challenges faced by hard to reach disproportionately impacted minorities within the EMA.

The overarching goal of the MAI is to improve health outcomes by preventing transmission or slowing disease progression for disproportionately affected communities, such as: a. getting persons with HIV into care at an earlier stage in their illness; b. assuring access to treatments that are consistent with established standards of care; and c. helping individuals to remain in care.

MAI funded services must be consistent with the epidemiologic data and the needs of the community, and be culturally appropriate. MAI funded services shall use population-tailored, innovative approaches or interventions that differ from the usual service methodologies and that specifically address the unique needs of prioritized sub-groups.

MAI funding may be allocated to any HRSA defined service. MAI funded services are determined by the HIV CARE Council on an annual basis.

<u>Current prioritized populations for MAI services include:</u>

- Individuals living in the Western geography of Palm Beach County (Glades area population)
- Individuals who are 50 years old and over
- Individuals who are justice-involved or re-entering society from incarceration
- Top five- geography zip codes with the highest rate of new HIV diagnoses

Organizations funded to provide MAI services must also meet the following criteria:

1. Are located in or near to the prioritized community they are intending to serve.
2. Have a documented history of providing services to the prioritized communities.
3. Have documented linkages to the prioritized populations, so that they can help close the gap in access to service for highly impacted minority communities.
4. Provide services in a manner that is culturally and linguistically appropriate.
5. Demonstrate understanding of the importance of cross-cultural, language appropriate communications, and general health literacy issues in an integrated approach to develop the skills and abilities needed by HRSA-funded providers and staff to effectively deliver the best quality health care to the diverse populations they serve.

Procedure

Subrecipients must provide specific and population-tailored services, including prioritized activities to improve HIV-related health outcomes, reduce existing racial and ethnic health disparities, and increase equity in the HIV care continuum. Subrecipient must be able to describe how these activities address the unique needs of the prioritized MAI populations. Subrecipients must clearly specify the prioritized population/s to be served within the client data management information system.

The following data shall be tracked and maintained for each priority population served under the initiative:

- Funding amount expended
- Number of clients served
- Units of service overall and by race/ethnicity and WICY (women, infants, children and youth)
- Client level outcomes (HRSA/HAB measures or local metrics)

National Monitoring Standards

Minority AIDS Initiative		
Standard	**Performance Measure/Method**	**Provider/Subrecipient Responsibility**
I.1. Minority AIDS Initiative (MAI) MAI funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care, and outcomes.	a) Documentation that the EMA/TGA is allocating and expending funds to serve racial and ethnic minority populations and subpopulations disproportionately impacted by HIV in their jurisdiction.	a) Establish and maintain a system that tracks and reports the following for MAI services: • Funds expended. • Number of clients served. • Units of service provided overall by race/ethnicity, women, infants, children, and youth. • Client-level outcomes within each minority population and/or subpopulation.

Ch 7. Subrecipient Monitoring

Purpose

To establish monitoring standards for Subrecipients providing any service through PBC RW Part A/MAI.

Policy

Subrecipients, including their sub-contractors, shall be monitored annually by the Recipient to ensure compliance with all applicable HRSA standards.

Procedure

The Subrecipient shall participate in an annual monitoring site visit, using the *Ryan White Part A/MAI Comprehensive Monitoring Tool* to assess compliance with the HRSA National Monitoring Standards (June 2022). Recipient may conduct unannounced site visits when deemed appropriate.

Subrecipients shall provide all requested documentation on or before day 1 (one) of monitoring site visit; including, but not limited to, applicable files, policy manuals, records, descriptions of accounts payable systems and policies, etc. Interviews with staff members and clients may also be requested.

The Subrecipient shall commit to annual monitoring dates at the beginning of the contract period. Subrecipient agrees to ensure that programmatic, fiscal, CQM designees and other leadership staff, as requested by the Recipient, are in attendance at all site visits.

Subrecipients shall provide all requested documentation including, but not limited to, applicable files, policy manuals, records, etc. Interviews with staff members and clients may also be requested.

The Subrecipient shall commit to annual monitoring dates at the beginning of the contract period.

A comprehensive monitoring report will be emailed to the authorizing official whose signature is on the contract.

Legislative and/or Contract Findings shall be addressed through a Corrective Action Plan (CAP). Failure of Subrecipient to resolve issues identified through the monitoring process may result in contract penalties, suspension, termination or more rigorous future monitoring.

Subrecipient shall establish policies and procedures to ensure compliance with federal and programmatic requirements.

National Monitoring Standards

Subrecipient Monitoring		
Standard	**Performance Measure/Method**	**Provider/Subrecipient Responsibility**
G.1. Any grant recipient or Subrecipient receiving federal funding is required to monitor for compliance with federal requirements and programmatic expectations.	a) Development and consistent implementation of policies and procedures that establish uniform administrative requirements governing the monitoring of awards.	a) Participate in and provide all the material necessary to carry out monitoring activities.
G.2. Monitoring activities expected to include annual site visits of all Subrecipients. Note: Site visit exemption requests must be submitted through the HRSA Electronic Handbooks (EHBs) using a prior approval request.	a) Review of the following program monitoring documents and actions: • Policies and procedures. • Tools, protocols, or methodologies. • Reports. • Corrective action plans. • Progress on meeting the goals of corrective action plans.	a) Establish policies and procedures to ensure compliance with federal and programmatic requirements. b) Submit audit reports. c) Provide the recipient with access to financial documentation, client charts, and other documents needed for monitoring.

G.3. Performance of fiscal monitoring activities to ensure RWHAP funds are only used for approved purposes.	a) Review of the following fiscal monitoring documents and actions: • Fiscal monitoring policy and procedures. • Fiscal monitoring tool or protocol. • Fiscal monitoring reports. • Fiscal monitoring corrective action plans. • Compliance with the goals of	a) Have documented evidence that federal funds have been used for allowable services and comply with federal regulations and RWHAP requirements.
	corrective action plans.	
G.4. Salary Rate Limitation HRSA funds may not be used to pay the salary of an individual at a rate in excess of an Executive Level II employee. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary rate limitation also applies to subawards/subcontracts for substantive work under a HRSA grant or cooperative agreement.	a) Identification and description of individual employee salary expenditures to ensure that salaries are within the HRSA Salary Rate Limitation. b) Determine whether individual staff receives additional HRSA income through other subawards or subcontracts.	a) Monitor staff salaries to determine whether the salary rate limitation is being exceeded. b) Monitor prorated salaries to ensure that the salary, when calculated at one hundred percent, does not exceed the HRSA Salary Rate Limitation. c) Monitor staff salaries to determine that the salary rate limitation is not exceeded when the aggregate salary funding from other federal sources, including all parts of the RWHAP, does not exceed the limitation. d) Review payroll reports, payroll allocation journals, and employee contracts.
G.5. Salary Rate Limitation Fringe Benefits If an individual is under the salary rate limitation, fringe is applied as usual. If an individual is over the salary rate limitation, fringe is calculated on the adjusted base salary.	a) Identification of individual employee fringe benefit allocation.	a) Monitor to ensure that when an employee's salary exceeds the salary rate limitation, the fringe benefit contribution is limited to the percentage of the maximum allowable salary.
G.6. Corrective actions taken when Subrecipient outcomes do not meet program objectives and recipient expectations, which may include: a) Improved oversight. b) Redistribution of funds. c) A corrective action letter. d) Sponsored technical assistance.	a) Review corrective action plans. b) Review resolution of issues identified in the corrective action plan. c) Maintain policies that describe actions to be taken when issues are not resolved in a timely manner.	a) Prepare and submit: • Timely and detailed responses to monitoring findings. • Timely progress reports on the implementation of corrective action plans.

Ch 8. Client Grievances

Purpose

To establish client grievance standards for Subrecipients providing any service through PBC RW Part A/MAI.

Policy

The Subrecipient shall establish a grievance policy for PBC RW Part A/MAI clients. The grievance policy must outline steps in the grievance process, including appeals and escalation, and provide the right to appeal to the Recipient's office after exhausting Subrecipients process.

Procedure

Subrecipient grievance policy must be provided to clients upon enrollment, and/or prior to providing services.

Subrecipient must track all grievances filed by clients and provide summary, including resolution, to Recipient upon request.

PBC RWHAP Monitoring Standards

Client Grievances		
Standard	**Performance Measure/Method**	**Provider/Subrecipient Responsibility**
Client grievance policy outlining steps in the grievance process, including appeals and escalation.	Documentation of client grievance policy Grievance policy provided to client upon enrollment, and/or prior to providing services Tracking of all Subrecipient grievances filed by clients with associated resolutions.	Establish client grievance policy Demonstrate grievance policy provided to clients upon enrollment, and/or prior to providing services Provide summary of all grievances filed by clients, including resolutions, to Recipient upon request

Ch 9. Client Data Management Information System Access & Reporting

Purpose

To establish client data management information system standards for Subrecipients providing any service through PBC RW Part A/MAI.

Policy

The PBC RW Part A/MAI client data management information system is Groupware Technologies, Inc. (GTI) Provide Enterprise (PE) Care Management Software.

Subrecipients must report all service delivery information using the client data management information system.

Subrecipients requesting discontinued access for a User must submit a User Deletion Request through the data management system. If the User is separated from the organization, the request shall be submitted no later than one (1) business day following separation of the User.

It is prohibited to enter fraudulent records into the system. Additionally, unauthorized use, destruction, stealing and/or alteration of data are prohibited. Incidents of fraud and/or misuse shall be reported immediately followed by submission of the Community Services PBC RWHAP Incident Notification Form to the Ryan White Program Manager.

Appendix F- Community Service Department Incident Report

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) continues to improve health outcomes through data utilization. National RWHAP client-level data is collected through the Ryan White HIV/AIDS Services Report (RSR). The RSR dataset is HAB's primary source of annual, client-level data collected from its nearly 2,000 funded grant recipients and Subrecipients.

Client-level RSR data have been used to assess the numbers and types of clients receiving services and their HIV outcomes. As such, the Recipient and Subrecipients are required to submit to HRSA an annual RSR, which draws from information from the client data management information system.

Subrecipients shall submit all required reports by the deadline, ensuring the data and subsequent analyses are accurate.

Procedures

Subrecipients shall:

- Follow instructions detailed in the Provide Enterprise Palm Beach HIV/AIDS Care Network CARE User Guide;
- Ensure all client data management information system users have signed the Provide Enterprise User Confidentiality Agreement
  Appendix G- PBC RWHAP PE & OSCARSS User Confidentiality Agreement
- Document all service delivery information in client data management information system before submitting request for reimbursement. Service-specific information requirements can be found within the Core Medical and Support Service sections.
- Secure data according to all local, state, and federal regulations;
- Establish a policy that addresses protection of data;

- Report any suspected data compromises to the PBC RWHAP Recipient immediately, but no later than one (1) business day.
- Submit the Ryan White HIV/AIDS Program Service Report RSR by the established deadline.

National Monitoring Standards

Data Reporting Requirements		
Standard	**Performance Measure/Method**	**Provider/Subrecipient Responsibility**
J.1. Submission of the RSR: There are three components to the RSR that EMAs/TGAs must successfully submit online: a) Recipient Report. b) Provider Report. c) Client Report. Note: Eligible Scope is the mechanism used to help HRSA HAB better understand the full scope of services that people seeking care from RWHAP providers receive. To be included in the RSR, the client must: • Meet the recipient's eligibility requirements for the RWHAP participation (see HAB PCN 21-02 for more information on client eligibility), and • Have received at least one of the core medical or support services for which the recipient/Subrecipient receives RWHAP-related funding.	a) Documentation that the EMA or TGA has submitted the annual online Recipient Report and that it includes a complete list of Subrecipient contracts and the services funded under each contract. b) Documentation that all Subrecipients have submitted Provider Reports through the RSR portal by the required due date. c) Documentation that all Subrecipients have submitted client-level data within the Provider Report by the required due date unless the provider has an approved exemption from reporting client-level data.	a) Report all the RWHAP-funded or RWHAP-related funded services the Subrecipient offers to clients during the funding year. b) Submit both interim and final reports by the specified deadlines. c) Maintain client-level data on each client served, including in each client record demographic status, HIV clinical information, HIV care medical and support services received, and the client's Unique Client Identifier. d) Submit this report online as an electronic file upload using the standard format.
F.1. Submission of standard reports as required in 2 CFR 200, as well as program-specific reports as outlined in the Notice of Award.	a) Records that contain and adequately identify the source of information pertaining to: • Federal award revenue, expenses, obligations, unobligated balances, assets, outlays, program income, rebates, and interest. • Client-level data. • Aggregate data on services provided, clients served, client demographics, and selected financial information.	a) Ensure: • Submission of timely Subrecipient reports. • File documentation or data containing an analysis of required reports to determine the accuracy and any reconciliation with existing financial or programmatic data. Example: Test program income final Federal Financial Report (FFR) with the calendar year RDR. • Submission of periodic financial reports that document the expenditure of RWHAP funds, positive and negative spending variances, and how funds have been reallocated to other line items or service categories.

F.1. Women, Infants, Children, and Youth (WICY) Use of grant funds each fiscal year for each of the populations of WICY is not less than the percentage constituted by the ratio of the population in such areas with HIV to the general population in such areas with HIV unless a waiver from this provision is obtained. Note 1: Funds expended should apply to all four populations, no matter how small the percentage. Note 2: A waiver is available if the recipient can document that sufficient funds to meet the needs of these population groups are being provided through other federal or state programs.	a) Documentation that the amount of Part A funding spent on services for WICY is at least equal to the proportion each of these populations represents of the entire population of people with HIV in the EMA or TGA. b) If a waiver is requested, documentation should show that the service needs of one or more of these populations are already met through funding from another federal or state program.	a) Track and report to the recipient the amount and percentage of Part A funds expended for services to each priority population.

Ch 10. Service Eligibility Override Request

Purpose

To establish service eligibility override request standards for Subrecipients providing any service through PBC RW Part A/MAI

Policy

Subrecipient may submit a service eligibility override to request Recipient review of client service eligibility determination made by PBC RWHAP client data management information system.

Service eligibility override requests shall not be used to request an exception to PBC RWHAP eligibility policies.

Service eligibility override requests shall only be submitted in instances where a client has an alternative payer source that does not provide coverage for the needed service (underinsured).

Service eligibility override requests shall be approved or rejected at the discretion of the Recipient.

Procedure

Subrecipient shall submit a service eligibility override request through the PBC RWHAP client data management information system.

Subrecipient shall include client-specific documentation to demonstrate that client has exhausted all alternative payer sources. (e.g. Summary of Benefits, Insurance Denial Letter, etc.)

Subrecipient may resubmit service eligibility override requests that are rejected based on lack of supporting documentation once necessary supporting documentation is obtained.

Section III: Universal Guidelines-Fiscal

Ch 1. Allowable & Unallowable/Prohibited Uses of Funds

Purpose

To establish standards for the use of RWHAP funds by Subrecipients providing RW Part A/MAI services in Palm Beach County.

Policy

Subrecipients shall only make use of RWHAP funds to support the following:

- Core Medical Services
- Support Services that are needed by individuals with HIV/AIDS to achieve medical outcomes related to their HIV/AIDS-related clinical status
- Clinical Quality Management
- Administrative activities

Subrecipients must comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and with any cancellation of unobligated funds.

Subrecipients shall comply with legislative requirements for RWHAP to participate in Medicaid and be certified to receive Medicaid payments or be able to document efforts under way to obtain such certification.

Limitations for RWHAP funds include the following:

- Inclusion of indirect costs only when the Subrecipient has an approved federally negotiated indirect cost rate, or if no such rate exists, either a rate negotiated between the recipient and the Subrecipient (in compliance with 2 CFR 200), or a de minimis rate of 10 percent of the modified total direct costs (per 2 CFR 200).
- Appropriate Subrecipient assignment of PBC RW Part A/MAI administrative expenses, with administrative costs to include:
  · Usual and recognized overhead activities, including rent, utilities, and facility costs (mortgage/property taxes are unallowable).
  · Costs of management oversight of specific programs funded under this title, including program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; computer hardware/ software not directly related to patient care
- Only first line supervisors responsible for oversight of direct patient care are allowable as Direct costs (PCN 15-01)

Procedures

Subrecipients shall:

- Use RWHAP funds in accordance with established federal regulations and limitations.
- Subrecipients shall bill and document for only allowable services.
- Prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses, quality management, program income, and expenses by service category.
- Inform the Recipient of any projected under-expenditures greater than 10% in any service category on a monthly basis.
- By June 30th provide status of 1st quarter expenditures, if 20% of expenditures have not been spent, agency is subject to 10% sweep of funds. Agency must submit Cash Flow Commitment Statement along with Statement of Cash Flows, Statement of Activities and Statement of Financial Position.

- By September 30th provide status of 2nd quarter expenditures, if 40% of expenditures have not been spent, agency is subject to 50% sweep of funds. Agency must submit Cash Flow Commitment Statement along with Statement of Cash Flows, Statement of Activities and Statement of Financial Position.
- By October 1st agency to provide projection of unspent/unobligated funds for end of grant year.
- By December 30th, provide status of 3rd quarter expenditures, if 75% of expenditures have not been spent, agency is subject to sweeps of 100% of remaining unspent funds. Agency must submit Cash Flow Commitment Statement along with Statement of Cash Flows, Statement of Activities and Statement of Financial Position.
- Provide annual audit within nine (9) months of fiscal year end.
- Provide copies of all grant audits and monitoring reports from other agencies by first day of monitoring by the County.
- Provide Final invoice by March 31st and label "Final Invoice" on each reimbursement submission.
- Provide Final closeout report and Financial Reconciliation Statement no later than 30 days from end of contract.

Program National Monitoring Standards

Section A: Allowable Uses of RWHAP Part A Service Funds		
A.1. RWHAP Part A funds		
Use only to support: • Core medical services. • Support services that are needed by people with HIV to achieve medical outcomes related to their HIV-related clinical status. • Clinical quality management (CQM) activities. • Administrative expenses (including Planning Council support).	A.1.i. Performance Measure/Method a) Request for Proposal (RFP), Request for Application (RFA), contract, provider agreement, Memorandum of Understanding (MOU)/Letter of Agreement (LOA), and/or statement of work language that describes and defines RWHAP Part A services within the range of activities, and the uses of funds allowed under the legislation and defined in Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Notices, including core medical and support services, clinical quality management (CQM) activities, and administration (including Planning Council support).	A.1.iii. Subrecipient Responsibility a) Provide the services described in the RFPs, RFAs, contracts, provider agreements, MOUs/LOAs, and/or statements of work. b) Bill only for allowable activities/services for eligible people with HIV. c) Maintain files and share them with the recipient and other U.S. Department of Health and Human Services (DHHS) audit and site visit teams upon request, documentation that only allowable activities are billed to the RWHAP Part A grant.

E.1. Administration Recipients are to spend no more than 10 percent of grant funds on administration. This 10 percent limitation does not include the up to five percent (five percent or $3,000,000, whichever is less) of funds that may be spent on CQM activities. a) Administrative funds are to be used for routine grant administration and monitoring activities, including: • Preparation of routine programmatic and financial reports. • Compliance with grant conditions and audit requirements. b) Activities associated with the recipient's contract award procedures, including: • The development of RFPs, RFAs, provider agreements, contracts, MOUs/LOAs, and/or statements of work. • Drafting, negotiation, awarding, and monitoring of contract awards. • Conducting comprehensive site visits to funded providers. • Development of the applications for Part A funds. • The receipt and disbursal of program funds. • Development and establishment of reimbursement and accounting systems. • Funding reallocation. • Planning Council/Body operations and support. Note: Please see RWHAP Part A Fiscal Monitoring Standards for additional information on the use of funds for administration.	E.1.i. Performance Measure/Method a) Documentation that recipient administrative costs paid by Part A funds do not exceed 10 percent of total grant funds. b) Review activities to ensure the proper categorization of allowable administrative functions	E.1.iii. Subrecipient Responsibility a) Provide documentation of administrative costs per recipient requirements.
Section F: Other Service Requirements		

F.1. Women, Infants, Children, and Youth (WICY) Use of grant funds each fiscal year for each of the populations of WICY is not less than the percentage constituted by the ratio of the population in such areas with HIV to the general population in such areas with HIV unless a waiver from this provision is obtained. Note 1: Funds expended should apply to all four populations, no matter how small the percentage. Note 2: A waiver is available if the recipient can document that sufficient funds to meet the needs of these population groups are being provided through other federal or state programs.	F.1.i. Performance Measure/Method a) Documentation that the amount of Part A funding spent on services for WICY is at least equal to the proportion each of these populations represents of the entire population of people with HIV in the EMA or TGA. b) If a waiver is requested, documentation should show that the service needs of one or more of these populations are already met through funding from another federal or state program.	F.1.iii. Subrecipient Responsibility a) Track and report to the recipient the amount and percentage of Part A funds expended for services to each priority population
F.2. Referral Relationships with Key Points of Entry The requirement that Part A Subrecipients maintain appropriate referral relationships with entities that constitute key points of entry. Key points of entry defined in legislation: • Emergency rooms. • Substance use disorder and mental health treatment programs. • Detoxification centers. • Detention facilities. • Clinics regarding sexually transmitted disease. • Homeless shelters. • HIV disease counseling and testing sites. • Healthcare points of entry specified by eligible areas. • Federally Qualified Health Centers (FQHCs). • Entities, such as RWHAP Part B, Part C, Part D, and Part F recipients.	F.2.i. Performance Measure/Method a) Documentation that written referral relationships exist between Part A Subrecipients and key points of entry.	F.2.iii. Subrecipient Responsibility a) Establish written referral relationships with specified points of entry. b) Document referrals from these points of entry.
Section G: Prohibition on Certain Activities and Additional Requirements		
G.1. Drug Use and Sexual Activity RWHAP funds cannot be used to support HIV programs or materials designed to promote or directly encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.	G.1.i. Performance Measure/Method a) Signed contracts, recipient and Subrecipient assurances, and/or certifications that define and specifically forbid the use of RWHAP funds for unallowable activities. b) Recipient review of Subrecipient budget and expenditures to ensure that they do not include any unallowable costs or activities.	G.1.iii. Subrecipient Responsibility a) Maintain a file with the signed Subrecipient agreement, assurances, and/or certifications that specify unallowable activities. b) Ensure that budgets and expenditures do not include unallowable activities. c) Ensure that expenditures do not include unallowable activities.

		d) Provide budgets and financial expense reports to the recipient with sufficient detail to document that they do not include unallowable costs or activities.
G.2. Purchase of Vehicles No use of RWHAP funds by recipients or Subrecipients for the purchase of vehicles without the written approval of the HRSA Grants Management Officer (GMO).	G.2.i. Performance Measure/Method a) Implementation of measure/method, recipient responsibility, and provider/Subrecipient responsibility actions specified in G.1 above. b) Where vehicles were purchased, review of files for written permission from the GMO.	G.2.iii. Subrecipient Responsibility a) Carry out Subrecipient actions specified in G.1 above. b) If vehicle purchase is needed, seek recipient assistance in obtaining written GMO approval, and maintain the document in a file.
G.3. Broad Scope Awareness Activities No use of RWHAP funds for broad scope awareness activities about HIV services that target the general public, including outreach programs, which have HIV prevention education as their exclusive purpose.	G.3.i. Performance Measure/Method a) Implementation of actions specified in G.1 above. b) Review of program plans, budgets, budget narratives for marketing, promotions, and advertising efforts to determine whether they are appropriately targeted to geographic areas and/or disproportionately affected populations rather than targeting the general public	G.3.iii. Subrecipient Responsibility a) Carry out Subrecipient actions specified in G.1 above. b) Prepare a detailed program plan and budget narrative that describe the planned use of any advertising or marketing activities
G.4. Lobbying Activities Prohibition on the use of RWHAP funds for influencing or attempting to influence members of Congress and other federal personnel. Note: Additional information can be found at: http://www.hhs.gov/grants/grants/grants-policies-regulations/lobbying-restrictions.html#	G.4.i. Performance Measure/Method a) Implementation of actions specified in G.1 above. b) Review of lobbying certification and disclosure forms for both the recipient and Subrecipients.	G.4.iii. Subrecipient Responsibility a) Carry out Subrecipient actions specified in G.1 above. b) Include in the personnel manual and employee orientation information regulations that forbid lobbying with federal funds.
G.5. Direct Cash Payments RWHAP funds may not be used to make cash payments to intended service recipients of RWHAP-funded services. This prohibition includes cash incentives and cash intended as payment for RWHAP core medical and support services. Where a direct provision of the service is not possible or effective, store gift cards, vouchers, coupons, or tickets that can be exchanged for a specific	G.5.i. Performance Measure/Method a) Implementation of actions specified in G.1 above. b) Review of Standards of Care and other policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance	G.5.iii. Subrecipient Responsibility a) Carry out Subrecipient actions specified in G.1 above. b) Service Standards and other policies and procedures prohibit making cash payments to clients of RWHAP-funded services. c) Maintain documentation that all provider staff have been informed of policies that prohibit the use of RWHAP funds for

service or commodity (e.g., food or transportation) must be used.	premiums, medical or medication copays, deductibles, food, and nutrition). c) Review of expenditures by Subrecipients to ensure that no cash payments were made to clients of RWHAP-funded services.	cash payments to clients of RWHAP-funded services.
G.6. Employment and Employment-Readiness Services Prohibition on the use of RWHAP funds to support employment, vocational, or employment- readiness services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services).	G.6.i. Performance Measure/Method a) Implementation of actions specified in G.1 above.	G.6.iii. Subrecipient Responsibility a) Carry out Subrecipient actions specified in G.1 above.
G.7. Maintenance of Privately-Owned Vehicle No use of RWHAP funds for direct maintenance expenses (tires, repairs, etc.) of a privately- owned vehicle or any other costs associated with a vehicle, such as a lease or loan payments, insurance, or license and registration fees. Note: This restriction does not apply to vehicles operated by organizations for program purposes.	G.7.i. Performance Measure/Method a) Implementation of actions specified in G.1 above. b) Documentation that RWHAP funds are not being used for direct maintenance expenses or any other costs associated with privately-owned vehicles, such as a lease or loan payments, insurance, or license and registration fees – except for vehicles operated by organizations for program purposes	G.7.iii. Subrecipient Responsibility a) Carry out Subrecipient actions specified in G.1 above
G.8. Syringe Services Part A funds may be used to support some aspect of support syringe service programs with prior approval and in compliance with HHS and HRSA policy.	G.8.i. Performance Measure/Method a) Implementation of actions specified in G.1 above. b) Documentation that RWHAP funds are not being used for programs related to sterile needles or syringe exchange for injection drug use	G.8.iii. Subrecipient Responsibility a) Carry out Subrecipient actions specified in G.1 above

G.9. Additional Prohibitions No use of RWHAP funds for the following activities or to purchase these items: • Clothing. • Funeral, burial, cremation, or related expenses. • Local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied). • Household appliances. • Pet foods or other non-essential products. • Off-premise social/recreational activities or payments for a client's gym membership. • Purchase or improve land, or purchase, construct, or permanently improve (other than minor remodeling) any building or other facility. • Pre-exposure prophylaxis (PrEP). • Post-exposure prophylaxis. • International travel. Note: RWHAP funds cannot pay for PrEP or non-occupational post-exposure prophylaxis (nPEP), as the person using PrEP is not an individual with HIV, and the person using nPEP is not diagnosed with HIV prior to the exposure, and therefore are not eligible for RWHAP- funded medications or medical services. Part A and Part B recipients and Subrecipients may provide some limited services under the EIS category. For more information, see the HAB RWHAP and PrEP Program Letter.	G.9.i. Performance Measure/Method a) Implementation of actions specified in G.1 above. b) Review and monitor recipient and Subrecipient activities and expenditures to ensure that RWHAP funds are not being used for any of the prohibited activities.	G.9.iii. Subrecipient Responsibility a) Carry out Subrecipient actions specified in G.1 above.

Fiscal National Monitoring Standards

Limitation on Uses of Part A Funding & Unallowable Costs		
Standard	**Performance Measure/ Method**	**Provider/Subrecipient Responsibility**
Section A: **Limitation on Uses of Part A funding**		

4. Aggregated subgrantee administrative expenses total not more than 10% of Part A service dollars	· Review of subgrantee budgets to ensure proper designation and categorization of administrative costs · Calculation of the administrative costs for each subgrantee · Calculation of the total amount of administrative expenses across all subgrantees to ensure that the aggregate administrative costs do not exceed 10%	Prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses

5. Appropriate subgrantee assignment of Ryan White Part A administrative expenses, with administrative costs to include: · Usual and recognized overhead activities, including rent, utilities, and facility costs · Costs of management oversight of specific programs funded under this title, including program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; computer hardware/ software not directly related to patient care	Review of subgrantee administrative budgets and expenses to ensure that all expenses are allowable	· Prepare project budget that meets administrative cost guidelines · Provide expense reports that track administrative expenses with sufficient detail to permit review of administrative cost elements
6. Inclusion of Indirect costs (capped at 10%) only where the grantee has a certified HHS- negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certificate of Indirect Costs, which has been reviewed by the HRSA/HAB Project Officer ***Note*:** To obtain an indirect cost rate through HHS's Division of Cost Allocation (DCA),visit their website at: http://rates.psc.gov/	For grantee wishing to include an indirect rate, documentation of a current Certificate of Cost Allocation Plan or Certificate of Indirect Costs that is HHS-negotiated, signed by an individual at a level no lower than chief financial officer of the governmental unit that submits the proposal or component covered by the proposal, and reviewed by the HRSA/HAB Project Officer	· If using indirect cost as part or all of its 10% administration costs, obtain and keep on file a federally approved HHS- negotiated Certificate of Cost Allocation Plan or Certificate of Indirect Costs · Submit a current copy of the Certificate to the grantee
8. Expenditure of not less than 75% of service dollars on core medical services, unless a waiver has been obtained from HRSA (Service dollars are those grant funds remaining after removal of administrative and clinical quality management funds)	· Review of budgeted allocations and actual program expenses to verify that the grantee has met or exceeded the required 75% expenditure on HRSA-defined core medical services	Report to the grantee expenses by service category
9. Total expenditures for support services limited to no more than 25% of service dollars. Support services are those services, subject to approval of the Secretary of Health and Human Services, that are needed for individuals with HIV/AIDS to achieve their medical outcomes.	· Documentation that support services are being used to help achieve positive medical outcomes for clients · Documentation that aggregated support service expenses do not exceed 25% of service funds	· Report to the grantee expenses by service category · Document that support service funds are contributing to positive medical outcomes for clients
Section B: **Unallowable Costs**		

1. The grantee shall provide to all Part A subgrantees definitions of unallowable costs	· Signed contracts, grantee and subgrantee assurances, and/or certifications that define and specifically forbid the use of Ryan White funds for unallowable expenses Note: Unallowable costs are listed in the Universal Monitoring Standards · Grantee review of subgrantee budgets and expenditures to ensure that they do not include any unallowable costs	· Maintain a file with signed subgrant agreement, assurances, and/or certifications that specify unallowable costs · Ensure that budgets do not include unallowable costs · Ensure that expenditures do not include unallowable costs · Provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs

2. No use of Part A funds to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility (other than minor remodeling)	Implementation of actions specified in B.1 above	Carry out subgrantee actions specified in B.1 above
3. No cash payments to service recipients Note: A cash payment is the use of some form of currency (paper or coins). Gift cards have an expiration date; therefore, they are not considered to be cash payments.	· Implementation of actions specified in B.1. above · Review of policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance premiums, medical or medication co- pays and deductibles, food and nutrition) · Review of expenditures by subgrantees to ensure that no cash payments were made to individuals	· Carry out subgrantee actions specified in B.1. above · Maintain documentation of policies that prohibit use of Ryan White funds for cash payments to service recipients
4. No use of Part A funds to develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual	Implementation of actions specified in B.1 above	Carry out subgrantee actions specified in B.1 above
5. No use of Part A funds for the purchase of vehicles without written Grants Management Officer (GMO) approval	· Implementation of actions specified in B.1. above · Where vehicles were purchased, review of files for written permission from GMO	· Carry out subgrantee actions specified in B.1 above · If vehicle purchase is needed, seek grantee assistance in obtaining written GMO approval and maintain document in file
6. No use of Part A funds for: · Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.) · Broad-scope awareness activities about HIV services that target the general public	· Implementation of actions specified in B.1. above · Review of program plans, budgets, and budget narratives for marketing, promotions and advertising efforts, to determine whether they are appropriately targeted to geographic areas and/or disproportionately affected populations rather than targeting the general public	· Carry out subgrantee actions specified in B.1. above · Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities

7. No use of Part A funds for outreach activities that have HIV prevention education as their exclusive purpose	· Implementation of actions specified in B.1. above · Review of program plans, budgets, and budget narratives for outreach activities that have HIV prevention education as their exclusive purpose	· Carry out subgrantee actions specified in B.1. above · Provide a detailed program plan of outreach activities that demonstrates how the outreach goes beyond HIV prevention education to include testing and early entry into care

8. No use of Part A funds for influencing or attempting to influence members of Congress and other Federal personnel	· Implementation of actions specified in B.1. above · Review of lobbying certification and disclosure forms for both the grantee and subgrantees Note: Forms can be obtained from the CFR website: http://ecfr.gpoAccess.gov	· Carry out subgrantee actions specified in B.1 above · Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds
9. No use of Part A funds for foreign travel	Implementation of actions specified in B.1 above · Review of program plans, budgets, and budget narratives for foreign travel	· Carry out subgrantee actions specified in B.1 above · Maintain a file documenting all travel expenses paid by Part A funds
Section I: **Matching or Cost- Sharing Funds**		
1. Grantees required to report to HRSA/HAB information regarding the portion of program costs that are not borne by the federal government Grantees expected to ensure that non-federal contributions: · Are verifiable in grantee records · Are not used as matching for another federal program · Are necessary for program objectives and outcomes · Are allowable · Are not part of another federal award contribution (unless authorized) · Are part of the approved budget · Are part of unrecovered indirect cost (if applicable) · Are apportioned in accordance with appropriate federal cost principles Include volunteer services, if used, that are an integral and necessary part of the program, with volunteer time allocated value similar to amounts paid for similar work in the grantee organization · Value services of contractors at the employees' regular rate of pay plus reasonable, allowable and allocable fringe benefits · Assign value to donated supplies that are reasonable and do not exceed the fair market value · Value donated equipment, buildings, and land differently according to the purpose of the award · Value donated property in accordance with the usual accounting policies of the recipient (not to exceed fair market value)	· Review grantee annual comprehensive budget · Review all grantee in-kind and other contributions to Ryan White program · Review grantee documentation of other contributed services or expenses	Where subgrantee on behalf of the grantee provides matching or cost sharing funds, follow the same verification process as the grantee

Ch 2. Program Income from Third Party Source/Fees for Services Performed

Purpose

To establish standards for program income from third party source/fees for services performed by Sub-recipients providing PBC RW Part A/MAI.

Policy

Subrecipients shall adhere to federal requirements and maximize program income from third party sources.

Procedure

Subrecipients shall:

- Document policies and procedures, including staff training, on meeting the requirement that Ryan White be the payer of last resort.
- Require that each client be screened for insurance coverage and eligibility for third party programs, and assist client to apply for such coverage, with documentation of this in client records.
- Establish and maintain medical practice management systems for billing.
- Document and maintain file information on agency Medicaid status and that the provider is able to receive Medicaid payments.
- Maintain file of contracts with Medicaid insurance companies. If no Medicaid certification, document current efforts to obtain such certification. If certification is not feasible, request a waiver where appropriate.
- Bill, track, and report to the Recipient all program income billed and obtained.
- Report expenses from third-party payer collections and adjustment reports or by the application of a revenue allocation formula.
- Report to the Recipient in detail, use of Program Income in PBC RW Part A/MAI.
- Utilize Provide Enterprise to report Program Income revenue and expenditures monthly.

Fiscal National Monitoring Standards

Income from Fees for Services Performed		
Standard	**Performance Measure/ Method**	**Provider/Subrecipient Responsibility**
Section C: **Income from Fees for Services Performed**		
1. Use of Part A and other funding sources to maximize program income from third party sources and ensure that Ryan White is the payer of last resort. Third party funding sources include: · Medicaid · State Children's Health Insurance Programs (SCHIP) · Medicare (including the Part D prescription drug benefit) and · Private insurance	· Information in client records that includes proof of screening for insurance coverage · Documentation of policies and consistent implementation of efforts to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance or other programs · Documentation of procedures for coordination of benefits by grantee and subgrantees	· Have policies and staff training on the requirement that Ryan White be the payer of last resort and how that requirement is met · Require that each client be screened for insurance coverage and eligibility for third party programs, and helped to apply for such coverage, with documentation of this in client records · Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third party payer is not available · Establish and maintain medical practice management systems for billing
2. Ensure billing and collection from third party payers, including Medicare and Medicaid, so that payer of last resort requirements are met	· Inclusion in subgrant agreements of language that requires billing and collection of third party funds · Review of the following subgrantee systems and procedures: o Billing and collection policies and procedures o Electronic or manual system to bill third party payers o Accounts receivable system for tracking charges and payments for third party payers	Establish and consistently implement: · Billing and collection policies and procedures · Billing and collection process and/or electronic system · Documentation of accounts receivable
3. Ensure subgrantee participation in Medicaid and certification to receive Medicaid payments.	· Review of subgrantee's/ provider's individual or group Medicaid number · If subgrantee is not currently certified to receive Medicaid payments, documentation of efforts under way to obtain documentation and expected timing	· Document and maintain file information on grantee or individual provider agency Medicaid status · Maintain file of contracts with Medicaid insurance companies · If no Medicaid certification, document current efforts to obtain such certification · If certification is not feasible, request a waiver where appropriate
4. Ensure billing, tracking, and reporting of program income by grantee and subgrantees	· Review of subgrantee billing, tracking, and reporting of program income, · Review of program income reported by the grantee in the FFR and annual reports	Bill, track, and report to the grantee all program billed and obtained

5. Ensure service provider retention of program income derived from Ryan White-funded services and use of such funds in one or more of the following ways: · Funds added to resources committed to the project or program, and used to further eligible project or program objectives · Funds used to cover program costs ***Note:*** Program income funds are not subject to the federal limitations on administration (10%), quality management (5%), or core medical services (75% minimum). For example, all program income can be spent on administration of the Part A program, however HRSA does encourage funds be used for services.	· Review of grantee and subgrantee systems for tracking and reporting program income generated by Ryan White-funded services · Review of expenditure reports from subgrantees regarding collection and use of program income · Monitoring of medical practice management system to obtain reports of total program income derived from Ryan White Part A activities	· Document billing and collection of program income. · Report program income documented by charges, collections, and adjustment reports or by the application of a revenue allocation formula

Ch 3. Program Income from RWHAP Client Fees and Use of Program Income

Purpose

To establish standards for program income from PBC RW Part A/MAI client fees and use of program income by Sub- recipients providing PBC RW Part A/MAI services.

Policy

The Subrecipient shall:

- Develop and implement a program income policy as defined in PCN 15-03.
- Charge clients for PBC RW Part A/MAI services based on established sliding fee schedule.
- Document each instance where a client is asked to pay, as well as instances where a client is unable to pay.
- Not refuse services for non-payment.
- Ensure that the accounting system for tracking patient charges and payments discontinues charges once the client has reached their annual cap.
- Uses the 'additive' alternative whereby program income must be used for the purposes for which the award was made, and may only be used for allowable costs under the award. For PBC RW Part A/MAI allowable costs are limited to core medical and support services, clinical quality management, and administrative expenses (including planning and evaluation) as part of a comprehensive system of care for low- income people with HIV and AIDS.
- Document and track all payments received in accordance with its program income policy, and report to the Recipient annually at the close of the grant year and when status update is requested during monitoring activities. Such revenue must be deposited into the account of the program that generated it, and must be used for the sole purpose to grow or benefit that program.

Procedure

The Subrecipient shall establish, document and have available for Recipient review:

- Program Income Policy
- Schedule of charges
- Fees charged by the Subrecipient and the payments made to that Subrecipient by clients and/or source of generated income
- Process for obtaining and documenting client charges and other generated income

Subrecipient charges shall:

- Be publicly posted (schedule of charges or sliding fee scale).
- Not be imposed on clients with income below 100% of the Federal Poverty Level (FPL). This shall be reflected in all Subrecipient program income policy.
- Be for clients with incomes greater than 100% FPL as determined by the schedule of charges.
- Note annual limitations on the amount of charge for PBC RW Part A/MAI services are based on the percent of the client's annual income as follows:
  - 5% for clients with incomes between 100% and 200% of FPL
  - 7% for clients with incomes between 201% and 300% of FPL
  - 10% for clients with incomes greater than 301% of FPL

Subrecipients shall:

- Determine clients' eligibility for established fees and caps.
- Track PBC RW Part A/MAI charges or medical expenses inclusive of enrollment fees, deductibles, co-payments, etc.

- Develop a process for alerting the billing system when the client has reached the cap and shall not be further charged for the remainder of the year.
- Ensure Subrecipient staff are following the established program income policy.

Subrecipients shall not:

- Deny services for non-payment
- Deny services for inability to produce income documentation
- Require full payment prior to service
- Include any other procedure that denies services for non-payment

Fiscal National Monitoring Standards

Imposition & Assessment of Client Charges		
Standard	**Performance Measure/ Method**	**Provider/Subrecipient Responsibility**
Section D: **Imposition & Assessment of Client Charges**		
1. Ensure grantee and subgrantee policies and procedures require a publicly posted schedule of charges (e.g. sliding fee scale) to clients for services, which may include a documented decision to impose only a nominal charge ***Note:*** This expectation applies to grantees that also serve as direct service providers	Review of subgrantee policies and procedures, to determine: · Existence of a provider policy for a schedule of charges. A publically posted schedule of charges based on current Federal Poverty Level (FPL) including cap on charges · Client eligibility for imposition of charges based on the schedule. · Track client charges made and payments received · How accounting systems are used for tracking charges, payments, and adjustments	Establish, document, and have available for review: · policy for a schedule of charges Current schedule of charges · Client eligibility determination in client records · Fees charged by the provider and the payments made to that provider by clients · Process for obtaining, and documenting client charges and payments through an accounting system, manual or electronic
2. No charges imposed on clients with incomes below 100% of the Federal Poverty Level (FPL)	Review of provider policy for schedule of charges to ensure clients with incomes below 100% of the FPL are not charged for services	Document that: · policy for schedule of charges does not allow clients below 100% of FPL to be charged for services · Personnel are aware of and consistently following the policy for schedule of charges Policy for schedule of charges must be publically posted

3. Charges to clients with incomes greater than 100% of poverty are determined by the schedule of charges. Annual limitation on amounts of charge (i.e. caps on charges) for Ryan White services are based on the percent of client's annual income, as follows: · 5% for clients with incomes between 100% and 200% of FPL · 7% for clients with incomes between 200% and 300% of FPL · 10% for clients with incomes greater than 300% of FPL	· Review of policy for schedule of charges and cap on charges · Review of accounting system for tracking patient charges and payments · Review of charges and payments to ensure that charges are discontinued once the client has reached his/her annual cap.	Establish and maintain a schedule of charges t policy that includes a cap on charges and the following: · responsibility for client eligibility determination to establish individual fees and caps · Tracking of Part A charges or medical expenses inclusive of enrollment fees, deductibles, co-payments, etc. · A process for alerting the billing system that the client has reached the cap and should not be further charged for the remainder of the year · Personnel are aware of and consistently following the policy for schedule of charges and cap on charges.

Ch 4. Financial Management & Fiscal Procedural Requirements

Purpose

To establish standards for financial management & fiscal procedural requirements for Subrecipients providing PBC RW Part A/MAI.

Policy

Subrecipients' financial management shall**:**

- Comply with established requirements in the Code of Federal Regulations (CFR) all applicable federal and local statutes and regulations governing contract award and performance.

Subrecipients' fiscal policies and procedures shall:

- Maintain policies and procedures for handling revenues from the Ryan White grant, including program income.
- Comply with the right of the Recipient to inspect and review records and documents that detail the programmatic and financial activities and the use of Ryan White funds, including payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds.
- Document employee time and effort.
- Ensure adequate reporting, reconciliation, and tracking of program expenditures.
- Coordinate fiscal activities with program activities.
- Have an organizational and communications chart for the fiscal department.

Procedure

Subrecipients provide Recipient access to the following evidence of financial management:

- Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports.
- All financial policies and procedures, including billing and collection policies and purchasing and procurement policies, and accounts payable systems and policies.
- Ensure adequate fiscal systems to generate needed budgets and expenditure reports with line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services.

Fiscal National Monitoring Standards

Financial Management & Fiscal Procedures		
Standard	**Performance Measure/ Method**	**Provider/Subrecipient Responsibility**
Section E: **Financial Management**		
1. Compliance by grantee with all the established requirements in the Code of Federal Regulations (CFR) for (a) state and local governments; and (b) non-profit organizations, hospitals, commercial organizations and institutions of higher education. Included are for: · Payments for services · Program income · Revision of budget and program plans · Non-federal audits · Property standards, including insurance coverage, equipment, supplies, and other expendable property · Procurement standards, including recipient responsibilities, codes of conduct, competition, procurement procedures, cost and price analysis, and procurement records. · Reports and records, including monitoring and reporting, program performance, financial reports, and retention and access requirements · Termination and enforcement and closeout procedures	· Review of grantee and subgrantee accounting systems to verify that they are sufficient and have the flexibility to operate the federal grant program and meet federal requirements · Review of the grantee's systems to ensure capacity to meet requirements with regard to: o Payment of subgrantee contractor invoices o Allocation of expenses of subgrantees among multiple funding sources · Review of grantee and subgrantee: o Financial operations policies and procedures o Purchasing and procurement policies and procedures o Financial reports · Review of subgrantee contract and correspondence files · Review of grantee's process for reallocation of funds by service category and subgrantee · Review of grantee's FFR trial worksheets and documentation	Provide grantee personnel access to: · Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports of the subgrantee · All financial policies and procedures, including billing and collection policies and purchasing and procurement policies · Accounts payable systems and policies
2. Comprehensive grantee and subgrantee budgets and reports with sufficient detail to account for Ryan White funds by service category, subgrantee, administrative costs, and (75/25 rule) core medical and support services rules, and to delineate between multiple funding sources and show program income	Review of: · Accounting policies and procedures · Grantee and subgrantee budgets · Accounting system used to record expenditures using the specified allocation methodology · Reports generated from the accounting system to determine if the detail and timeliness are sufficient to manage a Ryan White program	Ensure adequacy of agency fiscal systems to generate needed budgets and expenditure reports, including: · Accounting policies and procedures · Budgets · Accounting system and reports

3. Line-item grantee and subgrantee budgets that include at least four category columns: · Administrative · Clinical Quality Management (CQM) · HIV Services · MAI	· Review of grantee line-item budget and narrative for inclusion of required forms, categories, and level of detail to assess the funding to be used for administration, CQM, and direct provision of services and the budget's relation to the scope of services · Review of grantee's administrative budget and narrative for inclusion of sufficient Planning Council support funds to cover reasonable and necessary costs associated with carrying out legislatively mandated functions · Review of subgrantee line- item budget to ensure inclusion of required information and level of detail to ensure allowable use of funds and its relation to the proposed scope of services	Submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services
4. Revisions to approved budget of federal funds that involve significant modifications of project costs made by the grantee only after approval from the HRSA/HAB Grants Management Officer (GMO) ***Note:*** A significant modification occurs under a grant where the federal share exceeds $100,000, when cumulative transfers among direct cost budget categories for the current budget period exceed 25% of the total approved budget (inclusive of direct and indirect costs and federal funds and required matching or cost sharing) for that budget period or $250,000, whichever is less. Even if a grantee's proposed re-budgeting of costs fall below the significant re-budgeting threshold identified above, grantees are still required to request prior approval, if some or all of the re- budgeting reflects either of the following: · A change in scope · A proposed purchase of a unit of equipment exceeding $25,000 (if not included in the approved application)	· Comparison of grantee's current operating budget to the budget approved by the Project Officer · Documentation of written GMO approval of any budget modifications that exceeds the required threshold	Document all requests for and approvals of budget revisions

6. Provider subgrant agreements and other contracts meet all applicable federal and local statutes and regulations governing subgrant/contract award and performance Major areas for compliance: a. Follow state law and procedures when awarding and administering subgrants (whether on a cost reimbursement or fixed amount basis) b. Ensure that every subgrant includes any clauses required by federal statute and executive orders and their implementing regulations c. Ensure that subgrant agreements specify requirements imposed upon subgrantees by federal statute and regulation d. Ensure appropriate retention of and access to records e. Ensure that any advances of grant funds to subgrantees substantially conform to the standards of timing and amount that apply to cash advances by federal agencies	Develop and review Part A subcontract agreements and contracts to ensure compliance with local and federal requirements	· Establish policies and procedures to ensure compliance with subgrant provisions · Document and report on compliance as specified by the grantee
Section K: **Fiscal Procedures**		
1. Grantee and subgrantee policies and procedures in place for handling revenues from the Ryan White grant, including program income	· Review policies and procedures related to the handling of cash or Ryan White grantee or subgrantee revenue · Sample accounting entries to verify that cash and grant revenue is being recorded appropriately	· Establish policies and procedures for handling Ryan White revenue including program income · Prepare a detailed chart of accounts and general ledger that provide for the tracking of Part A revenue · Make the policies and process available for grantee review upon request
2. Advances of federal funds not to exceed 30 days and to be limited to the actual, immediate cash requirements of the program ***Note:*** Grantee permitted to draw down 1/12 of funds, but at the end of each month must do a reconciliation to actual expenses	· Review grantee's advance policy to assure it does not allow advances of federal funds for more than 30 days · Review subgrantee agreements for allowable advances · Review payments to subgrantees and payment management system draw- downs	Document reconciliation of advances to actual expenses
3. Right of the awarding agency to inspect and review records and documents that detail the programmatic and financial activities of grantees and subgrantees in the use of Ryan White funds	Review subgrantee agreements to ensure that language is included that guarantees access to records and documents as required to oversee the performance of the Ryan White subgrantee	Have in place policies and procedures that allow the grantee as funding agency prompt and full access to financial, program, and management records and documents as needed for program and fiscal monitoring and oversight

4. Awarding agency to have access to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds	Use of primary source documentation for review: · A sample of grantee and subgrantee payroll records · Grantee and subgrantee documentation that verifies that payroll taxes have been paid · Grantee and subgrantee accounts payable process, including a sampling of actual paid invoices with back-up documentation	· Maintain file documentation of payroll records and accounts payable, and hard-copy expenditures data · Make such documentation available to the grantee on request
5. Awarding agency not to withhold payments for proper charges incurred by grantee unless the grantee or subgrantee has failed to comply with grant award conditions or is indebted to the United States; grantee not to withhold subgrantee payments unless subgrantee has failed to comply with grant award conditions	Review the timing of payments to subgrantee through sampling that tracks accounts payable process from date invoices are received to date checks are deposited	· Provide timely, properly documented invoices · Comply with contract conditions
6. Awarding agency to make payment within 30 days after receipt of a billing, unless the billing is improperly presented or lacks documentation	· Review grantee payable records · Review subgrantee invoices, submission dates, and bank deposits of Part A payments · Review grantee policies on how to avoid payment delays of more than 30 days to subgrantees	· Submit invoices on time monthly, with complete documentation · Maintain data documenting reimbursement period, including monthly bank reconciliation reports and receivables aging report
7. Employee time and effort to be documented, with charges for the salaries and wages of hourly employees to: · Be supported by documented payrolls approved by the responsible official · Reflect the distribution of activity of each employee · Be supported by records indicating the total number of hours worked each day	Review documentation of employee time and effort, through: · Review of payroll records for specified employees · Documentation of allocation of payroll between funding sources if applicable	· Maintain payroll records for specified employees · Establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources · Make payroll records and allocation methodology available to grantee upon request
9. Grantee and subgrantee fiscal staff are responsible for: · Ensuring adequate reporting, reconciliation, and tracking of program expenditures · Coordinating fiscal activities with program activities (*For example, the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income)* *· Having an organizational and communications chart for the fiscal department*	· Review qualifications of program and fiscal staff · Review program and fiscal staff plan and full-time equivalents (FTEs) to determine if there are sufficient personnel to perform the duties required of the Ryan White grantee · Review grantee organizational chart	· Review the following: o Program and fiscal staff resumes and job descriptions o Staffing Plan and grantee budget and budget justification o Subgrantee organizational chart · Provide information to the grantee upon request

Ch 5. Property Standards

Purpose

To establish property standards for Subrecipients providing PBC RW Part A/MAI services.

Policy

Subrecipients shall:

- Track and report on tangible nonexpendable personal property, including exempt property, purchased directly with PBC RW Part A/MAI funds and having a useful life of more than one year, and an acquisition cost of $5,000 or more per unit (Lower limits may be established, consistent with Recipient policies).
- Implement adequate safeguards for all capital assets that assure that they are used solely for authorized purposes.
- Real property, equipment, intangible property, and debt instruments acquired or improved with federal funds held in trust by Subrecipient with title of the property vested in the Subrecipient but with the federal government retaining a reversionary interest.

Procedure

Subrecipients shall:

- Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source.
- Make the list and schedule available to the Recipient upon request.
- Establish policies and procedures that acknowledge the reversionary interest of the federal government over property improved or purchased with federal dollars.
- Maintain file documentation of these policies and procedures for Recipient review.
- Develop and maintain a current, complete, and accurate supply and medication inventory list and make the list available to the Recipient upon request.

Fiscal National Monitoring Standards

Property Standards		
Standard	**Performance Measure/ Method**	**Provider/Subrecipient Responsibility**
Section F: **Property Standards**		
1. Grantee and subgrantee tracking of and reporting on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part A funds and having: · A useful life of more than one year, and · An acquisition cost of $5,000 or more per unit (Lower limits may be established, consistent with recipient policies)	Review to determine that the grantee and each subgrantee has a current, complete, and accurate: · Inventory list of capital assets purchased with Ryan White funds · Depreciation schedule that can be used to determine when federal reversionary interest has expired	· Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source · Make the list and schedule available to the grantee upon request
2. Implementation of adequate safeguards for all capital assets that assure that they are used solely for authorized purposes	· Review grantee and subgrantee inventory lists of assets purchased with Ryan White funds · During monitoring, ensure that assets are available and appropriately	Carry out the actions specified in F.1 above

	registered · Review depreciation schedule for capital assets for completeness and accuracy	
3. Real property, equipment, intangible property, and debt instruments acquired or improved with federal funds held in trust by grantee and subgrantees, with title of the property vested in the grantee or subgrantee but with the federal government retaining a reversionary interest	· Implementation of actions specified in F.1. above · Review to ensure grantee and subgrantee policies that: o Acknowledge the reversionary interest of the federal government over property purchased with federal funds o Establish that such property may not be encumbered or disposed of without HRSA/HAB approval	· Carry out the actions specified in F.1. above · Establish policies and procedures that acknowledge the reversionary interest of the federal government over property improved or purchased with federal dollars · Maintain file documentation of these policies and procedures for grantee review
4. Assurance by grantee and subgrantees that: · Title of federally-owned property remains vested in the federal government · If the HHS awarding agency has no further need for the property, it will be declared excess and reported to the General Services Administration	Implementation of actions specified in F.1 above	Carry out the actions specified in F.1 above
5. Title to supplies to be vested in the recipient upon acquisition, with the provision that if there is a residual inventory of unused supplies exceeding $5,000 in total aggregate value upon termination or completion of the program and the supplies are not needed for any other federally-sponsored program, the recipient shall: · Retain the supplies for use on non-federally sponsored activities or sell them · Compensate the federal government for its share contributed to purchase of supplies	Review to ensure the existence of an inventory list of supplies including medications purchased with local drug assistance or ADAP funds	· Develop and maintain a current, complete, and accurate supply and medication inventory list · Make the list available to the grantee upon request

Ch 6. Cost Principles

Purpose

To establish cost principle standards for Subrecipients providing PBC RW Part A/MAI services.

Policy

Subrecipients shall ensure cost principles by:

- Ensuring services are cost based and relate to Ryan White administrative, quality management, and programmatic costs in accordance with standards cited under OMB Circulars or the Code of Federal Regulations.
- Ensuring cost for services to be reasonable, not exceeding costs that would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs.
- Maintain written procedures for determining the reasonableness of costs, the process for allocations, and the policies for allowable costs, in accordance with the provisions of applicable Federal cost principles and the terms and conditions of the award.
- Calculate unit costs based on an evaluation of reasonable cost of services; financial data must relate to performance data and include development of unit cost information whenever practical.
- Ensure the unit cost of a service shall not exceed the actual cost of providing the service, shall only include expenses that are allowable under Ryan White requirements, and the calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided.

Procedure

Subrecipients shall:

- Ensure that budgets and expenses conform to federal cost principles.
- Ensure fiscal staff familiarity with applicable federal regulations.

Fiscal National Monitoring Standards

Cost Principles		
Standard	**Performance Measure/ Method**	**Provider/Subrecipient Responsibility**
Section G: **Cost Principles**		
1. Payments made to subgrantees for services need to be cost based and relate to Ryan White administrative, quality management, and programmatic costs in accordance with standards cited under OMB Circulars or the Code of Federal Regulations	Review grantee and subgrantee budgets and expenditure reports to determine whether use of funds is consistent with OMB and CFR cost principles	· Ensure that budgets and expenses conform to federal cost principles · Ensure fiscal staff familiarity with applicable federal regulations

2. Payments made for services to be reasonable, not exceeding costs that would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs	· Review subgrantee budgets and expenditure reports to determine costs and identify cost components · When applicable, review unit cost calculations for reasonableness · Review fiscal and productivity reports to determine whether costs are reasonable when compared to level of service provided	· Make available to the grantee very detailed information on the allocation and costing of expenses for services provided · Calculate unit costs based on historical data · Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis
3. Written grantee and subgrantee procedures for determining the reasonableness of costs, the process for allocations, and the policies for allowable costs, in accordance with the provisions of applicable Federal cost principles and the terms and conditions of the award Costs are considered to be reasonable when they do not exceed what would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs	· Review policies and procedures that specify allowable expenditures for administrative costs and programmatic costs · Ensure reasonableness of charges to the Part A program	· Have in place policies and procedures to determine allowable and reasonable costs · Have in place reasonable methodologies for allocating costs among different funding sources and Ryan White categories · Make available policies, procedures, and calculations to the grantee on request
4. Calculate unit costs by grantees and subgrantees based on an evaluation of reasonable cost of services; financial data must relate to performance data and include development of unit cost information whenever practical ***Note:*** When using unit costs for the purpose of establishing fee-for-service charges, the GAAP† definition can be used. Under GAAP, donated materials and services, depreciation of capital improvement, administration, and facility costs are allowed when determining cost. · If unit cost is the method of reimbursement, it can be derived by adding direct program costs and allowable administrative costs, capped at 10%, and dividing by number of units of service to be delivered.	· Review unit cost methodology for subgrantee and provider services. · Review budgets to calculate allowable administrative and program costs for each service.	Have in place systems that can provide expenses and client utilization data in sufficient detail to determine reasonableness of unit costs
5. Requirements to be met in determining the unit cost of a service: · Unit cost not to exceed the actual cost of providing the service · Unit cost to include only expenses that are allowable under Ryan White requirements · Calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided	· Review methodology used for calculating unit costs of services provided · Review budgets to calculate allowable administrative and program costs for each service	· Have in place systems that can provide expenses and client utilization data in sufficient detail to calculate unit cost · Have unit cost calculations available for grantee review

Ch 7. Auditing Requirements

Purpose

To establish auditing requirement standards for Subrecipients providing PBC RW Part A/MAI services.

Policy

Subrecipients shall:

- Adhere to the audit requirements contained in the Single Audit Act Amendments of 1996 (31 USC 7501–7507) and revised OMB Circular A-133, with A- 133 audits required for all Subrecipients receiving more than $750,000 per year in federal grants.
- Based on criteria established by the Recipient, small Subrecipients (i.e. receive less than $750,000 per year in federal grants) may be subject to audit as a major program (i.e. a program that receives more than $750,000 in aggregate federal funding) pursuant to OMB Circular 1-133, Section .215 c).
- Select an auditor based on Audit Committee for Board of Directors (if non-profit) policy and process.
- Provide audited financial statements to verify financial stability of organization.
- Provide A-133 audits to include statements of conformance with financial requirements and other federal expectations.
- Note reportable conditions from the audit and provide a resolution.

Procedure

Subrecipients shall:

- Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds).
- Request a management letter from the auditor.
- Submit the audit and management letter to the Recipient on a timely basis within nine (9) months of agency's fiscal year end.

Fiscal National Monitoring Standards

Auditing Requirements		
Standard	**Performance Measure/ Method**	**Provider/Subrecipient Responsibility**
Section H: **Auditing Requirements**		

1. Recipients and sub- recipients of Ryan White funds that are institutions of higher education or other non- profit organizations (including hospitals) are subject to the audit requirements contained in the Single Audit Act Amendments of 1996 (31 USC 7501–7507) and revised OMB Circular A-133, with A- 133 audits required for all grantees and subgrantees receiving more than $750,000 per year in federal grants	· Review requirements for subgrantee audits · Review most recent audit (which may be an A-133 audit) to assure it includes: o List of federal grantees to ensure that the Ryan White grant is included o Programmatic income and expense reports to assess if the Ryan White grant is included · Review audit management letter if one exists · Review all programmatic income and expense reports for payer of last resort verification by auditor	· Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds) · Request a management letter from the auditor · Submit the audit and management letter to the grantee · Prepare and provide auditor with income and expense reports that include payer of last resort verification
2. Based on criteria established by the grantee, subgrantees or Sub-recipients of Ryan White funds that are small programs (i.e. receive less than $500,000 per year in federal grants) may be subject to audit as a major program (i.e. a program that receives more than $750,000 in aggregate federal funding) pursuant to OMB Circular 1-133, Section .215 c).	· Review requirements for "small program" subgrantee audits · Review most recent audit (which may be an A-133 audit) to determine if it includes: o List of federal grantees and determine if the Ryan White grant is included o Programmatic income and expense reports to assess if the Ryan White grant is included · Review audit management letter Review all programmatic income and expense reports for payer of last resort verification by auditor	· Prepare and provide auditor with financial and other documents required to conduct a major program audit (e.g. income and expense reports that include payer of last resort verification, timesheets, general ledger, etc.) · Comply with contract audit requirements on a timely basis
3. Selection of auditor to be based on Audit Committee for Board of Directors (if non-profit) policy and process	Review subgrantee financial policies and procedures related to audits and selection of an auditor	· Have in place financial policies and procedures that guide selection of an auditor · Make the policies and procedures available to grantee on request
4. Review of audited financial statements to verify financial stability of organization	Review Statement of Financial Position/Balance Sheet, Statement of Activities/Income and Expense Report, Cash Flow Statement, and Notes included in audit to determine organization's financial stability	· Comply with contract audit requirements on a timely basis · Provide audit to grantee on a timely basis
5. A-133 audits to include statements of conformance with financial requirements and other federal expectations	Review statements of internal controls and federal compliance in A-133 audits	· Comply with contract audit requirements on a timely basis · Provide audit to grantee on a timely basis
6. Grantees and subgrantees expected to note reportable conditions from the audit and provide a resolution.	· Review of reportable conditions · Determination of whether they are significant and whether they have been resolved · Development of action plan to address reportable conditions that have not been resolved	· Comply with contract audit requirements on a timely basis · Provide grantee the agency response to any reportable conditions

Ch 8. Reallocation and Unobligated Balance

Purpose

To establish reallocation and unobligated balance standards for Subrecipients providing PBC RW Part A/MAI services.

Policy

Subrecipient shall demonstrate its ability to expend funds efficiently, and submit an estimation of unobligated balance projecting expenditures through end of grant year to Recipient by October 1st.

Procedure

The Subrecipient shall provide the following to the Recipient:

- Monthly Reimbursement Requests for each service category of expenditure by the 25th of the month following expenditures
- Variance in expenditures
- Timely reporting of unspent funds by the 15th of the month following expenditures and on a quarterly basis at the end of the 1st, 2nd and 3rd quarter ending by the 30th of the following month, position vacancies, etc.
- Final Invoice due by March 31st and marked "Final Invoice".

Appendix H: GY25 Ryan White Part A/MAI Reimbursement Model Summary

The Subrecipient shall:

- Establish and implement a process for tracking unspent Part A funds and provide accurate and timely reporting to the Recipient
- Carry out monthly monitoring of expenses to detect and implement cost- saving strategies

Fiscal National Monitoring Standards

Unobligated Balances		
Standard	**Performance Measure/ Method**	**Provider/Subrecipient Responsibility**
Section L: **Unobligated Balances**		
1. EMA/TGA demonstration of its ability to expend fund efficiently by expending 95% of its formula funds in any grant year Note: EMA/TGA must submit an estimation of unobligated balance 60 days prior to the end of the grant period – by December 31 of every calendar year.	· Review grantee and subgrantee budgets · Review grantee accounting and financial reports that document the year-to-date and year-end spending of grantee and subgrantee obligated funds, including separate accounting for formula and supplemental funds · Calculation of unspent funds and potential unspent funds to determine estimated unobligated balance	· Report monthly expenditures to date to the grantee Inform the grantee of variance in expenditures.

2. EMA/TGA annual unobligated balance for formula dollars of no more than 5% reported to HRSA/HAB in grantee's Federal Financial Report (FFR)	Determination of the breakdown of the unobligated balance in the FFR by Formula, Supplemental, and Carryover · Submission of the final annual FFR no later than the July 30 after the closing of the grant year, without exception	· Provide timely reporting of unspent funds, position vacancies, etc. to the grantee · Establish and implement a process for tracking unspent Part A funds and providing accurate and timely reporting to the grantee · Be an active participant in the re-allocation process by informing the grantee on a timely basis of funds not spent or funds spent too quickly
3. EMA/TGA recognition of consequences of unobligated balances and evidence of plans to avoid a reduction of services, if any of the following penalties is applied: a. Future year award is offset by the amount of the unobligated balance less any approved carry over b. Future year award is reduced by amount of unobligated balance less the amount of approved carry over c.The grantee is not eligible for a future year supplemental award	· Review EMA/TGA compliance with any cancellation of unobligated funds · Review EMA/TGA grantee and subgrantee budgets and implementation of plans on how not to reduce services in a penalty year	· Report any unspent funds to the grantee · Carry out monthly monitoring of expenses to detect and implement cost- saving strategies

Ch 9. Anti-Kickback Statute

Purpose

To establish anti-kickback statute standards for Subrecipients providing PBC RW Part A/MAI services.

Policy

Subrecipients shall demonstrate structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement). Subrecipients and their employees (as individuals or entities) are prohibited from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.

Procedure

Subrecipients shall:

- Maintain and review file documentation of:
  - Corporate Compliance Plan (required by CMS if providing Medicare- or Medicaid-reimbursable services)
  - File documentations of any employee or Board Member violation of the Code of Ethics or Standards of Conduct
  - Documentation of any complaint of violation of the Code of Ethics or Standards of Conduct and its resolution

Universal National Monitoring Standards

Section D: Anti-Kickback Statute (AKS) The Anti-Kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal healthcare programs (e.g., drugs, supplies, or healthcare services for Medicare or Medicaid patients)	D.1.i. Performance Measure/Method a) Documentation that shows effective measures are in place to ensure adherence to the AKS, which prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by a federal healthcare program (e.g., drugs, supplies, or healthcare services). Note 1: Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. The statute covers the payers of kickbacks, those who offer or pay remuneration, as well as the recipients of kickbacks, those who solicit or receive remuneration. Note 2: Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation	D.1.iii. Subrecipient Responsibility a) Have adequate policies and procedures that ensure compliance with AKS; such as: • A corporate compliance plan, if a Medicaid and/or Medicare provider, that provides for a compliance officer, compliance committee, communication lines to report noncompliance, auditing, corrective action plans, and method for reporting noncompliance with AKS. • An anti-kickback policy that prohibits the solicitation of cash or in-kind payments for awarding contracts, referring clients, purchasing goods and/or services, and submitting fraudulent billings. It should also include the uses and applications of safe harbor laws. • Written bylaws and board policies, if it is a non-profit, include conflict of interest, the prohibition on the use of organization assets for personal use, and procedures for open communication. • Code of Ethics or Standards of Conduct that include conflict of interest, prohibition on the use of agency property without approval, fair and open competition, confidentiality, use of company assets, timely and truthful disclosure of accounting

	in the federal healthcare programs. Providers who pay or accept kickbacks also face penalties of up to $50,000 per kickback, plus three times the amount of the remuneration.	deficiencies and non-compliance, and penalties and disclosure procedures for conduct deemed to be felonies. • Written personnel policies that discourage large signing bonuses or hiring persons with a criminal record relating to, or who are currently being investigated for, healthcare fraud. Refer to 42 CFR 1001 to ensure compliance related to hiring anyone with a criminal record relating to healthcare fraud, prescription drugs, or patient care. • Maintain documentation of service contracts, key employee background checks, recruitment policies and practices, and audit reports and findings.

Ch 10. Grant Accountability and Stewardship of Funds

Purpose

To establish grant fund stewardship standards for Subrecipients providing PBC RW Part A/MAI services.

Policy

Subrecipients shall:

- Ensure proper stewardship of all grant funds including compliance with programmatic requirements.

Procedure

Subrecipients shall:

Universal National Monitoring Standards

Section E: Recipient Accountability E.1. Proper stewardship of all grant funds, including compliance with programmatic requirements.	E.1.i. Performance Measure/Method a) Policies, procedures, and contracts that require: • Timely submission of detailed fiscal reports by funding source, with expenses allocated by service category. • Timely submission of programmatic reports. • Documentation of the method used to track unobligated balances, carryover funds, and gift cards used as participant incentives. • A documented reallocation process. b) Report on the total number of funded Subrecipients. c) Compliance with the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 2 CFR 200 – Subpart F, if applicable, or a single audit. d) Auditor management letter.	E.1.iii. Subrecipient Responsibility a) Meet contracted programmatic and fiscal requirements, which include • Providing financial reports that specify expenditures by RWHAP service category and use of RWHAP funds as specified by the recipient. • Developing/maintaining a policies and procedures manual that meets federal and RWHAP fiscal and programmatic requirements. • Documenting policies and procedures are being followed. • Commissioning an independent audit; for those meeting thresholds, an audit that meets 2 CFR 200 – Subpart F requirements and responds to audit requests initiated by the recipient.

E.2. Accountability for the expenditure of funds shared with Subrecipients (e.g., lead/administrative agencies, consortia, fiduciary agents, direct service providers).	E.2.i. Performance Measure/Method a) A copy of each contract. b) Fiscal and program site visit reports and action plans. c) Audit reports. d) Documented reports that track funds by formula, supplemental, and service categories. e) Documented reports that track unobligated balance and carryover funds. f) Documented reallocation process. g) Report on the total number of funded Subrecipients. h) Recipient audit per 2 CFR 200 – Subpart F or single audit conducted annually and made available to the state every two years. i) Auditor management letter.	E.2.iii. Subrecipient Responsibility a) Establish and implement: • Fiscal and general policies and procedures that include compliance with federal and RWHAP requirements. • Flexible fiscal reporting systems that allow the tracking of unobligated balances and carryover funds and detail service reporting of funding sources. • Timely submission of independent audits (2 CFR 200 – Subpart F audits, if required) to the recipient.
E.3. Demonstrate structured and ongoing efforts to avoid fraud, waste, and abuse (mismanagement) in any federally funded program.	E.3.i. Performance Measure/Method Employee Code of Ethics including: • Conflict of Interest. • Prohibition on the use of property, information, or position without approval or to advance personal interest. • Fair dealing – engaged in fair and open competition. • Confidentiality. • Protection and use of company assets. • Compliance with laws, rules, and regulations. • Timely and truthful disclosure of significant accounting deficiencies. • Timely and truthful disclosure of non-compliance.	E.3.iii. Subrecipient Responsibility a) Maintain and review file documentation of: • Corporate Compliance Plan (required by the Centers for Medicare & Medicaid Services (CMS) if providing Medicare- or Medicaid-reimbursable services). • Personnel policies. • Code of Ethics or Standards of Conduct. • Bylaws and board policies. • File documentation of any employee or board member violation of the Code of Ethics or Standards of Conduct. • Documentation of any complaint of a violation of the Code of Ethics or Standards of Conduct and its resolution. b) For not-for-profit Subrecipient organizations, ensure documentation of Subrecipient bylaws, Board Code of Ethics, and business conduct practices.
E.4. Business management systems that meet the requirements of 2 CFR 200.	E.4.i. Performance Measure/Method a) Review of Subrecipient contracts. b) Fiscal and program site visit reports and action plans. c) Policies and procedures that outline compliance with federal and RWHAP requirements. d) Independent audits. e) Auditor management letter	E.4.iii. Subrecipient Responsibility a) Ensure that the following are in place: • Documented policies and procedures. • Fiscal/programmatic reports that provide effective control over and accountability for all funds in accordance with federal and RWHAP requirements.

Ch 11. Subrecipient Fiscal Monitoring

Purpose

To establish standards for the Subrecipients fiscal monitoring for PBC RW Part A/MAI.

Policy

As a condition for receiving PBC RW Part A/MAI funds, Subrecipient agencies and contractors agree to being fiscally monitored each grant year to ensure fiscal compliance with related federal statutes, HRSA program rules and regulations, PBC RW Part A/MAI award document, state statutes, local and department rules and regulations and agencies' PBC RW Part A/MAI contract.

Procedure

PBC RW Part A/MAI primarily utilizes four monitoring tools in complying with the Subrecipient fiscal monitoring responsibilities. These tools include annual financial statement analysis, financial risk assessments, management inquiries, and onsite fiscal compliance reviews. All PBC RWHAP Sub- recipients, regardless of amount, are included in the onsite review. Onsite reviews include review of fiscal policies and procedures for compliance with funding source requirements, substantive testing of the organization's primary transaction cycles (revenue, disbursements, and payroll) and inquiry with management.

Major areas of review include:

- Fiscal requirements related to specific contract conditions
- Applicable Federal and State rules and regulations
- Appropriate chart of accounts, general ledger, and financial reporting
- Accurate and complete property management records for all capital assets and related depreciation
- Adequacy of required minimum accounting records for all major transaction cycles (revenue, general disbursements, and payroll)
- Verification that internal controls are operating as expected
- Payroll expense and personnel records include required documentation related to time, program, rate, and eligibility to work in the United States
- Verification of compliance with payroll taxing authorities
- Inclusion of required topics in written financial policies and procedures

Subrecipient accounting practices are measured against PBC RWHAP documents, all applicable Federal and State rules and regulations as well as the following authoritative accounting pronouncements:

- Generally Accepted Accounting Principles
- Generally Accepted Auditing Standards
- Applicable AICPA Industry Audit and Accounting Guides
- OMB Circular 2 CRF Part 200
- Government Auditing Standards
- Contract specific attachments and special conditions

PBC RWHAP review the following of each Subrecipient:

- Written fiscal policies and procedures for such elements as internal controls, accounts payable, purchasing, and reimbursements for travel and other expenses
- Documentation of expenditures to enable the award recipient to determine:
    - Whether the Subrecipient reconciles budgeted expenditures to actual expenditures
    - Whether costs are allowable, reasonable, and allocable
    - Whether expenses are supported by clear, complete, and detailed documentation

    - Whether the Subrecipient has followed the rules about limiting funds to support direct medical, dental, mental health, or legal services
- Single Audit Report (if applicable), conducted annually by an independent accounting firm in compliance with 2 CFR 200.500–521; or other audit, review, financial statements, or corrective action plan for any fiscal or other audit findings
- Records of employee time and effort, including:
    - Assurances that employees are tracking actual time spent on PBC RWHAP services rather than just reporting budgeted hours per day
    - Allocations of operating and/or other costs for employees who are not funded 100 percent by this program
- System for Award Management (SAM) registration for all Subrecipients to ensure they have an active account with accurate information and are eligible to receive federal funding
- Timeliness of fiscal reporting
- Adherence to the federal record retention policy

Section IV: Core Medical Services Guidelines

Ch 1. Local- AIDS Pharmaceutical Assistance Program (LPAP)

Purpose

To establish service standards for Subrecipients providing Local AIDS Pharmaceutical Assistance Program services through PBC RW Part A/MAI.

Policy

Description:

The Local Pharmaceutical Assistance Program (LPAP) is a supplemental means of providing ongoing medication assistance when Florida RWHAP ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

Subrecipients must adhere to the following guidelines:

- Provide uniform benefits for all enrolled clients throughout the service area
- Establish and maintain a recordkeeping system for distributed medications
- Participate in the QMEC committee when reviewing LPAP formulary needs
- Utilize the drug formulary that is approved by the QMEC Committee (Service Delivery Standards)
- Establish and maintain a drug distribution system
- Screening for alternative medication payer sources, including but not limited to Patient Assistance Programs (PAP), rebate/discount programs, Health Care District, and Florida RWHAP ADAP prior to dispensing.
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:

LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications. The Food Bank- Nutritional Supplements service category may assist with dispensing nutritional supplements as prescribed.

Medications may be added to the LPAP formulary by request to the Ryan White Program Manager. LPAP formulary additions must be approved by the PBC HIV CARE Council QMEC Committee.

Procedure

Unit of Service Description

1 unit= 1 medication fill/refill

Service Specific Criteria & Required Documentation

Referral documentation, including prescription by medical provider
Letter of Medical Necessity for Chronic Opioid Medication
Appendix I- **PBC RWHAP Letter of Medical Necessity for Opioid Medications**

Caps/Limitations

Medications dispensed must not be included on the ADAP formulary

National Monitoring Standards

Local AIDS Pharmaceutical Assistance Program	
Performance Measure/Method	**Provider/ Subrecipient Responsibility**
a) Documentation that the Local Pharmaceutical Assistance Program's (LPAP) drug distribution system has: • A client enrollment and eligibility process that includes screening for ADAP and LPAP eligibility consistent with guidance put forth in HRSA HAB PCN 21-02. • Uniform benefits for all enrolled clients throughout the EMA or TGA. • An LPAP advisory board. • Compliance with the RWHAP requirement of payor of last resort. • A recordkeeping system for distributed medications. • A drug distribution system that includes a drug formulary approved by the local advisory committee/board. b) Documentation that the LPAP is not dispensing medications: • As a result or component of a primary medical visit. • As a single occurrence of short duration (an emergency). • While awaiting ADAP eligibility determination. • By vouchers to clients on a single occurrence. c) Documentation that the LPAP is: • Consistent with the most current HHS Clinical Practice Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. • Coordinated with the state's ADAP. • Implemented in accordance with requirements of the 340B Drug Pricing Program, Prime Vendor Program, and/or Alternative Methods Project.	a) Provide to the Part A recipient, on request, documentation that the LPAP meets HRSA HAB requirements. b) Maintain documentation, and make available to the recipient upon request proof of client LPAP eligibility that includes HIV status, residency, medical necessity, and low-income status, as defined by the EMA/TGA, based on a specified percentage of the FPL. c) Provide reports to the recipient on the number of individuals served and the medications provided.

PBC RWHAP Local Monitoring Standards
• Dispensing of a medication to a client on an ongoing basis, requiring more than a thirty (30) day supply during any 12-month period. • A client must apply, and be denied access to the medication from all other medication assistance programs for which the client may be eligible (ADAP, pharmaceutical manufacturer patient assistance program, etc.). • Medications dispensed must not be included on the ADAP formulary. Clients needing emergency access to medications included on the ADAP formulary shall utilize Emergency Financial Services. • Medications dispensed shall be included on the most recently published Florida Medicaid PDL Preferred Drug List.* • Medications defined by Florida Medicaid PDL as "Clinical PA Required", "Cystic Fib Diag Auto PA", or "Requires Med Cert 3" shall require submission and approval of an override request prior to dispensing. • Any ongoing medication needs not specified in this service standard shall require submission and approval of an override request prior to dispensing. Override requests shall not be submitted as exception to policy (e.g. medication is included on the ADAP formulary). *Florida Medicaid PDL https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

Ch 2. Early Intervention Services (EIS)

Purpose

To establish service standards for Subrecipients providing Early Intervention Services through PBC RW Part A/MAI.

Policy

Description:

The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:

The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. Subrecipients shall include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
  - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
  - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

Procedure

Unit of Service Description

1 unit=15 minutes of service

Service Specific Criteria & Required Documentation

Client is not required to meet PBC RW Part A/MAI eligibility criteria to receive EIS services

Caps/Limitations

None

National Monitoring Standards

Early Intervention Services	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation that: • Part A funds are used for HIV testing only where existing federal, state, and local funds are not adequate, and RWHAP funds will supplement and not supplant existing funds for testing. • Individuals who test positive are referred and linked to healthcare and supportive services. • Health education and literacy training are provided, enabling clients to navigate the HIV system. • EIS is provided at or in coordination with documented key points of entry. • EIS is coordinated with HIV prevention efforts and programs.	a) Establish MOUs with key points of entry into care to facilitate access to care for those who test positive. b) Document provision of all four required EIS components with Part A or other funding. c) Document and report on numbers of HIV tests and positives, as well as where and when Part A-funded HIV testing occurs. d) Document that HIV testing activities and methods meet the Centers for Disease Control and Prevention (CDC) and state requirements. e) Document the number of referrals for healthcare and supportive services. f) Document referrals from key points of entry to EIS programs. g) Document training and education sessions designed to help individuals navigate and understand the HIV system of care. h) Establish linkage agreements with testing sites where Part A is not funding testing but is funding referral and access to care, education, and system navigation services. i) Obtain written approval from the recipient to provide EIS in points of entry not included in the original scope of work.

PBC RWHAP Local Monitoring Standards
• EIS staff will have documentation of completed written training plan; which includes, at a minimum, HIV 501 training, Trauma Informed Care, Motivational Interviewing, Home/Field Visit Best Practices, Case Note Documentation Best Practices, RW System of Overview, Local Resources. • Documentation of the Subrecipient effort to link the client to an initial medical appointment, including lab testing and initiation of ART, within 30 days. • Of those clients who attended their initial medical appointment: documentation of the client's attendance (or lack thereof) to a follow-up medical appointment, including completed lab tests, within no more than 90 days from initial appointment. • Documentation of achieving viral suppression OR being referred to case management for adherence support before closing to EIS services.

Ch 3. Health Insurance Premium & Cost Sharing Assistance (HIPCSA)

Purpose

To establish service standards for Subrecipients providing Health Insurance Premium & Cost Sharing Assistance through PBC RW Part A/MAI.

Policy

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients
- Paying cost-sharing on behalf of the client

Program Guidance:

See PCN 18-01: Clarifications Regarding the use of RWHAP Funds for Health Care Coverage Premium and Cost Sharing Assistance

Procedure

Unit of Service Description

1 unit= 1 deductible, 1 co-payment, OR 1 monthly premium

Service Specific Criteria & Required Documentation

Summary of Benefits from Coverage

Caps/Limitations

An approved plan released annually

Appendix J- PBC RW Part A/MAI Health Insurance Continuation Guidance

National Monitoring Standards

Health Insurance Premium & Cost Sharing Assistance	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation of an annual cost-effectiveness analysis illustrating the greater benefit of purchasing public or private health insurance, pharmacy benefits, copays, and/or deductibles for eligible low-income clients compared to the full cost of medications and other appropriate HIV outpatient/ambulatory health services. b) Documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications. c) Documentation that the (Oral Health) insurance plan purchased provides comprehensive oral healthcare services. d) Documentation, including a physician's written statement that the eye condition is related to HIV infection	a) Conduct an annual cost-effectiveness analysis (if not done by the recipient) that addresses the noted criteria. b) Provide proof that where RWHAP funds cover premiums, the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications. c) Provide proof that where RWHAP funds cover premiums, the dental insurance policy provides comprehensive oral healthcare services. d) Maintain proof of low-income status. e) Provide documentation demonstrating that funds were not used to cover costs associated with the creation, capitalization, or administration of liability risk pools or Social Security costs. f) When funds are used to cover copays for prescription eyewear, provide a physician's written statement that the eye

when funds are used for copays of eyewear. e) Assurance that any cost associated with the creation, capitalization, or administration of a liability risk pool is not being funded by RWHAP. f) Assurance that RWHAP funds are not being used to cover costs associated with Social Security. g) Documentation of clients' low-income status as defined by the EMA/TGA	condition is related to HIV infection. g) Have policies and procedures outlining processes for informing, educating, and enrolling people in healthcare and documenting the vigorous pursuit of those efforts. h) Develop a system to ensure funds pay only for in-network outpatient services. i) Coordinate with CMS, including entering into appropriate agreements, to ensure that funds are appropriately included in TrOOP or donut hole costs.

Ch 4. Medical Case Management Services (MCM)

Purpose

To establish service standards for Subrecipients providing Medical Case Management Services through PBC RW Part A/MAI.

Policy

Description:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

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

Program Guidance:

Activities provided under the Medical Case Management service category have as their objective improving health care outcomes (including Treatment Adherence), whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit shall be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit shall be reported under the Outpatient/Ambulatory Health Services category.

Procedure

Unit of Service Description

1 unit=15 minutes of service

Service Specific Criteria & Required Documentation

None

Caps/Limitations

None

National Monitoring Standards

Medical Case Management	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation that Subrecipients are trained professionals, either medically credentialed persons or other healthcare staff who are part of the clinical care team. b) Documentation that the following activities are being carried out for clients as necessary: • Initial assessment of service needs. • Development of a comprehensive, individualized care plan. • Coordination of services required to implement the plan. • Continuous client monitoring to assess the efficacy of the plan. • Periodic re-evaluation and adaptation of the plan at least every six months during the enrollment of the client. c) Documentation in program and client records of case management services and encounters, including: • Types of services provided. • Types of encounters/communication. • Duration and frequency of the encounters. d) Documentation in client records of services provided, such as: • Client-centered services that link clients with healthcare, psychosocial, and other services and assist them in accessing other public and private programs for which they may be eligible. • Coordination and follow up of medical treatments. • Ongoing assessment of the client's and other key family members' needs and personal support systems. • Treatment adherence counseling. • Client-specific advocacy.	a) Provide written assurances and maintain documentation showing that medical case management services are provided by trained professionals who are either medically credentialed or trained healthcare staff and operate as part of the clinical care team. b) Maintain client records that include the required elements for compliance with contractual and RWHAP programmatic requirements, including required case management activities, such as services and activities, the type of contact, and the duration and frequency of the encounter.

PBC RWHAP Local Monitoring Standards
• Case Management staff will have documentation of completed written training plan; which includes, at a minimum, HIV 501 training, Trauma Informed Care, Motivational Interviewing, Home/Field Visit Best Practices, Case Note Documentation Best Practices, RW System of Overview, Local Resources.

Ch 5. Mental Health Services (MHS)

Purpose

To establish service standards for Subrecipients providing Mental Health Services through PBC RW Part A/MAI.

Policy

Description:

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

Program Guidance:

Mental Health Services are allowable only for PWH who are eligible to receive PBC RW Part A/MAI services.

Procedure

Unit of Service Description

1 unit=1 hour of service

Service Specific Criteria & Required Documentation

None

Caps/Limitations

None

National Monitoring Standards

Mental Health Services	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation of appropriate and valid licensure and certification of mental health professionals as required by the state. b) Documentation of the existence of a detailed treatment plan for each eligible client that includes: • The diagnosed mental illness or condition. • The treatment modality (group or individual). • Start date for mental health services. • Recommended number of sessions. • Date for reassessment. • Projected treatment end date. • Any recommendations for follow up. • The signature of the mental health professional rendering service. c) Documentation of service provided to ensure that: • Services provided are allowable under RWHAP guidelines and contract requirements. • Services provided are consistent with the treatment plan.	a) Obtain and have on file and available for recipient review, appropriate and valid licensure, and certification of mental health professionals. b) Maintain client records that include: • A detailed treatment plan for each eligible client that includes the required components and signature. • Documentation of services provided, dates, and consistency with RWHAP requirements and with individual client treatment plans.

PBC RWHAP Local Monitoring Standards

Psychological Assessment:
• Clients receiving assessment have documentation of a referral in Provide.
• Assessments include:
  • Relevant history
  • Current functioning
  • Assessment of medical/psychological/ social needs
  • Mental status
  • Diagnostic impression based upon DSM IVTR criteria Axis I through IV
• Clients have initial screening within 10 business days of referral. If not completed within 10 days, documented attempts must be evident.
• Clients that present with imminent risk to self or others have immediate crisis intervention.
• Clients receive assessment of cultural/language preferences.
(eliminated Intimal Treatment Plan as it's required under HRSA NMS)
Progress in Treatment Plan:
• Client Records document progress towards meeting goals or variance explained.
• Desired outcomes should be achieved in accordance with treatment plan.
• Client treatment plans are updated (at a minimum) every 12 sessions or every 6 months, whichever occurs first, and/or at discharge.
• Progress reports shared with case management agency for clients who have provided consent.

Ch 6. Oral Health Care (OHC)

Purpose

To establish service standards for Subrecipients providing Oral Health Care through PBC RW Part A/MAI.

Policy

Description:

Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:

Oral Health Care shall be provided based on the following priorities:

- Elimination of infection, preservation of dentition and restoration of functioning
- Elimination of presenting symptoms, including control of pain and suffering
- Prevention of oral and/or systemic disease where the oral cavity serves as an entry point

Procedure

Subrecipient shall adhere to the American Dental Association Dental Practice Parameters.

Unit of Service Description

1 unit=1 CDT Code

Reimbursement is based on Florida Medicaid Dental General Fee Schedule

Service Specific Criteria & Required Documentation

None

Caps/Limitations

Maximum of 24 visits per client annually

National Monitoring Standards

Oral Health Care	
Performance Measure/Method	**Provider/ Subrecipient Responsibility**
a) Documentation that: • Oral healthcare services, which meet current dental care guidelines, are provided by dental professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants. • Oral healthcare professionals providing services have appropriate and valid licensure and certification based on state and local laws. • Clinical decisions are supported by the American Dental Association Dental Practice Parameters. • An oral healthcare treatment plan is developed for each eligible client and signed by the oral health professional rendering the services. • Services fall within specified service caps, expressed by dollar amount, type of procedure, the limitations on the number of procedures, or a combination of any of the above, as determined by the Planning Council or recipient under RWHAP Part A.	a) Maintain a dental record for each client that is signed by the licensed provider and includes a treatment plan, services provided, and any referrals made. b) Maintain and provide to the recipient on request, copies of professional licensure and certification.

PBC RWHAP Local Monitoring Standards
• Review Medical/Dental history at least annually • Clients receive oral hygiene education as part of the routine visit and self-management of infections and lesions when necessary • Documentation of current medications, CD4 and Viral Loads at time of visit. • Treatment of oral opportunistic infection is coordinated with the client's medical provider

Ch 7. Outpatient/Ambulatory Health Services (OAHS)

Purpose

To establish service standards for Subrecipients providing Outpatient/Ambulatory Health Services through PBC RW Part A/MAI.

Policy

Description:

Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Vaccinations/Immunizations
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:

Provision of Outpatient/Ambulatory Health Services must be adherent to HHS Clinical Guidelines for the Treatment of HIV/AIDS https://clinicalinfo.hiv.gov/en/guidelines

Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

The HIV CARE Council has allocated funding to the OAHS subcategories of OAHS-Primary Care, Laboratory/Diagnostic and Specialty Medical Care. Each of the three subcategories are addressed below separately.

Procedure for OAHS-Primary Care

Unit of Service Description

1 unit=1 CPT Code

Reimbursement is based on Medicare Physician Fee Schedule (MPFS), which includes 1.815 Geographic Practice Cost Index (GPCI)

Service Specific Eligibility Criteria & Required Documentation

None

Caps/Limitations

No caps. No limitations.

Procedure for Laboratory/Diagnostic Testing

Unit of Service Description

1 unit=1 lab test

Reimbursement is based on Medicare Clinical Diagnostic Laboratory Fee Schedule

Service Specific Eligibility Criteria & Required Documentation

None

Caps/Limitations

No caps. No Limitations.

Procedure for Specialty Medical Care

Unit of Service Description

1 unit= 1 CPT Code

Reimbursement is based on Medicare Physician Fee Schedule (MPFS), which includes 1.815 Geographic Practice Cost Index (GPCI)

Service Specific Eligibility Criteria & Required Documentation

Specialty Care Medical Referral Form signed by Primary Care Provider

Caps/Limitations

Unallowable expenses for Specialty Medical Care include services for cosmetic purposes only, corrective lenses, or any service provided that does not follow Specialty Medical Care service procedures.

Allowable Specialty Medical Care services are included on the *Palm Beach County Ryan White Program Allowable Medical Conditions List for Specialty Medical Referrals* form.

Appendix K- PBC RW Part A/MAI Specialty Medical Care Allowable Conditions and Referral

National Monitoring Standards

Outpatient/Ambulatory Health Services	
Performance Measure/Method	**Provider/Subrecipient Responsibility**

a) Documentation of the following: • Care is provided by a healthcare provider, certified in their jurisdictions to prescribe medications, in an outpatient setting, such as clinics, medical offices, or mobile vans. • Only allowable services are provided to eligible people with HIV. • Services are provided as part of the treatment of HIV infection. • Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects. • Services are consistent with HHS Clinical Guidelines for the Treatment of HIV. • Services are not being provided in an emergency room, hospital, or any other type of inpatient treatment setting. b) Documentation that diagnostic and laboratory tests are: • Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider. • Consistent with medical and laboratory standards. • Approved by the FDA and/or certified under the Clinical Laboratory Improvement Amendments (CLIA) Program.	a) Ensure that client medical records document services provided, the dates and frequency of services provided, and that services are for the treatment of HIV. b) Include clinical notes signed by the licensed service provider in patient records. c) Maintain professional certifications and licensure documents, and make them available to the recipient upon request. d) For diagnostic and laboratory tests: • Document and include in client medical records when appropriate, and make available to the recipient upon request: - The number of diagnostic and laboratory tests performed. - The certification, licenses, or FDA approval of the laboratory from which tests were ordered. - The credentials of the individuals ordering the tests.

PBC RWHAP Local Monitoring Standards
• Maintain written agreements/contracts with Specialty Medical Care Providers • Ensure Specialty Medical Care service providers are credentialed by Medicaid and/or Medicare. • Ensure Specialty Medical Care service providers have entered into a participation agreement under the Medicaid State plan and be qualified to receive payments under such plan, or have received a waiver from this requirement. • Release encumbered services if services are not initiated within 90 days of Specialty Medical Care approval. •Ensure Specialty Medical Care service reports are received by the PCP prior to Specialty Medical Care service invoice being paid.

Section V: Support Services Guidelines

Ch 1. Emergency Financial Assistance (EFA)

Purpose

To establish service standards for Subrecipients providing Emergency Financial Assistance through PBC RW Part A/MAI.

Policy

Description:

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist the PBC RW Part A/MAI client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, and medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:

The Emergency Financial Assistance service category may assist with short-term assistance for medications. LPAP funds are not to be used for emergency or short-term financial assistance. The Food Bank- Nutritional Supplements service category may assist with dispensing nutritional supplements as prescribed.

Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client shall not be funded through emergency financial assistance.

Procedure

Subcategory A: Essential utilities, housing, food, transportation, etc.

Unit of Service Description

1 unit=1 emergency assistance

Service Specific Criteria & Required Documentation

Documented need for assistance based on income/expense ratio (Financial Assessment)

Caps/Limitations

Up to 4 accesses per grant year for no more than a combined total of $1,000, and/or housing assistance as one access per 12 month period to equal 1 month of rent and/or one security deposit.

Subcategory B: Medication

Unit of Service Description

1 unit= 1 medication fill/refill

Service Specific Criteria & Required Documentation

Prescription from a medical provider

Letter of Medical Necessity for Chronic Opioid Medication

Appendix I- PBC RWHAP Letter of Medical Necessity for Opioid Medications

Caps/Limitations

Dispensing of one (1) emergency medication not exceeding a thirty (30) day supply to a client during any 12-month period.

National Monitoring Standards

Emergency Financial Assistance	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation of services and payments to verify that: • EFA to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the recipient. • Assistance is provided only for the following essential services: utilities, housing, food (including groceries and food vouchers), transportation, and medication. • Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to clients. • Emergency funds are allocated, tracked, and reported by type of assistance. • RWHAP is the payor of last resort.	a) Maintain client records that document for each client: • Client eligibility and need for EFA. • Types of EFA provided. • Date(s) EFA was provided. • Method of providing EFA. b) Maintain and make available to the recipient program documentation of assistance provided, including: • Number of clients and amount expended for each type of EFA. • Summary of the number of EFA services received by the client. • Methods used to provide EFA (e.g., payments to agencies, vouchers). c) Provide assurance to the recipient that all EFA: • Was for allowable types of assistance. • Was used only in cases where RWHAP was the payor of last resort. • Met recipient-specified limitations on amount, frequency, and duration of assistance to an individual client. • Was provided through allowable payment methods.

PBC RWHAP Local Monitoring Standards
● Dispensing of one (1) emergency medication not exceeding a thirty (30) day supply to a client during any 12-month period. ● Medications dispensed shall be included on the most recently published Florida Medicaid PDL Preferred Drug List.* ● Medications defined by Florida Medicaid PDL as "Clinical PA Required", "Cystic Fib Diag Auto PA", or "Requires Med Cert 3" shall require submission and approval of an override request prior to dispensing. ● One (1) additional dispensing of an emergency medication not exceeding a thirty (30) day supply during any 12 month period may be permitted in instances where a client has applied, and been denied access to the medication from all other medication assistance programs for which the client may be eligible (ADAP, pharmaceutical manufacturer patient assistance program, etc.). Documentation of medication access denial must be provided, and shall require submission and approval of an override request prior to dispensing. ● Dispensing of any medication under Emergency Financial Assistance may not exceed a sixty (60) day supply during any 12 month period. ● Any emergency medication needs not specified in this service standard shall require submission and approval of an override request prior to dispensing. Override requests shall not be submitted as exception to policy (e.g. more than a sixty (60) day supply during any 12-month period). *Florida Medicaid PDL https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

Ch 2. Food Bank/Home Delivered Meals (FBHDM)

Purpose

To establish service standards for Subrecipients providing Food Bank/Home Delivered Meals through PBC RW Part A/MAI.

Policy

Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:

Unallowable costs include household appliances, pet foods, and other non-essential products.

Procedure

Subcategory A: Food Bank

Unit of Service Description

1 unit=1 voucher or 1 food box

Service Specific Criteria & Required Documentation

Must apply for and maintain enrollment in Food Stamps, when eligible

Caps/Limitations

At or below 200% FPL; with 0-150% FPL receiving up to $75 per client per month and 151-200% FPL receiving up to $50 per client per month

Subcategory B: Nutritional Supplements

Unit of Service Description

1 unit=1 prescription

Service Specific Criteria & Required Documentation

Requires a prescription from a medical provider

Caps/Limitations

None

National Monitoring Standards

Food Bank/Home Delivered Meals	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation that: • Services supported are limited to food banks, home-delivered meals, and/or food voucher programs. • Types of non-food items provided are allowable. • If water filtration/purification systems are provided, the community has water purity issues. b) Assurance of: • Compliance with federal, state, and local regulations, including any required licensure or certification for the provision of food banks and/or home-delivered meals. • Use of funds only for allowable essential non-food items. • Monitoring of providers to document actual services provided, client eligibility, number of clients served, and level of services to these clients.	a) Maintain and make available to the recipient documentation of: • Services provided by type of service, number of clients served, and levels of service. • The amount and use of funds for the purchase of non-food items, including the use of funds only for allowable non-food items. • Compliance with all federal, state, and local laws regarding the provision of food banks, home-delivered meals, and food voucher programs, including any required licensure and/or certifications. b) Provide assurance that RWHAP funds were used only for allowable purposes and RWHAP was the payor of last resort.

Ch 4. Legal Services (LS) - Other Professional Services

Purpose

To establish service standards for Subrecipients providing Legal Services through PBC RW Part A/MAI.

Policy

Description:

Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the PBC RW Part A/MAI -eligible PWH and involving legal matters related to or arising from their HIV, including:
  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under PBC RW Part A/MAI
  - Preparation of healthcare power of attorney, durable powers of attorney, and living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance:

Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under PBC RW Part A/MAI.

See 45 CFR § 75.459

Procedure

Unit of Service Description

1 unit=1 hour of service

Reimbursement is based on $90 per billable hour of legal services

Service Specific Criteria & Required Documentation

None

Caps/Limitations

None

National Monitoring Standards

Legal Services (Other Professional Services)	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation that funds are used only for allowable professional services, such as: • Legal Services. • Permanency Planning. • Income Tax Preparation. b) Assurance that program activities do not include any criminal defense or class action suits unrelated to access to services eligible for funding under the RWHAP.	a) Document and make available to the recipient upon request, services provided, including specific types of professional services provided. b) Provide assurance that: • Funds are being used only for professional services directly necessitated by an individual's HIV status. • RWHAP serves as the payor of last resort. c) Document in each client file: • Client eligibility. • A description of how professional services are necessitated by the individual's HIV status. • Types of services provided. • Hours spent in the provision of such services.

PBC RWHAP Local Monitoring Standards
• Competent provision of legal services to HIV/AIDS community and dependents. • Show evidence of State of Florida license to practice law (as applicable). • Training of paralegals and other support staff occurs for programmatic staff (those working with HIV/AIDS population). • Minimum training requirement (HIV 101 for support staff, HIV 104 for attorneys and paralegals). • Procedures in place to route calls/referrals to available staff, with reasonable response time to telephone inquiries/referrals. • Grievance procedures in place when client feels calls are not returned in a timely manner. • Records display intake documentation and outcome or resolution of presenting issue. • Notification of progress and outcome for resolution is provided to referring agency, if applicable. • Clients or caretakers receive disposition or resolution of legal issue.

Ch 5. Medical Transportation Services (MTS)

Purpose

To establish service standards for Subrecipients providing Medical Transportation Services through PBC RW Part A/MAI.

Policy

Description:

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

Program Guidance:

Medical transportation may be provided through:

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

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Procedure

Unit of Service Description

1 unit=1 trip/voucher

Service Specific Criteria & Required Documentation

None

Caps/Limitations

None

National Monitoring Standards

Medical Transportation	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation that medical transportation services are used only to enable an eligible individual to access HIV-related health and support services. b) Documentation that services are provided through one of the following methods: • A contract or some other local procurement mechanism with a provider of transportation services. • A voucher or token system that allows for tracking the distribution of vouchers or tokens. • A system of mileage reimbursement that does not exceed the federal per mile reimbursement rates. • A system of volunteer drivers, where insurance and other liability issues are addressed. • Purchase or lease of organizational vehicles for client transportation, with prior approval from HRSA HAB for the purchase.	a) Maintain program files that document: • The level of services/number of trips provided. • The reason for each trip and its relation to accessing health and support services. • Trip origin and destination. • Client eligibility. • The cost per trip. • The method used to meet the transportation need. b) Maintain documentation showing that the provider is meeting stated contract requirements with regard to methods of providing transportation: • Reimbursement methods that do not involve cash payments to service recipients. • Mileage reimbursement that does not exceed the federal reimbursement rate. • Use of volunteer drivers that appropriately addresses insurance and other liability issues. c) Collection and maintenance of data documenting that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services. d) Obtain recipient approval prior to purchasing or leasing a vehicle(s).

Ch 6. Non-Medical Case Management Services (NMCM)

Purpose

To establish service standards for Subrecipients providing Non-Medical Case Management services through PBC RW Part A/MAI.

Policy

Description:

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

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:

Non-Medical Case Management services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes (including Treatment Adherence).

Procedure

Unit of Service Description

1 unit=15 minutes of service

Service Specific Criteria & Required Documentation

None

Caps/Limitations

None

National Monitoring Standards

Non-Medical Case Management	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation that: • The scope of activity includes guidance and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services. • Where benefits/entitlement counseling and referral services are provided, they assist clients in obtaining access to both public and private programs, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other state or local healthcare and supportive services. • Services cover all types of encounters and communications (e.g., face-to-face, telephone contact, etc.). b) Where transitional case management for justice-involved persons is provided, assurance that such services are provided either as part of discharge planning or for individuals who are in the correctional system for a brief period.	a) Maintain client records that include the required elements, as detailed by the recipient, including: • Date of encounter. • Type of encounter. • Duration of encounter. • Key activities, including benefits/entitlement counseling and referral services.

PBC RWHAP Local Monitoring Standards
• Case Management staff will have documentation of completed written training plan; which includes, at a minimum, HIV 501 training, Trauma Informed Care, Motivational Interviewing, Home/Field Visit Best Practices, Case Note Documentation Best Practices, RW System of Overview, Local Resources.

Ch 7. Psychosocial Support Services (PSS)

Purpose

To establish service standards for Subrecipients providing Psychosocial Support Services through PBC RW Part A/MAI

Policy

Description:

Psychosocial Support Services provide group or individual support and counseling services to assist eligible people with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:

Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds may not be used for social/recreational activities or to pay for a client's gym membership.

Procedure

Unit of Service Description

1 unit=15 minutes of service

Service Specific Criteria & Required Documentation

None

Caps/Limitations

None

National Monitoring Standards

Psychosocial Support Services	
Performance Measure/Method	**Provider/Subrecipient Responsibility**
a) Documentation that psychosocial services' funds are used only to support eligible activities, including: (eliminated Support and counseling activities, Caregiver support) • Bereavement counseling. • Child abuse and neglect counseling. • HIV support groups. • Nutrition counseling is provided by a non-registered dietitian. • Pastoral care/counseling. b) Documentation that psychosocial support services meet all stated requirements: • Counseling is provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available. • Pastoral counseling is available to all individuals eligible to receive RWHAP services, regardless of their religious denominational affiliation. • Assurance that no funds under this service category are used for the provision of nutritional supplements, social/recreational activities, or gym memberships.	a) Document the provision of psychosocial support services, including: • Types and level of activities provided. • Client eligibility determination. b) Maintain documentation demonstrating that: • Funds are used only for allowable services. • No funds are used for the provision of nutritional supplements. • Any pastoral care/counseling services are available to all clients regardless of their religious denominational affiliation

Section VI: References

Ch 1. Glossary

Below are terms used most frequently in HRSA's Ryan White HIV/AIDS Program (RWHAP).

A

Administrative or Fiscal Agent
Entity that functions to assist the Ryan White HIV/AIDS Program recipient or planning body in carrying out administrative activities (e.g., disbursing program funds, developing reimbursement and accounting systems, developing funding announcements, monitoring contracts).

Affordable Care Act (ACA)
Federal law comprised of expanded health insurance coverage and health care delivery innovations designed to achieve better health outcomes by increasing the number of insured Americans, reducing care costs, and improving the overall American health care system. Enacted in 2010 as the Patient Protection and Affordable Care Act.

Agency for Healthcare Research and Quality (AHRQ)
Federal agency within HHS that supports research designed to improve the outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services.

AIDS Drug Assistance Program (ADAP)
Administered by States and authorized under Part B of the Ryan White HIV/AIDS Treatment Extension Act. Provides FDA-approved medications to low-income individuals with HIV who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured Ryan White HIV/AIDS Program clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program at least match those offered through ADAP.

ADAP Data Report (ADR)
Reporting requirement for ADAPs to provide client-level data on individuals served, services being delivered, and costs associated with these services.

AIDS
Acquired Immune Deficiency Syndrome. A disease caused by the human immunodeficiency virus (HIV).

AIDS Education and Training Center (AETC)
Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs are authorized under Part F of the Ryan White HIV/AIDS Program.

AIDS Service Organization (ASO)
An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease.

Annual Gross Income
A measure of income. There are several ways to measure an individual’s Annual Gross Income. For example, these forms of income could be used by the provider for the purposes of imposition of charges:

- Gross Income: the total amount of income earned from all sources during the calendar year before taxes.
- Adjusted Gross Income: gross income less deductions.

Antiretroviral Therapy
An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV that is designed to reduce viral load to undetectable levels.

Applicable Services
Any RWHAP service with a distinct fee typically charged in the local market. In the broader healthcare community this distinct fee is often referred to as a usual, customary, and reasonable (UCR) fee.

C

Cap on Charges

The limitation on aggregate charges imposed during the calendar year based on patient's annual gross income. All fees must be waived once a RWHAP patient reaches their cap for that calendar year.

Capacity

Core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services. Capacity development activities shall increase access to the HIV/AIDS service system and reduce disparities in care among underserved people with HIV (PWH) in the EMA.

CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act)

Now referred to as the Ryan White HIV/AIDS Program, this was the name of the original federal legislation (link is external) created to address the unmet health care and service needs of people with HIV Disease (PWH) disease and their families. The legislation was enacted in 1990 and reauthorized in 1996 and 2000. The legislation was subsequently reauthorized as the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and later as the Ryan White HIV/AIDS Treatment Extension Act of 2009.

CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment

This advisory committee, often referred to as the CHAC, advises the Secretary, HHS; the Director, CDC; and the Administrator, HRSA, regarding objectives, strategies, policies, and priorities for HIV, Viral Hepatitis, and STD prevention and treatment efforts.

Centers for Disease Control and Prevention (CDC)

Federal agency within HHS that administers disease prevention programs including HIV/AIDS prevention.

Centers for Medicare and Medicaid Services (CMS)

Federal agency within HHS that administers the Medicaid, Medicare, the Children's Health Insurance Program (CHIP) and the Health Insurance Marketplace.

Chief Elected Official (CEO)

The official recipient of Part A or Part B Ryan White HIV/AIDS Program funds. For Part A, this is usually a city mayor, county executive, or chair of the county board of supervisors. For Part B, this is usually the governor. The CEO is ultimately responsible for administering all aspects of their Part's RWHAP Act funds and ensuring that all legal requirements are met.

Client Level Data (CLD)

Information collected on each client eligible for and receiving RWHAP core medical services or support services. The data elements reported per client are determined by the specific RWHAP services that the agency is funded to provide.

Community-based Organization (CBO)

An organization that provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

Community Based Dental Partnership Program (CBDPP)

A program under the Ryan White HIV/AIDS Program (Part F) that delivers HIV/AIDS dental care while simultaneously training dental professionals in these areas in order to expand community capacity to deliver HIV oral health care.

Community Forum or Public Meeting

A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion. Similar to but less formal than a focus group, it usually includes a larger group; participants are often self-selected (i.e., not randomly selected to attend).

Co-morbidity

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

Comprehensive Planning

The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PWH.

Community Health Centers

See Health Centers.

Cone of Silence

A prohibition on any non-written communication regarding an RFP between any respondent or respondent's representative and any County Commissioner

Consortium/HIV Care Consortium

A regional or statewide planning entity established by many State recipient under Part B of the Ryan White HIV/AIDS Program to plan and sometimes administer Part B services. An association of health care and support service agencies serving PWHA under Part B.

Clinical Quality Management

Clinical quality management under the Ryan White HIV/AIDS Program involves activities to improve client health outcomes by developing and implementing quality management programs. These efforts focus on establishing standards and systems to measure and improve performance.

Continuum of Care

The extent to which a person living with HIV disease is engaged in HIV/AIDS care and is realizing the full advantages of care and treatment—from initial diagnosis and engagement in care to full viral suppression. Generally referred to as the HIV Care Continuum.

Core Medical Services

Essential, direct, health care services for HIV/AIDS care specified in the Ryan White legislation. Recipient/Subrecipient expenditures are limited to core medical services, support services, and administrative expenses.

Cultural Competence

The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

D

Data Terms

For definitions of terms, see data dictionaries for the Ryan White Services Report (RSR) (link is external) and the ADAP Data Report (ADR) (link is external).

Documentation

Papers and documents required from clients, as defined by the recipient, in order to assure all RWHAP statutory requirements are met.

E

Early Intervention Services (EIS)

Activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Parts A and B of the Ryan White HIV/AIDS Program, includes outreach, counseling and testing, information and referral services. Under Part C Ryan White HIV/AIDS Program, also includes comprehensive primary medical care for individuals living with HIV/AIDS.

Eligible Metropolitan Area (EMA)

Geographic areas highly-impacted by HIV/AIDS that are eligible to receive Ryan White HIV/AIDS Program Part A funds To be an eligible EMA, an area must have reported more than 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000. See also Transitional Grant Area, TGA.

Eligible Scope

A method of data collection based on a client's ability to receive federally funded RWHAP services using established recipient criteria.

Epidemiologic Profile

A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area. Specific to HIV planning, a description of the burden of HIV in the population of an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, PWH, and persons at higher risk for infection.

Epidemiology

The branch of medical science that studies the incidence, distribution, and control of disease in a population.

eUCI (encrypted Unique Client Identifier)

An alphanumeric code that distinguishes one RWHAP client from all others and is the same for the client across all provider settings.

F

Family-Centered Care

A model in which systems of care under Ryan White Part D are designed to address the needs of PWHA and affected family members as a unit, providing or arranging for a full range of services. Family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated caregivers.

Federal Poverty Level (FPL)

A measure of income issued every year by HHS. Federal poverty levels are commonly used to determine eligibility for certain programs and benefits such as Medicaid, Food Stamps, the Children's Health Insurance Program (CHIP), and RWHAP.

Fee-for-Service

The method of billing for health services whereby a physician or other health service provider charges the payer (whether it be the patient or his or her health insurance plan) separately for each patient encounter or service rendered.

Fee Schedule

A complete listing of billable services, those with UCR fees, and their associated fees based on locally prevailing rates or charges. A fee schedule is used by healthcare providers to identify which services they bill for and for how much. A fee schedule is not a schedule of charges. A fee schedule is not required by the RWHAP legislation, but it may be useful as the basis for a schedule of charges. Having one in place is considered a best practice and, for those multi-funded clinics, is a requirement for HRSA Bureau of Primary Health Care (BPHC) grant recipients.

Financial Status Report (FSR - Form 269)

A report that is required to be submitted within 90 days after the end of the budget period that serves as documentation of the financial status of grants according to the official accounting records of the recipient organization.

Food and Drug Administration (FDA)

Federal agency within HHS responsible for ensuring the safety and effectiveness of drugs, biologics, vaccines, and medical devices used (among others) in the diagnosis, treatment, and prevention of HIV infection, AIDS, and AIDS-related opportunistic infections. The FDA also works with the blood banking industry to safeguard the nation's blood supply.

G

Grant Contract Management System

An electronic data system that RWHAP recipients use to manage their Subrecipient contracts.

H

Health Centers

Community-based and patient-directed organizations funded by HRSA that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English

proficiency, migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing.

Health Resources & Services Administration (HRSA)
The agency of the U.S. Department of Health and Human Services that administers various primary care programs for the medically underserved, including the Ryan White HIV/AIDS Program.

HRSA HIV/AIDS Bureau (HAB)
The bureau within HRSA of the U.S. Department of Health and Human Services (HHS) that is responsible for administering the Ryan White HIV/AIDS Program. See the HRSA HAB Program Administration fact sheet (link is external).

HIV Care Continuum
The stages of HIV care, from initial diagnosis to achieving the goal of viral suppression. The effectiveness of HIV testing and care in a given jurisdiction is typically depicted as the proportion of individuals living with HIV who are engaged at each stage.

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

HIV-related Charges
Those charges a RWHAP recipient imposes on the patient plus any other out of-pocket charges related to their HIV care (as determined by their provider) that a patient incurs and reports to their RWHAP recipient/provider. These charges can be from any provider as long as the service is a RWHAP allowable service.

Housing Opportunities for People With AIDS (HOPWA)
A program administered by the U.S. Department of Housing and Urban Development (HUD) that provides funding to support housing for PWHA and their families.

HUD (U.S. Department of Housing and Urban Development)
The Federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for People with AIDS (HOPWA).

I

Imposition of Charges
All activities, policies, and procedures related to assessing RWHAP patient charges as outlined in legislation.

Incidence
The number of new cases of a disease that occur during a specified time period.

Incidence Rate
The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 persons. AIDS incidence rates are often expressed this way.

Intergovernmental Agreement (IGA)
A written agreement between a governmental agency and an outside agency that provides services.

L

Lead Agency
The agency within a Part B consortium that is responsible for contract administration; also called a fiscal agent (an incorporated consortium sometimes serves as the lead agency).

M

Medicaid Spend-down
A process whereby an individual who meets the Medicaid medical eligibility criteria, but has income that exceeds the financial eligibility ceiling, may "spend down" to eligibility level. The individual accomplishes spend-down by deducting accrued medically related expenses from countable income. Most State Medicaid

programs offer an optional category of eligibility, the "medically needy" eligibility category, for these individuals.

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

Multiply Diagnosed
A person having multiple morbidities (e.g., hepatitis and HIV, substance abuse and HIV infection) (see co-morbidity).

N

Needs Assessment
A process of collecting information about the needs of PWH (both those receiving care and those not in care), identifying current resources (Ryan White HIV/AIDS Program and other) available to meet those needs, and determining what gaps in care exist.

Nominal Charge
A fee greater than zero.

Notice of Funding Opportunity (NOFO)
An open and competitive process for selecting providers of services.

O

Office of Management and Budget (OMB)
The office within the executive branch of the Federal government that prepares the President's annual budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulations.

Opportunistic Infection
An infection or cancer that occurs in people with weak immune systems due to HIV, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi’s sarcoma, Pneumocystis jiroveci pneumonia, toxoplasmosis, and cytomegalovirus are all examples of such infections.

P

Patient Assistance Programs (PAPs)
Programs operated by pharmaceutical companies and foundations that provide medicines at little or no cost to eligible patients.

Part A
The part of the Ryan White HIV/AIDS Program that provides emergency assistance to localities disproportionately affected by the HIV/AIDS epidemic.

Part B
The part of the Ryan White HIV/AIDS Program that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PWHA and their families.

Part C
The part of the Ryan White HIV/AIDS Program that supports outpatient primary medical care and early intervention services (EIS) to PWH through grants to public and private non-profit organizations. Part C also funds planning grants to prepare programs to provide EIS services.

Part D
The part of the Ryan White HIV/AIDS Program that supports family-centered, comprehensive care to women, infants, children, and youth living with HIV.

Part F: AIDS Education and Training Centers (AETC)
National and regional centers providing education and training for primary care professionals and other AIDS-related personnel.

Part F: Dental Programs
The part of the Ryan White HIV/AIDS Program that provides additional funding for oral health care for people with HIV through the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program.

Part F: SPNS: Special Projects of National Significance
The part of the Ryan White HIV/AIDS Program that funds demonstration and evaluation of innovative models of care delivery for hard-to-reach populations.

Part F : Minority AIDS Initiative
The Minority AIDS Initiative provides funding to evaluate and address the impact of HIV/AIDS on disproportionately affected minority populations.

People with HIV (PWH)
Descriptive term for persons living with HIV disease.

Planning Council/Planning Body
There are various types of planning groups. For Part A of the RWHAP, a planning council is a body appointed or established by the Chief Elected Official with responsibility to assess needs, establish a plan for the delivery of HIV care in the area, and establish priorities for the use of Part A funds. Part B planning bodies conduct similar tasks but do not establish service dollar allocations. In addition, jurisdictions directly funded by CDC are responsible for convening planning bodies to address HIV prevention, care and treatment issues. Many jurisdictions facilitate collaboration through joint care/prevention planning bodies and/or shared planning tasks.

Planning Process
Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.

PrEP
Pre-exposure prophylaxis is a prevention method for people at higher risk for HIV exposure and involves taking an antiretroviral pill every day to greatly reduce, if not eliminate, the risk of becoming infected with HIV if exposed to the virus.

Prevalence
The total number of persons in a defined population living with a specific disease or condition at a given time (compared to incidence, which is the number of new cases).

Prevalence Rate
The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

Primary Health Care Service
Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client living with HIV. Examples include medical, subspecialty care, dental, nutrition, mental health, or substance use disorder treatment services; medical case management; pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; and counseling and testing.

Priorities & Allocations Process (P&A)
A decision-making process utilized by the P&A Committee of the HIV CARE Council to establish priorities among service categories and develop funding allocation recommendations addressing locally identified needs.

Program Income
Gross income earned by the Subrecipient that is directly generated by a supported activity or earned as a result of the RWHAP service provision during the contract year. For purposes of the RWHAP, program income includes, but is not limited to, income from fees for services performed (i.e. fees paid by clients based

on a sliding fee schedule, or other third parties). Direct payments include charges imposed by Subrecipients for RWHAP Part A services as required under Section 2605 (e) of the RWHAP legislation, such as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges. Additionally, income a Subrecipient earns as the result of a benefit made possible by receipt of the RWHAP funds. Program income does not include rebates, credits, discounts, and interest earned on any of them.

Prophylaxis

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

Provider (or service provider)

The agency that provides direct services to clients (and their families) or the recipient. A provider may receive funds as a recipient (such as under RWHAP Parts C and D) or through a contractual relationship with a recipient funded directly by RWHAP. Also, see Subrecipient.

Q

Quality

The degree to which a health or social service meets or exceeds established professional standards and user expectations.

Quality Assurance (QA)

The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.

Quality Improvement (QI)

Also called Continuous Quality Improvement (CQI). An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care.

R

Recipient

An organization that receives RWHAP funds directly from. Recipients may provide direct services and/or may contract with Subrecipients for services. Replaces the term "Grantee." See also Recipient/Subrecipient.

Recipient-provider

An organization that receives RWHAP funds directly from HRSA HAB and provides direct client services. Replaces the term “grantee-provider.”

Recipient of record (or recipient)

An organization receiving financial assistance directly from an HHS- awarding agency to carry out a project or program. A recipient also may be a recipient-provider if it provides direct services in addition to administering its grant. Replaces the term “grantee of record.”

Reflectiveness

The extent to which the demographics of the planning body's membership look like the demographics of the epidemic in the service area.

Representative

Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

Request for Proposal (RFP)

A public solicitation for proposals for providing HIV/AIDS core medical and support services for Palm Beach County residents.

Resource Allocation

The Part A planning council responsibility to assign Ryan White HIV/AIDS Program amounts or percentages to established priorities across specific service categories, geographic areas, populations, or subpopulations.

Resource Inventory
An inventory of the financial resources available in a jurisdiction to meet the HIV prevention, care, and treatment needs of its population as well as resource gaps. The inventory also details the CDC-funded high impact prevention services and the HRSA-funded core medical and support services.
Ryan White HIV/AIDS Program Services Report (RSR)
Data collection and reporting system for reporting information on programs and clients served (Client Level Data).

S
Schedule of Charges
Fees imposed on the RWHAP patient for services based on the patient's annual gross income. A schedule of charges may take the form of a flat rate or a varying rate (e.g. sliding fee scale). The schedule of charges is how you know what amount of money to charge a patient. The schedule of charges applies to uninsured patients with incomes above 100% FPL, and may be applied to insured patients as determined by RWHAP recipients' policies and procedures. When applied to insured patients, recipients shall consider how their policy will be applied uniformly to all insured patients, rather than on a case-by-case basis.
Section 340B Drug Discount Program
A program administered by the HRSA's Office of Pharmacy Affairs that was established by Section 340B of the Veteran's Health Care Act of 1992, which limits the cost of drugs to Federal purchasers and to certain recipients of federal agencies.
Seroprevalence
The number of persons in a defined population who test HIV-positive based on HIV testing of blood specimens. (Seroprevalence is often presented either as a percent of the total specimens tested or as a rate per 100,000 persons tested.)
Service Gaps
HIV prevention and care services for persons at risk for HIV and PWH that do not exist in the jurisdiction.
Sexually Transmitted Disease (STD)
Socio-demographics
Demographic (e.g. race, age, gender identity, sex) and socioeconomic data (e.g. income, education, health insurance status) characteristics of individuals and communities. Also known as: SES, demographic data.
Special Projects of National Significance (SPNS)
The part of the Ryan White HIV/AIDS Program under Part F that funds demonstration and evaluation of innovative models of care delivery for hard-to-reach populations.
Statewide Coordinated Statement of Need (SCSN)
The process of identifying the needs of persons at risk for HIV infection and people with HIV (those receiving care and those not receiving care); identifying current resources available to meet those needs, and determining what gaps in HIV prevention and care services exist. The SCSN is a culminating report which consists of information gathered through needs assessments conducted by three separate entities: RWHAP Part A Recipients, RWHAP Part B Recipients, and CDC funded recipients. Required component of the Integrated HIV Prevention and Care Plan.
Sub-Grantee/Subrecipient
A governmental or private nonprofit agency receiving HRSA funds through a contract originating from the Palm Beach County Community Services Department.
Subrecipient/Sub-Grantee
The legal entity that receives Ryan White HIV/AIDS Program funds from a recipient and is accountable to the recipient for the use of the funds provided. Subrecipients may provide direct client services or administrative services directly to a recipient. Subrecipient replaces the term "Provider (or service provider)."
Substance Abuse and Mental Health Services Administration (SAMHSA)
Federal agency within HHS that administers programs in substance abuse and mental health.

Support Services
Services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV/AIDS. Recipient/Subrecipient expenditures are limited to core medical services, support services, and administrative expenses.
Surveillance
An ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases (e.g., Centers for Disease Control and Prevention surveillance system for AIDS cases).
Surveillance Report
A report providing information on the number of reported cases of a disease such as AIDS, nationally and for specific sub-populations.

T
Prioritized Population
A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.
Technical Assistance (TA)
The delivery of practical program and technical support to the Ryan White community. TA is to assist Recipients/Subrecipients, planning bodies, and affected communities in designing, implementing, and evaluating Ryan White-supported planning and primary care service delivery systems.
Transitional Grant Area (TGA)
Geographic areas highly-impacted by HIV/AIDS that are eligible to receive Ryan White HIV/AIDS Program Part A funds To be an eligible TGA, an area must have reported at least 1,000 but fewer than 2,000 new AIDS cases in the most recent 5 years and a population of at least 50,000. See also Eligible Metropolitan Area, EMA.
Transmission Category
A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include, for example, men who have sex with men, injection drug use, heterosexual contact, and perinatal transmission.

U
Unmet Need
The unmet need for primary health services among individuals who know their HIV status but are not receiving primary health care.
UCR
Usual, customary, and reasonable, as in services for which there is a usual, customary, and reasonable fee associated. Such services are found on a fee schedule.

V
Viral Load
In relation to HIV, the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.

W
Waiver
A waiver of the imposition of charges requirement can only be requested by RWHAP recipients operating as free clinics (e.g. healthcare for the homeless clinics). Only a handful of RWHAP recipients are operating as free clinics; therefore, other RWHAP recipients/Subrecipients shall be charging patients over 100% FPL for applicable services – even if it is only $1.Organizations that receive funding from RWHAP and other Federal funding sources (i.e., facilities operated directly by the Indian Health Service or by Tribes through a contract with the Indian Health Service, Community Health Centers) must follow the requirements imposed by each

Federal program. To the extent that services under the RWHAP are provided and attributed to the RWHAP, RWHAP statutory requirements on imposition of charges must be followed.

X

XML (Extensible Markup Language)

A standard, simple, and widely adopted method of formatting text and data so that it can be exchanged across all of the different computer platforms, languages, and applications.

Ch 2. Acronyms

ACA - Affordable Care Act

ADAP- AIDS Drug Assistance Program

AETC – AIDS Education and Training Centers

AHCA- Agency for Health Care Administration

AICP- AIDS Insurance Continuation Program

AITRP - AIDS International Training and Research Program, FIC

ART – Anti-Retroviral Treatment

ARTAS - Anti-Retroviral Treatment and Access to Services

ASO – AIDS Services Organization

ATIS -HIV/AIDS Treatment Information Service

B/START - Behavioral Science Track Award for Rapid Transition, NIMH & NIDA

BCC: The Palm Beach County Board of County Commissioners

CAB - Community Advisory Board

CAMCODA - Center on AIDS and Other Medical Consequences of Drug Abuse

CAPS - Center for AIDS Prevention Studies

CARF: The Committee on Accreditation of Rehabilitation Organizations

CBC - Congressional Black Caucus

CBO - Community-Based Organization

CDC - Centers for Disease Control and Prevention

CFAR - Center for AIDS Research

CMS- Children Medical Services

CMS- Center for Medicare and Medicaid Services

CMV - Cytomegalovirus

CMV - Cytomegalovirus

CNS - Central Nervous System

CPP- Community Planning Partnership

CPCRA - Community Program for Clinical Research on AIDS

CQM- Clinical Quality Management

CSF - Cerebrospinal Fluid

CSN - Coordinator Statement of Need

CTL - Cytotoxic T Lymphocyte

CW - CAREWare

DHHS - Department of Health and Human Services

DIS - Disease Intervention Specialist

DOH- Department of Health

DNA - Deoxyribonucleic Acid

DRG - Division of Research Grants, NIH (now the Center for Scientific Review)

EBV - Epstein-Barr Virus

EHB – Electronic Hand Book (HRSA reporting system)

EIIHA - Early Identification of Individuals with HIV/AIDS

EIS - Early Intervention Services

EMA - Eligible Metropolitan Area

ETI - Expanded Testing Initiative

FDOH - Florida Department of Health

FIRCA - Fogarty International Research Collaboration Award, FIC

FLAETC- Florida AIDS Education Treatment Center

FPL – Federal Poverty Level

FQHC – Federally Qualified Healthcare Center

FY - Fiscal Year

GCRC - General Clinical Research Center

GIS – Geographic Information System

HAART – Highly Active Anti-Retroviral Therapy

HAB – HIV/AIDS Bureau

HAPC - HIV/AIDS Program Coordinator

HBCU - Historically Black Colleges and Universities

HCD - Health Care District

HCSEF- Health Council of Southeast Florida

HHV-8 -Human Herpesvirus-8

HIVIG - HIV Immunoglobulin

HMS – Health Management System

HPV - Human Papillomavirus

HRSA – Health Resources & Services Administration, a subsidiary of the US Department of Health and Human Services

IDU- Injection Drug User

IHS - Indian Health Service

IVIG- Intravenous Immunoglobulin

JCAHO: The Joint Commission for the Accreditation of Healthcare Organizations

JCV - JC Virus

MAC - Mycobacterium Avium Complex

MAI- Minority AIDS Initiative

MCT - Mother-to-Child Transmission

MOE – Maintenance of Effort

MSM - Men who have Sex with Men

NAFEO - National Association for Equal Opportunity in Higher Education

NHAS - National HIV/AIDS Strategy

NOE - Notice of Eligibility

OAR - Office of AIDS Research, NIH

OARAC - Office of AIDS Research Advisory Council

OI - Opportunistic Infection

P&A - Priorities & Allocations Committee, of the HIV CARE Council

PBCHD – Palm Beach County Health Department

PBCSAC – Palm Beach County Substance Abuse Coalition

PBMC - Peripheral Blood Mononuclear Cell

PCN – Policy Clarification Notice (HRSA)

PIR- Parity, Inclusion and Representation

PWH/A - Person(s) Living with HIV/AIDS Disease

PML - Progressive Multifocal Leukoencephalopathy

PWA/PLWA - Person With AIDS: A person living with AIDS

QIP – Quality Improvement Project

RARE - Rapid Assessment Response Evaluation

RCMI - Research Center in Minority Institution

RDR – Ryan White Program Data Report

RFP – Request for Proposals

RNA - Ribonucleic Acid

RSR – Ryan White Services Report

SAMHSA – Substance Abuse and Mental Health Services Administration

SCID - Severe Combined Immunodeficiency

SI - Synctia-Inducing

SMART - Specific, Measurable, Achievable, Realistic and Time Sensitive

SRA - Scientific Review Administration

STD – Sexually Transmitted Disease

STI - Structured Treatment Interruption

STI – Sexually Transmitted Infection

TB- Tuberculosis

TGA – Transitional Grant Area

TOPWA- Targeted Outreach for Pregnant Women Act

UOB – Unobligated Balance

VA - Veterans Administration

WHO -World Health Organization

WICY – Women, Infant, Children and Youth

ZDV - Zidovudine

Section VII. Appendix

Appendix A- PBC RW Part A/MAI Organizational Chart

PALM BEACH COUNTY, FLORIDA

Department of Community Services

Palm Beach County COMMUNITY SERVICES

HIV Elimination Services

Ryan White Part A/MAI Program Section

ORGANIZATIONAL CHART

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

County Administration
Verdenia Baker, County Administrator

County Administration
Patrick Rutter, Deputy County Administrator

County Administration
Tammy Fields, Assistant Administrator

Community Services Department
James Green, Director

Community Services Department
Taruna Malhotra, Assistant Director

People with HIV & Community | Federal HIV Programs | Public Health & Health Planning | Health & Social Service Providers

Palm Beach County HIV CARE Council

HIV CARE Council Coordinator
Neeta Mahani

Director – Finance & Support Services
Julie Dowe

HIV Elimination Services Program Manager
Dr. Casey Messer

Fiscal Manager
Thomas Eaton

Contract Manager
Michael Wright

Financial Analyst II
Jeffrey Lesanti

Financial Analyst I
Jason Gross

Grant Compliance Specialist II
Anna Balla

Health Planner II
Geneve Simeus

Quality Management Coordinator
Shoshana Ringer

Quality Management Clinician
Dr. Daisy Wiebe

Quality Management Clinician
Jasmine Parrish

Program Assistant
August Frohnhoefer

Health Equity Coordinator
Vacant

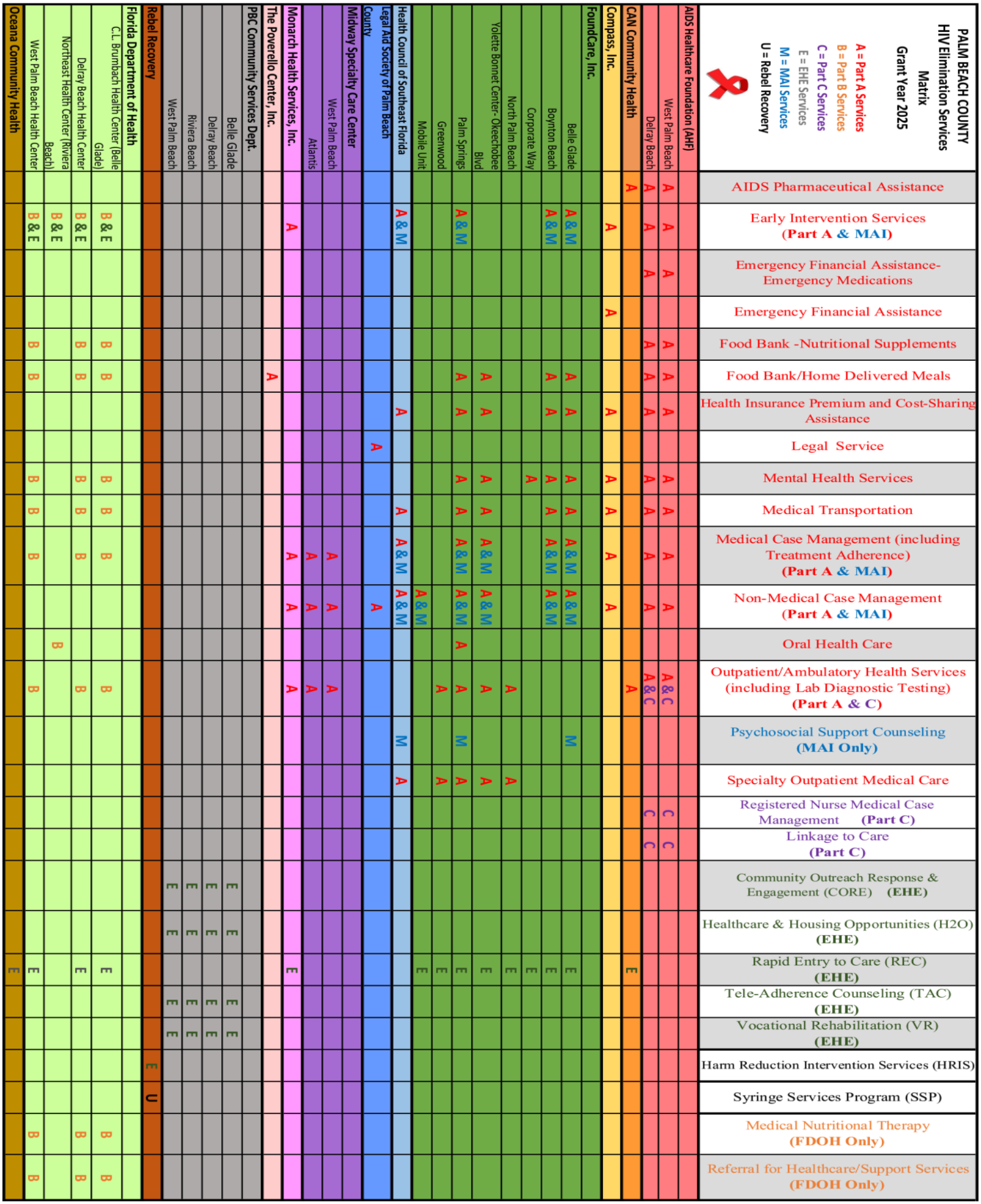
Ryan White Part A/MAI

**** For additional information contact Dr. Casey Messer, Program Manager (561) 355-4730 ****

August 2024

HIV Care Council

Appendix B- PBC HIV Elimination Services Matrix



PBC HIV Elimination Programs
Subrecipients (GY2025-2026)

AIDS Healthcare Foundation (AHF)

AIDS Pharmaceutical Assistance, Early Intervention Services, Medical Case Management, including Treatment Adherence, Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Emergency Financial Assistance/Emergency Medication, Food Bank/Home Delivered Meals, Food Bank/Nutritional Supplements, Medical Transportation, Non-Medical Case Management, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Mental Health Services; ***Part C funded services: Registered Nurse MCM, Linkage to Care, Outpatient Medical and Labs***

Location(s):
(1) 200 Congress Park Drive, Delray Beach, FL 33445
(2) 1411 North Flagler Drive, West Palm Beach, FL 33401

Phone(s):
(1) (561) 279-0991
(2) (561) 284-8182

Fax: (561) 279-0539

Program Contact: Kristen Harrington
Email: Kristen.Harrington@ahf.org
Phone: (561) 350-2196

Fiscal Contact: Nataliya Johnson
Email: Nataliya.Johnson@ahf.org
Phone: (813) 505-1193

Quality Management Contact: Neil Walker
Email: Neil.Walker@ahf.org
Phone: (786) 457-9023

CAN Community Health

AIDS Pharmaceutical Assistance, Outpatient/Ambulatory Health Services; ***EHE Rapid Entry to Care (REC)***

Location(s): 201 N. Dixie Highway, Lake Worth, FL 33460
Phone: (561) 867-9991
Fax: (561) 484-5813

Program Contact: Hardeep Singh
Email: hsingh@cancommunityhealth.org
Phone: (786) 800-5631 x 19206

Fiscal Contact: Max Wilson
Email: mwilson@cancommunityhealth.org
Phone: (904) 234-4661

Quality Management Contact: Tim Emanzi
Email: temanzi@cancommunityhealth.org
Phone: (941) 300-4440 ext. 111954

Compass, Inc.

Early Intervention Services, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Mental Health Services, Emergency Financial Assistance, Medical Transportation, Non- Medical Case Management
Location(s): 201 N. Dixie Highway, Lake Worth, FL 33460
Phone: (561) 533-9699
Fax: (561) 318-6671

Program Contact: Raymond Cortes
Email: raymond@CompassLGBTQ.com
Phone: (561) 533-9699 ext. 4008

Fiscal Contact: Julie Seaver
Email: julie@CompassLGBTQ.com
Phone: (561) 533-9699 ext. 4038

Joseph Zabas
Email: Joseph@CompassLGBTQ.com
Phone: (561) 533-9699 ext. 4001

Lysette Pérez
Email: lysette@CompassLGBTQ.com
Phone: (561) 533-9699 ext. 4007

Quality Management Contact: Lysette Pérez
Email: lysette@CompassLGBTQ.com
Phone: (561) 533-9699 ext. 4007

Raymond Cortes
Email: raymond@CompassLGBTQ.com
Phone: (561) 533-9699 ext. 4008

FoundCare, Inc.

Early Intervention Services, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Specialty Outpatient Medical Care, Food Bank/Home Delivered Meals, Medical Transportation, Non-Medical Case Management, Early Intervention Services (MAI), Medical Case Management (MAI), Non-Medical Case Management (MAI), Psychosocial Support Counseling (MAI); *EHE Rapid Entry to Care (REC)*
Call Center main phone number: 561-432-5849
Call Center main fax number: 561-432-9732
Care Coordination fax number: 561-283-0224
Location(s):

(1) 2330 S. Congress Avenue, Palm Springs, FL 33406
(2) 1901 South Congress Ave Suite 100 Boynton Beach, FL 33426
(3) 840 US Highway 1 North Palm Beach FL 33408
(4) 1500-A NW Ave. L, Belle Glade, FL 33430
(5) 5730 Corporate Way #100, West Palm Beach, FL 33407
(6) 5867 Okeechobee Blvd, West Palm Beach, FL 33417 (Yolette Bonnet Center)
(7) 5205 Greenwood Ave, Suite 150 West Palm Beach, FL 33407
(8) Riviera Beach Health Center COMING 2025, 3501 Broadway Avenue, Riviera Beach FL 33404

Phone(s):

(1) (561) 472-2466 (Palm Springs)
(2) (561) 274-6400 (Boynton Beach)
(3) (561) 776-8300 (North Palm Beach)
(4) (561) 996-7059 (Belle Glade)
(5) (561) 863-7800 (Corporate Way)
(6) (561) 660-5468 (Okeechobee Blvd)
(7) (561) 848-8701 (Greenwood Ave)

Fax (es):

(1) (561) 304-0472 (Palm Springs)
(2) (561) 274-3912 (Boynton Beach)
(3) (561) 776-0727 (North Palm Beach)
(4) (561) 996-1567 (Belle Glade)
(5) (561) 840-0747 (Corporate Way)
(6) (561) 899-4867 (Okeechobee Blvd)
(7) (561) 848-9059 (Greenwood Ave)

Program Contact: Brittany Henry
Email: bhenry@foundcare.org
Phone: (561) 432-5849 ext.1085

Fiscal Contact: Andy Antenor
Email: aantenor@foundcare.org
Phone: (561) 472-9160 ext. 1072

Quality Management Contact: Lilia Perez
Email: lperez@foundcare.org
Phone: (561) 472-2466 ext. 1204

EHE Contact: Quinton Dames
Email: Qdames@foundcare.org
Phone: (561) 472-9160 ext. 1256
Cell phone: (561) 323-5845

Legal Aid Society of Palm Beach County

Legal Services, Non-Medical Case Management
Location(s): 423 Fern Street, Suite 200, West Palm Beach, FL 33401
Phone: (561) 655-8944
Fax: (561) 822-9827

Program Contact: Sandra Powery Moses
Email: smoses@legalaidpbc.org
Phone: Direct (561) 822-9821; Work Cell (561)383-1530

Fiscal Contact: Shane Ramsaroop
Email: sramsaroop@legalaidpbc.org
Phone: (561) 822-9765

Quality Management Contact: Marcy Classe
Email: mclasse@legalaidpbc.org
Phone: (561) 721-6096

Midway Specialty Care Center

Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Non-Medical Case Management, Medical Case Management, including Treatment Adherence; *EHE Rapid Entry to Care (REC)*

Location(s): (1) 2247 Palm Beach Lakes Blvd, Suite 209A, West Palm Beach, FL 33409
(2) 5507 South Congress Ave, Suite 150, Atlantis, FL 33462
Phone: (1) (561) 249-2279
(2) (561) 766-0590
Fax(es): (1) (561) 720-2970
(2) (561) 766-0591

Program Contact: Jiovanna Allen
Email: jallen@midwaycare.org
Phone: (407) 745-1171

Fiscal Contact: Kathyrn Hayden
Email: khayden@midwaycare.org
Phone: (772) 742-9276

Quality Management Contact: Tiffany Elias-Bender
Email: telias@midwaycare.org
Phone: (561) 200-3772

Monarch Health Services, Inc.

Early Intervention Services, Lab Diagnostic Testing, Non-Medical Case Management, Medical Case Management, including Treatment Adherence; *EHE Rapid Entry to Care (REC)*

Location(s):
(1) 2580 Metrocentre Blvd., Ste. 1, West Palm Beach, FL 33407
(2) 14000 S. Military Trail, Ste. 110, Delray Beach, FL 33445
Phone: (561) 523-4589
Fax: (561) 491-2602

Program Contact: Jeanice Petit-Frere
Email: jpetitfrere@monarchealth.org
Phone: (561)523-4589 ext 407

Fiscal Contact: Damion Baker
Email: dbaker@monarchealth.org
Phone: (561) 523-4589 ext 404

Quality Management Contact: Jeanice Petit-Frere
Email: jpetitfrere@monarchealth.org
Phone: (561)523-4589 ext 407

The Poverello Center, Inc.

Food Bank/Home Delivered Meals Location(s):
(1) Grocery and Gift Card Home Deliveries throughout Palm Beach County,
(2) Administrative Offices at 2056 N Dixie Hwy, Wilton Manors, FL 33305

Phone: (954) 361-9242
Intake: intake@poverello.org

Program Contact: James Stevenson or Emma Roca
Email: jstevenson@poverello.org or eroca@poverello.org

Fiscal Contact: Jose Castillo
Email: jcastillo@poverello.org

Quality Management Contact: Brad Barnes
Email: Bbarnes@poverello.org

Treasure Coast Health Council, Inc. d/b/a Health Council of Southeast Florida

Early Intervention Services, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Specialty Outpatient Medical Care, Medical Transportation, Non-Medical Case Management, Early Intervention Services (MAI), Medical Case Management (MAI), Non-Medical Case Management (MAI), Psychosocial Support Counseling (MAI)
Location(s): 600 Sand Tree Drive, Suite 101, Palm Beach Gardens, FL 33403
Mobile, community-based and virtual services available
Phone: (561) 844-4220
Fax: (561) 844-3310

Program Contacts:
Anil Pandya, COO
Email: apandya@hcsef.org Phone:
Extension 2400

Marsharee Chronicle, Director of Programs
Email: mchronicle@hcsef.org
Phone: Extension 1800

Fiscal Contacts:
Anne Costello, CFO
Email: acostello@hcsef.org
Phone: Extension 2000

Rosemary Ingram-Newton, Senior Accountant
Email: ringram@hcsef.org
Phone: Extension 2200

Quality Management Contacts:
Marsharee Chronicle, Director of Programs
Email: mchronicle@hcsef.org
Phone: Extension 1800

Ashnika Ali, Senior Program Manager
Email: aali@hcsef.org
Phone: (561) 323-0459

Part B, EHE, Harm Reduction Services ONLY:

Florida Department of Health, Palm Beach County
Accepting Referrals (***Part B & EHE REC services ONLY***)

Appointment Line: (561) 625-5180

Location(s):

(1) 851 Avenue P, Riviera Beach, FL 33404 Northeast
Health Center- Dental Clinic
(2) 1250 Southwinds Dr, Lantana, FL 33462
Lantana/Lake Worth Health Center- Maternity, Family Planning, STD Clinic, PrEP
(3) 225 S. Congress Avenue, Delray Beach, FL 33445
Delray Beach Health Center- IDC, STD Clinic, PrEP, Maternity, Family Planning
(4) 38754 State Road 80, Belle Glade, FL 33430
C.L. Brumback Health Center- IDC, STD Clinic, PrEP, Maternity, Family Planning
(5) 1150 45th Street, West Palm Beach, FL 33407
West Palm Beach Health Center- IDC, STD Clinic, PrEP, Maternity, Family Planning
(6) 5985 10th Ave, Greenacres, FL 33463 WIC
Greenacres Center- WIC

Phone(s):

(1) (561) 803-7300
(2) (561) 547-6800
(3) (561) 274-3100
(4) (561) 983-9220
(5) (561) 514-5300
(6) (561) 357-6000

Program Contact: Robert Scott
Email: Robert.Scott@flhealth.gov
Phone: (561) 722-9289

Fiscal Contact: Courtney Koontz
Email: Courtney.Koontz@flhealth.gov
Phone: (561) 530-6887 or (561) 446-5643

Quality Management Contact: Dr. Berthline Isma, PhD, MPH, MSPH, MBA, CEPH
Email: Berthline.Isma@flhealth.gov
Phone: (561) 514-5322 or (561) 828-1346

EHE Contract Manager: Erin McSpadden
Email: Erin.McSpadden@flhealth.gov
Phone: (561) 592-3836

EHE Coordinator: Keri Ramnarace
Email: Keri.Ramnarace@flhealth.gov
Phone: (561) 946-8910

Oceana Community Health
EHE REC Services ONLY

Location(s): 2828 S. Seacrest Blvd., Suite 208, Boynton Beach, FL 33435

Program Contact: Dr. Youssef Motii
Email: youssef@oceanahealth.org
Phone: (561) 543-2236

Fiscal Contact: Herman Viglione, CPA
Email: info@oceanahealth.org
Phone: (855) 479-4404 ext. 5

PBC Community Services Department

***EHE Services ONLY*- Community Outreach, Response & Engagement (CORE), Tele-Adherence Counseling (TAC), Healthcare & Housing Opportunities (H2O), Vocational Rehabilitation (VR)**
Call Center: (833) PBC-HIV1 / (833) 722-4481

Location(s):

(1) 38754 State Road 80, Belle Glade, FL 33430
C.L. Brumback Health Center
(2) 1441 Dr. Martin Luther King Jr. Blvd, Riviera Beach, FL 33404
Mayme Frederick Center
(3) 810 Datura Street, West Palm Beach, FL 33401
PBC Community Service Department
(4) 345 S. Congress Avenue, Delray Beach, FL 33445
Delray Beach Community Service Department

Program Contact: Bianca Murphy
Email: bmurphy@pbc.gov
Phone: (561) 355-3129

Fiscal Contact: Jeffrey Lesanti
Email: jlesanti@pbc.gov
Phone: (561) 355-1945

Rebel Recovery

EHE Harm Reduction Intervention Services (HRIS); Syringe Services Program (SSP)

Location(s): See Calendar on website for updated locations
https://pbc.rebelrco.org/flash-calendar/#flipbook-df_597/1/
Phone: (561) 508-8388

Program Contact: Nikita Jordon
Email: nikita@rebelrco.org
Phone: (561) 508-8388

Fiscal Contact: Georgeanne Dorney
Email: georgeanne@rebelrco.org
Phone: (561) 508-8388

SSP Director: Austin Wright
Email: Austin@rebelrco.org
Phone: (561) 646-7701

Appendix C- PBC RW Part A/MAI Client Eligibility Determination Table

Palm Beach County RW Part A/MAI Program
Client Eligibility Determination & Confirmation
Required Documentation Table

Eligibility Requirements	Initial Eligibility Determination & Annual/12-Month Confirmation
HIV Status	Documentation is ONLY required for initial eligibility determination
Income	Documentation is required
Residency	Documentation is required
Insurance Status / Third Party Payer	Subrecipient must verify if applicant is enrolled in other health care coverage and document status in client file.

Appendix D- PBC RW Part A/MAI Allowable Eligibility Documentation List

PBC RW Part A/MAI Allowable Eligibility Documentation List	
HIV	
Western Blot or Immunofluorescence Assay (IFA).	A detectable (quantitative) HIV viral load (undetectable viral load tests are NOT proof of HIV)
A positive qualitative HIV NAT (DNA or RNA) or HIV-1 p24 antigen test	An HIV nucleotide sequence (genotype)
If client is an exposed infant (up to 12 months), document mother's HIV status	STARS Report
Certified medical record documenting HIV diagnosis (ICD-10: B20; ICD-9: 042)	Signed letter from a licensed medical provider (MD, DO, PA, NP) attesting to HIV diagnosis
Viral resistance test result	4th Generation (Ag/Ab) test result
Palm Beach County Residency	
Unemployment documentation with street address	Recently postmarked letter mailed to client at street address
Current and valid Health Care District card	Current and valid license or photo ID
Receipt of payment for rent with name, address, and signature of landlord	Mortgage or rent agreement with name and address (the entire document is not required- signature page and page with client name and address are required)
Letter from person with whom client resides	Letter from homeless shelter or social service agency
Utility bill with name and street address	Documentation of homelessness with client signature & date
Prison records (if recently released)	PBC Insurance Verification form (for clients who cannot get paystubs)
Recent School records	Bank statement with name and street address
Property tax receipt or W-2 form for previous year	Current voter/vehicle registration card.
Declaration of Domicile (Section 222.17, Florida Statutes).	Any acceptable Proof of Income documentation with street address
Income at or below 400% FPL	
Pay Stubs (enough stubs to determine an average annual income)	TPQY (not older than 90 days for proof of no income or annually for proof of income)
Self-Employment documentation (1040 Schedule SE or C)	Retirement/Disability Income (SSI, SSDI, other)
Letter of Support (if no income explain)	Military/Veteran Pension or VA Benefits
1040 or W2 form (with TPQY and, if no income, a Letter of Support)	Unemployment Letter (website print screen for current status and payment history)
Self-Tracking Form or DCF Work Calendar	Alimony/Child Support/Survivor Benefits
SEQY (if no income- required annually, or as necessary)	SSA.gov printout
TANF/Section 8 benefit award/assistance letter	Other governmental letters of Notification of Benefits (SNAP, WIC, LIS, Worker's Comp, etc.)
Verification/Screening for Other Payer Sources	
Medicaid (**copy of card is not sufficient**, must be a current Medicaid check from FLMISS or other source/Community Partners verification)	Current and valid Health Care District card
FLMMIS Screen	Medicaid Prescreen (myflorida.com/accessflorida/)
Private Insurance	Medicare (Part A/B/C/D)
Affordable Care Act (ACA) Insurance	Indian Health Service (IHS)
Veteran's Administration (VA)	Children's Health Insurance Program (CHIP)
Insurance Documentation from Employer	Patient Assistance Programs (PAP's)
PBC Insurance Verification form	Patient Advocate Foundation (PAF)/Patient Access Network (PAN) Foundation
PBC RWHAP will allow an active, current (less than 12 months old) Notice of Eligibility from a RW HIV/AIDS Program Part A or Part B/ADAP within the state of Florida as acceptable source documentation for PBC RWHAP eligibility so long as the NOE contains sufficient information from which an eligibility determination can be made (current address, income/household size/FPL, 3rd party payer source, etc.). If the information contained in the NOE is insufficient (i.e. address outside of PBC), additional documentation must be provided from this list.	

*Documentation above can be utilized for both Residency and Income confirmation.

*Only one documentation is required for each category. List above is not all inclusive. If other documents are available for confirmation, please utilize.

Appendix E- PBC RWHAP Coordinated Services Network (CSN) Client Consent

Client Name: _____ DOB: _____

CONSENT TO SHARE CONFIDENTIAL INFORMATION AND PRIVACY/SECURITY OF YOUR CLIENT RECORDS

This document provides you with information regarding sharing of confidential information, and privacy/security practices in the Palm Beach County HIV Coordinated Services Network.

The HIV Coordinated Services Network (CSN) is a collaborative group of organizations that provide medical and support services to people with HIV through public and private funding by federal, state and local sources, including but not limited to the U.S. Health Resources and Services Administration (HRSA), U.S. Housing and Urban Development (HUD), the State of Florida, Palm Beach County, municipalities, private grants and donations.

The HIV CSN uses a shared data management information system and is committed to ensuring that the information maintained in your client record remains confidential, secure, and shall only be accessed by individuals authorized to do so. **Your confidential information will only be shared with your written consent between entities who are a part of the HIV CSN.**

Your demographic, health and service utilization data will be shared for the purposes of facilitating coordination, linkage, access, or adherence to care and treatment services needed to achieve and maintain optimum health outcomes and/or the coordination of payment for care, treatment, health care operations, and to improve the quality of the system of care. If you receive housing services through the HOPWA program, your demographic and housing service utilization data will also be shared with the Continuum of Care (CoC) Housing Management Information System (HMIS) as required for HUD reporting purposes.

If you disengage from HIV medical care and treatment for unknown reasons, HIV CSN entities may use information you have previously shared and/or obtain additional information from the Florida Department of Health for the purpose of locating, initiating contact and offering assistance with linkage/re-engagement to HIV medical care and treatment.

Client Name: _____

Client Signature: _____

Client Name: _____ DOB: _____

In order to accomplish this, you will be involved in the following ways:

You maintain control of confidential information shared between HIV CSN entities by signing the attached release of information form.

You will receive notice of any changes made to our privacy and security practices.
You may provide preferred means of communication, acknowledging each form of communication presents unique risks for unintentional disclosure of confidential information.

I authorize you to contact me for appointment reminders and other medical or dental matters by the below method(s):

Initials

_____Phone call: Primary # (___) ____-____ Secondary # (____) ____-____

_____Text (check all that apply): Primary # ☐ Secondary # ☐

_____Mailing address:_____

_____

City:_____, State:_____, Zip: _____

_____**Medical Lab Test Results** may be mailed to me
_____Email: _____@_____
_____Other means of communication: _____

Security of Your Hard-Copy Client Record
Even though we use electronic client records, we still receive paper-based correspondence and must maintain a small paper-based file.

Security of Your Electronic Record

As a recipient of medical and supportive services through the HIV Coordinated Services Network (CSN), your records are maintained on a secure computer system. The system requires each individual to enter his or her personal user ID and password to authenticate identity and establish the specific records and information the user is authorized to view. Passwords expire every forty-two days and must be changed for continued access to the database. All electronic client records are stored on a highly secure server separate from where you receive services with a backup created daily in the event that disaster recovery of information is necessary.

Staff Training

The staff of this agency undergoes training as new employees and annually thereafter to ensure adherence to privacy/security policies and practices.

Revocation of Consent to Share Confidential Information

I understand that I can revoke this consent at any time in writing. I understand that Palm Beach County and HIV CSN entities are required to retain my health, demographic, housing, and billing information, and are not able to take back any information already shared with my permission. I understand that by revoking consent to share my health, demographic, housing and financial information with the HIV CSN, I will no longer be eligible for services provided by Palm Beach County Ryan White Part A/MAI, End the HIV Epidemic and HOPWA programs.

Acknowledgement of receipt of this form:

This is to acknowledge that I have reviewed this form, and have discussed it with the agency representative whose signature appears below**. I consent to entering into a client-HIV CSN relationship in order to receive needed services.** I have:

____Received a copy of this form (Initial) _____ Declined a copy of this form (Initial)

_____ _____
Client / Representative or Guardian's Signature Date

_____
Client Representative / Guardian's Relationship

_____ _____ _____
Agency Representative Signature Date Printed Name of Agency Representative

THE ORIGINAL SIGNED COPY OF THIS FORM IS FILED IN THE CLIENT'S RECORD
NOTE: THIS CONSENT CAN BE REVOKED BY COMPLETING THE FOLLOWING PAGE.

Client Name: _____ DOB: _____

WITHDRAWAL OF CONSENT
TO SHARE CONFIDENTIAL INFORMATION

The HIV Coordinated Services Network (CSN) is mandated to collect certain personal information that is entered and saved in a database system. Records are maintained in an encrypted database on a secure server. Aggregate reports may be used without revealing names or other confidential information that would identify any specific client.

I understand that Palm Beach County and HIV CSN entities are required to retain my health, demographic, housing, and billing information and are not able to take back any information already shared with my permission.

I understand that if I disengage from HIV medical care and treatment for unknown reasons, HIVCSN entities may use the information I have previously shared and/or obtain additional information from the Florida Department of Health for the purpose of locating, initiating contact and offering assistance with linkage/re-engagement to HIV medical care and treatment.

I understand that I have a right to withdraw consent to share confidential information; however, I will no longer be eligible for services provided by Palm Beach County Ryan White Part A/MAI, End the HIV Epidemic and HOPWA programs.

(1) I__(Print Name) hereby withdraw my consent to share further confidential information with the HIV CSN.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

Appendix F- Community Service Department Incident Report

Palm Beach County Ryan White HIV/AIDS Program Incident Notification Form

Agency: _____

Date Incident Occurred: _____

Person Completing Form: _____

Date of Report: _____

Email (*Optional*)**:** _____ **Phone #:** _____

Method of Communication: (Please check the appropriate box)

- ☐ Drop Off
- ☐ Standard Mail
- ☐ Provide Enterprise-Secure Transmission
- ☐ Certified Mail

Incidents Reported: (Please check the appropriate box)

❖ *Timeline to notify Funder - Incidents related to Children shall be notified between 2-4 hours.*

- Client injury/accident requiring medical attention or hospitalization that could pose an Agency liability
- Allegation of neglect, physical, mental and sexual abuse of a client by an Agency staff
- Incidents that may portray the Agency in a negative manner (service delivery, safety and/or fiscal)

❖ *Timeline to notify Funder - Incidents related to Adults shall be notified between 4-8 hours.*

- Client injury/ accident requiring medical attention or hospitalization that could pose an Agency liability
- Allegation of neglect, physical, mental and sexual abuse of a client by an Agency staff
- Incidents that may portray the Agency in a negative manner (service delivery, safety and/or fiscal)

❖ *Timeline to notify Funder- Programmatic Incidents (within 14 business days)*

- Resignation/Termination of CEO, President, or CFO
- Resignation/Termination of key Ryan White funded staff
- Ryan White funded staff vacancy over 30 days
- Change in AGENCY'S name
- Loss of License
- Loss of funding from another Funder that could impact services
- Temporary interruption of service delivery (i.e. natural and unnatural disasters)
- Other (Issues that impact service delivery to Ryan White clients)
  Specify:

Summary of incident: (Do not include the name of client or staff involved in incident)

_____

_____

_____

_____

Will there be an investigation?

- Yes
- No
- NA

_____ _____

Individual Completing Report: Print Name Position /Title

_____ _____

Individual Completing Report: Signature **Date**

Appendix G- PBC RWHAP PE & OSCARSS User Confidentiality Agreement

Provide Enterprise (PE) and Online System for Community Access to Resources and Social Services (OSCARSS)
User Confidentiality Security Agreement

Palm Beach County Department of Community Services I understand that the purpose of this agreement is to emphasize that all client information contained in Palm Beach County PE and OSCARSS is confidential.

I understand that access to confidential information is governed by Federal, State and Local laws regarding protection of client privacy. Client confidential information includes medical, social, and financial data.

I understand that client information shall not be viewed unless it is essential to provide services or conduct evaluation.

I acknowledge that violation of the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160 & 164, and corresponding regulations established by the U.S. Department of Health and Human Services may result in prosecution, civil liability, or civil penalty, and may subject me to disciplinary action, including possible termination of employment, by my employer.

I will comply specifically with Federal confidentiality regulations as contained in the Code of Federal Regulations, 42 CFR Part 2, regarding disclosure of alcohol and/or drug abuse records.

I understand that I must participate in any PE and OSCARSS training provided by Palm Beach County Community Service Department.

I understand that I must follow policy and procedure manuals, as well as program manuals, when accessing PE and OSCARSS.

I understand my professional responsibility to report suspected or known security violations or confidentiality breaches to Palm Beach County Community Services Department.

Client data collected by interview, observation or review of documents must be in a setting that protects the client's privacy. I further understand and acknowledge the following:

1. Registered user ID's and/or passwords are not to be disclosed.
2. Information, electronic or paper-based, is not to be obtained for my own or another person's personal use.
3. Client services information, data and information technology resources shall be used only for official business purposes.
4. Copyright law prohibits the unauthorized use or duplication of software.

I am requesting a User account for_____Provide Enterprise (PE)
I am requesting a User account for_____Online System for Community Access to Resources and Social Services (OSCARSS)

User Name (print): _____
User Signature: _____
Date Signed _____
Supervisor Name (print): _____
Supervisor Signature: _____
Date Signed _____

Appendix H- GY25 PBC RW Part A/MAI Reimbursement Model Summary

Palm Beach County HIV Elimination Services

GY25 Ryan White Part A/MAI Reimbursement Model Summary

Service Category	Reimbursement Model	Reimbursement Rate/Unit
Outpatient/Ambulatory Health Services	FFS	1 CPT Code Medicare Physician Fee Schedule (MPFS) which includes 1.815 Geographic Practice Cost Index (GPCI)
Laboratory Diagnostic Testing	FFS	1 Lab Test Medicare Clinical Diagnostic Laboratory Fee Schedule
Specialty Outpatient Medical Care	FFS	1 CPT Code Medicare Physician Fee Schedule (MPFS) which includes 1.815 Geographic Practice Cost Index (GPCI)
Oral Health Care	FFS	1 CDT Code Florida Medicaid Dental General Fee Schedule
Legal Services	FFS	1 hour $90 per billable hour of legal services
AIDS Pharmaceutical Assistance	Actual	1 medication fill/refill
Health Insurance Premium and Cost-Sharing Assistance	Actual	1 deductible, co-payment, or monthly premium
Emergency Financial Assistance	Actual	1 Emergency Assistance
Emergency Financial Assistance-Medication	Actual	1 medication fill/refill
Food Bank/Home Delivered Meals	Actual	1 Voucher
Nutritional Supplements	Actual	1 Prescription
Medical Transportation	Actual	1 Trip/Voucher
Early Intervention Services	Actual*	15 minutes of service
Medical Case Management	Actual*	15 minutes of service
Mental Health Services	Actual*	1 hour of service
Non-Medical Case Management	Actual*	15 minutes of service
Psychosocial Support Services	Actual*	15 minutes of service

*Reimbursement based on staff time and effort

Appendix I- PBC RW Part A/MAI Letter of Medical Necessity for Opioid Medications

Palm Beach County Ryan White Part A/MAI Program
Letter of Medical Necessity/Chronic Opioid Medication

Date: _____

As the health care practitioner treating _____, and
Patient Name
in accordance with **Section 456, Florida Statutes**[1] and **F.A.C. 64B8-9.013**[2], it is my clinical opinion that the opioid medication below be prescribed.

Medication Name: _____

Strength/Dosage: _____

Directions/SIG: _____

Duration of Therapy: _____

The patient's diagnosis for this medication is_____. This diagnosis is related to the patient's HIV/AIDS status, complication of HIV or HIV-related co-morbidity because

_____

- ☐ I have documented that non-opioid pain medications have been used and have failed, or were not tolerated by the patient. It is my professional judgement that an opioid is the best medication for treating this patient's chronic pain.
- ☐ I have discussed the risk of opioid dependency with the patient.
- ☐ I have discussed other modalities for the treatment of pain with the patient.
- ☐ To my knowledge, the patient is not being prescribed other medications that can cause serious adverse events when taken with the opioid medication I am prescribing.
- ☐ I have consulted the Florida PDMP (E-FORSE) prior to prescribing the opioid medication.

I attest the above conditions have been met and are fully documented in the patient's medical record.

Sincerely,

_____

Print Name with Practitioner Degree(s)

Please note: All questions should be directed to the Ryan White Program Recipient, at (561) 355-4730.

[1]Florida Statute Section 456.44 Controlled Substance Prescribing
[2] Florida Administrative Code 64B8-9.013 Standards for the Use of Controlled Substances for the Treatment of Acute Pain. Specific Authority Florida Statute 458.309 and 458.331.

Created and Approved by LPAP 10/20/2020 CC 10/22/2020

Appendix J- PBC RW Part A/MAI Health Insurance Continuation Guidance

Palm Beach County Ryan White Part A/MAI Program
Health Insurance Premium & Cost Sharing Assistance Limitations & Processes
2025 Open Enrollment Period

PBCRWA has determined the following requirements for providing Health Insurance Continuation services under this program funding. Please inform agency staff and clients of these requirements for assistance in the upcoming 2025 ACA Open Enrollment period.

PBCRWA limitations:

- ☐ Monthly Premiums cannot exceed $1500
- ☐ Annual Total cost (premiums, deductibles, out-of-pocket costs) cannot exceed $20,000
- ☐ Federal Poverty Level (FPL) cannot be greater than or equal to 50% FPL
- ☐ Client should not be eligible for ADAP assistance
- ☐ If qualified for tax credits, Premium Tax Credits must be taken up front and not at the end of the year.

❖ *If a client exceeds either A or B or both limitations, the client should be enrolled in a plan option most cost- effective for their needs. A request for approval will need to be submitted to Shoshana Ringer through the Part A PE database Secure Messaging feature prior to enrollment. Documentation of cost-effective plan and description of reason for request is required.*

PBCRWA & B Processes for enrollment of clients:

Process for RW Part A Clients

- RW clients less than 50% of FPL should be enrolled or re-enrolled in a qualified health plan through RW Part A assistance.
- Enrollment assistance may be provided by RW CAC certified case management staff, referred to Navigators (enrollment only), or referred to Broward Regional Health Planning Council (BRHPC) (enrolment and/or premium payment).
  - ***Navigators*** *https://widget.getcoveredamerica.org/ to schedule an appointment for enrollment. When scheduling an appointment through Navigator website, please utilize* ***the funder identifier*** *(A) after the First name of the client (e.g. John (A) Doe). Completed Enrollment information will be directed back to case management for reference. Please include a reference to* ***the agency name*** *(e.g. John (A- Compass) Doe).*
  - *Part A Case Management staff can utilize the BRHPC website for direct enrollments for Part A and ADAP clients. https://enroll.brhpc.org/*
  - ***BRHPC*** *will determine if a client is eligible for ADAP first and enroll for Part A assistance if not. The toll-free number for the Palm Beach Part A program enrollments is* ***(833) 442-3116****. Referrals for payment assistance can be submitted through the Part A PE system.*

Process for ADAP Eligible Clients

- Clients **50%** FPL and over under RW determination, should be referred to either
  - **Navigator** website - https://widget.getcoveredamerica.org/ to schedule an appointment for assistance in enrolling in ADAP approved plans. *When scheduling an appointment, please utilize* ***the funder identifier*** *(B) after the First name of the client (e.g. John (B) Doe).* Navigators will assist clients by enrolling or re-enrolling through the Broward Regional Health Planning Council (BRHPC) website. Navigators will direct Completed Enrollment information back to ADAP to confirm BRHPC enrollment for payments.
  - **BRHPC** website- https://enroll.brhpc.org/ to enroll for ADAP eligible clients.
- RW clients, new to any ADAP assistance, will need to complete ADAP eligibility prior to enrolling in ACA ADAP assistance. Please fax the current NOE, with the next eligibility appointment documented, to 561-840-4830.

All Part A enrollment for health insurance continuation is subject to available funds.

If there are any questions pertaining to PBCRWA limitations or processes, please contact Shoshana Ringer sringer@pbcgov.org Thank you.

Created 11/13/14 Revised 11/4/2024

Palm Beach County Ryan White Part A/MAI Program
Health Insurance Premium & Cost Sharing Assistance
Guidance for individuals that are categorically ineligible for ACA Marketplace plans (off market plans).
2025 Open Enrollment Period

PBCRWA has determined the following requirements for providing Health Insurance Continuation services under this program funding, for **individuals that are categorically ineligible for ACA Marketplace plans**. Please inform agency staff and clients of these requirements for assistance in the Open Enrollment period.

PBCRWA limitations:

- ☐ Client must not be eligible for ACA Marketplace plan enrollment (undocumented without Social Security number)
- ☐ Monthly Premiums cannot exceed $1500
- ☐ Annual Total cost (premiums, deductibles, out-of-pocket costs) cannot exceed $20,000
- ☐ Client must meet and maintain eligibility for the RW program

❖ *If a client exceeds either B or C or both limitations, a request for approval will need to be submitted to Shoshana Ringer through the Part A PE database Secure Messaging feature prior to enrollment. Documentation of cost-effective plan and description of reason for request is required.*

PBCRWA Processes for enrollment of off-marketplace insurance plans:

RW clients less than 400% of FPL should be enrolled in a qualified health plan through Ryan White program assistance.

- Enrollments must be completed through the form in the link provided: **https://redcap.pbcgov.org/redcap/surveys/?s=XPM7TMRKCACATTP4**
- Submitted enrollments will be sent to the Navigation Partner- Jesus Cova to process.
- Once enrollment in one of the selected plan options is completed, enrollment information will be sent back to the Case Manager listed on the enrollment form.
  * Available plans for 2025 include Cigna Gold CMS or Ambetter Gold 202.
- Clients will need to receive health literacy training on how to utilize their insurance plans, including utilizing pharmacy pickup and utilizing Part A services for copay/deductible assistance.
- Funded Subrecipients will be responsible for processing and paying premiums for these enrollments. In addition, referrals can be sent to Broward Regional Health Planning Council (BRHPC) for premium payments of the Part A Off-Marketplace enrollments.
- Referring Case Managers will be responsible for follow-up needs on ensuring clients are aware/capable of utilizing the coverage provided and any payment request needs.
- Please complete the disenrollment information when clients are no longer enrolled in these 2 plans: **https://redcap.pbcgov.org/redcap/surveys/?s=8PCFT4CENWMXPTE4**

All Part A enrollment for health insurance continuation is subject to available funds.

If there are any questions pertaining to PBCRWA limitations or processes, please contact Shoshana Ringer
sringer@pbcgov.org

Thank you.

Appendix K- PBC RW Part A/MAI Specialty Medical Care Allowable Conditions and Referral

PALM BEACH COUNTY RYAN WHITE PBC PART A/MAI PROGRAM
ALLOWABLE SPECIALTY MEDICAL CARE
CONDITIONS LIST

These conditions are related to or exacerbated by HIV, comorbidities related to HIV, or complications of HIV treatment.

Conditions listed may be accessible under multiple specialties though not specifically referenced.

This list is intended to address the federal Health Resources and Services Administration's requirement that services provided through outpatient medical care be related to an individual's HIV status. This list is not exhaustive and is a sample guideline created to assist medical providers with specialty care referrals and to emphasize the importance of documenting the link between an individual's HIV status and the specialty care service to which a client is referred.

***"Health Maintenance"** category for routine medical diagnostic testing (e.g., Pap smear, mammogram, bone density test, colonoscopy, colorectal cancer screening, and ophthalmologic screening) is allowable as long as such testing follows established medical guidelines, such as U.S. Public Health Service (PHS), American Medical Association, Health Resources and Services Administration (HRSA), or other local guidelines, as a standard of care. Please see the most current, local Ryan White Program Manual- Service Delivery for more information.*

When provided in an outpatient setting, labs, diagnostics, and treatments related to HIV, as indicated above, including complications of HIV treatment related to the following conditions may be covered:

BONE AND JOINT DISEASES (E.G., ORTHOPEDICS/RHEUMATOLOGY):
osteoarthritis

BONE AND JOINT DISEASES (E.G., ORTHOPEDICS/RHEUMATOLOGY) and CHIROPRACTIC/PHYSICAL MEDICINE:
avascular necrosis of hip, knee, etc. (Stage 1 or 2 only for CHIROPRACTIC/PHYSICAL MEDICINE)
fibromyalgia
myopathy/myalgia, HIV-related (chronic for CHIROPRACTIC/PHYSICAL MEDICINE)
osteopenia/osteoporosis
rheumatic diseases

CARDIOLOGY:
atherosclerosis coronary
artery disease heart
disease hyperlipidemia
peripheral artery disease phlebitis

CHIROPRACTIC/PHYSICAL MEDICINE:
HIV-related chronic arthralgia
peripheral neuropathy

IMPORTANT NOTE: According to CDC, chronic pain is defined as pain having duration of at least three months. Chronic pain is considered a co-morbidity of HIV. This may also contribute to the depression with pain comorbidity complex (DPC). Treatment of acute pain is not covered.

COLORECTAL:
abnormal anal Pap smears fistulas
hernias

COLORECTAL and ONCOLOGY:
anal cancers

DENTAL (ORAL HEALTH CARE):
giant aphthous ulcers

DENTAL (ORAL HEALTH CARE); and EAR, NOSE and THROAT (ENT)/OTOLARYNGOLGY:
human papillomavirus associated oral lesions

DENTAL (ORAL HEALTH CARE); EAR, NOSE and THROAT (ENT)/OTOLARYNGOLGY; and ONCOLOGY:
dental cancers
oral cancers

DERMATOLOGY:
dermatitis eczema/seborrheic
dermatitis eosinophilic
folliculitis impetigo
Methicillin-resistant Staphylococcus aureus (MRSA) molluscum
contagiosum
photodermatitis
pruritus (as a symptom of undiagnosed xerosis, psoriasis, scabies, lymphoma, etc.) psoriasis
skin conditions and symptoms, including skin appendages and oral mucosa warts

DERMATOLOGY and GENITOURINARY (GU)/ GYNECOLOGY (GYN)/OBSTETRICS (OB):
tinea infections

DERMATOLOGY and INFECTIOUS DISEASES:
herpes simplex virus

DERMATOLOGY and ONCOLOGY:
Kaposi's sarcoma
skin cancers (squamous cell carcinoma, etc.)

DERMATOLOGY and PODIATRY:
~~onychomycosis~~

EAR, NOSE AND THROAT (ENT)/OTOLARYNGOLOGY:
chronic sinusitis
oral human papillomavirus

ENDOCRINOLOGY:
diabetes
hormone replacement therapy (for individuals of trans experience) hypogonadism

GASTROINTESTINAL:
colitis (syphilitic colitis--very rare) diarrhea
esophageal candidiasis
nausea/vomiting

GENITOURINARY (GU)/ GYNECOLOGY (GYN)/OBSTETRICS (OB):
abnormal Pap smear
cervical human papillomavirus
erectile dysfunction*
hematuria (related to neoplasms) pregnancy
scrotal candidiasis vaginitis

GENITOURINARY (GU)/ GYNECOLOGY (GYN)/OBSTETRICS (OB) and ONCOLOGY:
gynecological cancers
prostate cancer

**IMPORTANT NOTE: the local Ryan White Part A/MAI Program will only pay for evaluation and diagnostics of erectile dysfunction; but the treatment of erectile dysfunction is <u>not</u> covered by the local Ryan White Part A/MAI Program.*

HEMATOLOGY:
anemia neutropenia
thrombocytopenia

HEMATOLOGY and ONCOLOGY:
polycythemia vera

INFECTIOUS DISEASE:
histoplasmosis
leishmaniasis
non-tuberculous mycobacterial infections
syphilis
varicella zoster infections
viral hepatitis (hepatitis B and C)

INFECTIOUS DISEASE and DERMATOLOGY:
Mpox

INFECTIOUS DISEASE and OPHTHAMOLOGY:
toxoplasmosis

INFECTIOUS DISEASE and PULMONOLOGY:
tuberculosis

NEPHROLOGY:
human immunodeficiency virus-associated nephropathy
renal failure (may be related to coronary artery disease induced by HIV or diabetes mellitus induced by HIV, etc.)

NEUROLOGY:
delirium
HIV-associated neurocognitive disorder (HAND) [1, 2]
HIV- related encephalopathy
neuropathy
neurosyphilis

[1] National Institute of Mental Health info: https://www.nimh.nih.gov/about/organization/dar/developmental-and-clinical-neuroscience-of-hiv-prevention-and-treatment-branch/clinical-neuroscience-of-hiv-infection-program

[NOTE: old NIMH web link not accessible. Additional link added below by OMB-GC/Ryan White Program]

[2] UCSF Weill Institute for Neurosciences:
https://memory.ucsf.edu/sites/memory.ucsf.edu/files/wysiwyg/UCSF_HIV%20Dementia_Providers_11-6-17.pdf

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NUTRITION:
lipodystrophy
wasting weight
gain weight
loss

ONCOLOGY:
Cancers-may include but not limited to: breast, eye (e.g., squamous cell carcinoma of the eye, etc.), lymphoma, polycythemia vera, prostate

IMPORTANT NOTE: the local Ryan White Part A/MAI Program is restricted to evaluation, diagnostics, and treatment in an outpatient setting.

OPHTHALMOLOGY/OPTOMETRY:

Clients must also meet at least one of these criteria to access ophthalmology/optometry services:

- ~~Client has a low CD4 count (at or less than 200 cells/mm^3)~~ *currently*

- Client has a comorbidity (e.g., diabetes, hypertension, STI, etc.)
- Client has a prior diagnosis of cytomegalovirus retinitis (CMV)
- Client has Immune Reconstitution Syndrome

Referrals to an optometrist or ophthalmologist must indicate a condition attempting to rule out complications of HIV. These conditions are related to or exacerbated by HIV, comorbidities related to HIV, or complications of HIV treatment. Any one of these conditions listed below would apply as examples.

Manifestations due to opportunistic infections:

- acute retinal necrosis
- bacterial retinitis
- candida endophthalmitis
- cryptococcus chorioretinitis
- cytomegalovirus retinitis
- pneumocystis choroiditis

Visual disturbances to rule out complication of HIV due to:

- cataracts
- dry eyes (sicca)
- glaucoma
- intra-retinal hemorrhages
- reactive arthritis
- trichomegaly or eyelash hypertrichosis (exaggerated growth of the eye lashes found in the later stages of the disease)
- uveitis

History of STI and complications of STI:

- herpes simplex virus
- herpes zoster-varicella visual changes
- syphilis

IMPORTANT NOTE: the local Ryan White Part A/MAI Program will only pay for evaluation, diagnostics and treatment for HIV-related eye problems/complications such as the examples listed above and will not pay for the filling of prescriptions for corrective lenses.

PODIATRY:

diabetic foot care foot
and ankle pain*
plantar fasciitis related to lipoatrophy and other known associated causes

**IMPORTANT NOTE: the local Ryan White Part A/MAI Program will only pay for evaluation, diagnosis, and treatment of foot and ankle pain for HIV related conditions or co-morbidities. Conditions such as hammer toes, bunions, and heel spurs may be covered if related to neuropathies. Sprains or fractures are not covered unless a direct connection to neuropathies is present.*

PSYCHIATRY:

mental health disorder caused or exacerbated by HIV diagnosis or HIV treatment

mental health disorder/condition that significantly hinders a client's HIV treatment adherence

IMPORTANT NOTE: Under Psychiatry, a Psychiatrist will assess, diagnose, and treat mental illness in an outpatient/ambulatory health care setting.

PULMONARY:
mycobacterium
pneumocystis pneumonia
recurrent pneumonia

PE ID#_____

PBC RW Part A/MAI Specialty Medical Care Referral

Date:_____Client Name:_____DOB: _____

_____

Specialty Service- Allowable Medical Condition Requested: ___ (drop down box)_____

Name of Specialist:_____Phone number: _____

Name of Referring Physician:_____Phone number: _____

Appointment Date/Time/Location:

_____

Type of Referral Requested: ☐ Initial ☐ Follow up ☐ Other (please specify): _____

Reason for Referral:

_____

_____

_____

Comments/special questions:

_____

_____

Attached: ☐ recent clinical encounters ☐ Imaging ☐ lab results ☐ other _____

By the signature below, as the ID Primary Care Provider, I certify that this referral falls under Specialty Medical Care and requires the services of a Medical Specialist.

_____

ID Primary Care Provider's Signature/stamp Date

Your evaluation and recommendations are appreciated. Please send your consult report to the referring physician at this address or fax number:

Created 11/1/18; Revised 3/1/2024