Palm Beach County Ryan White Part A Eligibility Procedures Manual

2013

Palm Beach County

Department of Community Services

Ryan White Part A Grantee Program

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ACKNOWLEDGEMENTS

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SECTION 1: General Information

As per Chapter 64D-4 Florida Administrative Code (F.A.C.), Eligibility Requirements for HIV/AIDS patient care programs, this manual standardizes the eligibility requirements for all programs funded through the HIV/AIDS and Hepatitis Program and Ryan White Part A Grantee in Palm Beach County. These procedures can be used in both centralized and non-centralized eligibility determination systems.

Purpose	The purpose of the patient care programs within the HIV/AIDS and Hepatitis Program is to provide primary health care and support services to low-income persons living with HIV disease based on availability, accessibility and funding. The patient care programs are responsible for ensuring services are provided to those intended by establishing eligibility requirements and procedures that will be fairly applied to all who request eligibility for services.
Goal	• To provide a standardized system of core eligibility across HIV/AIDS patient care programs. • To prevent duplication of effort.
Staff Procedures Manual	When determining eligibility, this manual: • Provides eligibility staff with standardized procedures and forms • Ensures persons requesting services from the patient care programs have been appropriately determined eligible or ineligible • Applies only to the patient care programs under the Ryan White Part A program, in conjunction with Chapter 64D-4, F.A.C. • Does not preclude local, state or federal programs from adopting the requirements and procedures referenced in this document. The information in this manual replaces the eligibility requirement determination procedures established by the individual programs. Programmatic qualifications and requirements can be found in each program's respective manual or guidelines.
Statutory and Programmatic Authority	The statutory authority for the HIV/AIDS and Hepatitis Program eligibility requirements, process, and procedures is stated in Chapter 381, Florida Statutes (F.S.), and Chapter 64D-4, F.A.C., hereinafter referred to as the "eligibility rule." This manual is developed in conjunction with the statute and the eligibility rule requirements, as well as Palm Beach County Ryan

White Part A eligibility requirements.

HIV/AIDS patient care programs include the following:

- Ryan White Part B Consortia Program.
- Ryan White Part B AIDS Drug Assistance Program (ADAP).
- Ryan White Part B ADAP Premium Plus Insurance.
- State Housing Opportunities for Persons with AIDS (HOPWA) Program.
- Patient Care Networks (PCN) and County Health Departments (CHD).

Not included under the eligibility rule authority are the HIV/AIDS services provided by other local, state, or federal HIV/AIDS patient care programs such as:

- Ryan White Part A (Eligible Metropolitan Areas).
- Ryan White Part C.
- Ryan White Part D.
- Ryan White Part F.
- Medicaid, Project AIDS Care (PAC) Waiver and Medicare.
- City HOPWA.
- Local indigent programs.

For the purpose of this Manual, Part A is included under these requirements.

Florida Statutes

Chapter 381, F.S., Public Health. This statute requires the DOH to be responsible for the state's public health system which shall be designed to promote, protect, and improve the health of all people in the state. Chapter 381, F.S. is often referred to as Florida's Public Health Law, which provides the statutory authority for the DOH HIV/AIDS and Hepatitis Program, to establish the eligibility requirements and procedures developed through the administrative rulemaking process for the HIV/AIDS patient care programs.

Ryan White Part A in Palm Beach County has elected to adopt this statute as a baseline for local eligibility requirements.

HIV/AIDS

- Section 381.0042, F.S. - Patient Care for Persons with Human Immunodeficiency Virus Infection. This section provides the authority for the DOH to establish HIV patient care networks to plan for the care and treatment of persons with HIV/AIDS.

- Section 381.0037, F.S. - This section is specific to HIV/AIDS, and addresses the unique nature of the disease by establishing programs and requirements related to HIV/AIDS. Care and treatment programs must balance medical necessity, the right to privacy, and protection of the public from harm.

Florida

Chapter 64D-4, F.A.C., Eligibility Requirements for HIV/AIDS Patient Care

Administrative Code (F.A.C.)

Programs, is the "eligibility rule" for the patient care programs and was developed through a process that included statewide input, workshops, public hearings, and notification to the affected parties. An administrative rule or code is a legal binding document based on statutory authority. The eligibility rule can be found at the following link.
https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64D-4
The eligibility rule states the following:

- Purpose.
- Eligibility definitions.
- Documentation requirements.
- Provisions for determining and re-determining eligibility or ineligibility, and
- Applicant and eligibility staff's rights and responsibilities.

It is important that all staff read 64D-4 in its entirety.

State/Federal Laws/Regulations

Other laws and regulations affecting the patient care programs under the DOH, HIV/AIDS and Hepatitis Program, include the Ryan White Treatment Extension Act of 2009 and the AIDS Housing Opportunity Act (AHOA).

Allowable Services (Attachment A)

- The HIV/AIDS patient care programs and Ryan White Part A are eligibility programs, and not entitlement programs such as Medicaid; therefore, the services provided by these programs are subject to accessibility, availability, and funding statewide.   Local areas have the authority to determine funding priorities, allocations, and limitations. Consequently, services vary widely across the state.
- The services provided are listed in the current federal Glossary of Services as referenced by the Health Resources and Services Administration (HRSA) and the DOH, HIV/AIDS and Hepatitis Program, and Ryan White Part A (refer to Attachment A).

Please Note: Eligibility is a prerequisite for enrollment in the specialty programs of ADAP, ADAP Premium Plus Insurance or State HOPWA; however, there are program-specific qualifications and requirements.

SECTION 2: Confidentiality

Staff must take prudent and reasonable steps to protect applicant/client confidential information. This section provides minimum criteria regarding the security of records and the management of confidential information.

Authority	Section 384.29, 392.65, and 455.667, Florida Statutes, Health Insurance Portability and Accountability Act (HIPAA).
	This section provides the minimum criteria regarding security of records and the management of confidential information. Florida Statutes, Florida Administrative Code, and HIPAA are the guiding authorities for the DOH security policies.
	The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirement of HIPAA. The Privacy Rule addresses the use and disclosure of individuals' health information (called "protected health information") by organizations subject to the Privacy Rule (called "covered entities"). The rule also ensures that individuals understand and control how their health information is used.
Policy and Procedure	All written and verbal communications with applicants during and after eligibility must be maintained in strict confidence as required by law. These procedures are the same for eligibility and case management agencies.
	The Palm Beach County Grantee has a written policy for the Eligibility Determination Staff. The DOH has written security policies, protocols and procedures to ensure the security of information, and to protect confidentiality, data integrity, and access to information in accordance with the Florida Statutes.

- For Palm Beach County Part A, these policies are included in the Coordinated Services Network (CSN) form.
- These policies are entitled "Information Security Policy DOHP 50-10-07."
- Contracted and subcontracted providers for DOH HIV/AIDS programs may create their own security policies, protocols, and procedures; however, they must be consistent with the DOHP 50-10-07.
- All employees and volunteers with access to client information must receive annual training on confidentiality, the proper exchange of information, and required consent. Documentation of training must be maintained in personnel records.

Forms

The following forms were developed by the DOH for the purpose of securing confidential information. Providers are <u>not required</u> to use the following DOH forms; therefore Part A has developed similar forms consistent with HIPAA and HIV laws.

DH 1120 Computer Use and Confidentiality Agreement

DH 3204 Initiation of Services

Notice of Privacy Practices

DH 3203 Authorization to Disclose Confidential Information

DH 2116 Client Consent for Fax – OPTIONAL

Palm Beach County Part A has developed a Coordinated Services Network (CSN) form that is required in place of the DOH forms- DH 1120, DH 3204, Notice of Privacy, DH 3203, and DH 2116. (Attachment B)

Phone Calls

All telephone calls in which confidential information is discussed must be made from an area that ensures confidentiality is maintained.
- Cell phones and BlackBerry devices are not considered secure and should not be used for confidential phone calls unless the client consents.
- Cell phone calls regarding confidential information must be limited to the minimum information.
- The call recipient must be informed the call is taking place on a cell phone.
- The employee must determine the identification of the caller and what information may be disclosed.

Mailing

A secured mail intake site must be used to receive incoming confidential information.
- Mailrooms and mailboxes must be secured to prevent unauthorized access to incoming and outgoing mail.
- Double-enveloping is required for mailing confidential information. The outside envelope is addressed to the recipient. The inside envelope specifies "Confidential" and the recipient's name.

Faxes

Confidential information may be faxed in a medical emergency or with the written consent of the client.
- Fax machine must be in a secured area.
- Fax cover sheets must have the appropriate language and state

"Confidential." This language should state, ***"This transmission may contain material that is confidential under Federal law and Florida Statutes and is intended to be delivered to only the named addressee. Unauthorized use of this information may be a violation of criminal statutes. If this information is received by anyone other than the named addressee, the recipient shall immediately notify the sender at the address or telephone number above and obtain instructions as to the disposal thereof. Under no circumstances shall the material be shared, retained or copied by anyone other than the named addressee."***

- Medical information that is faxed must have a permanent copy in the record and documentation in the progress notes.

Email
- Per the DOH policy, email to a client is not allowable.
- Clients should be informed that email is not secure, especially from a CHD where all emails are considered public record for three years.
- Email as a method of communication is at the discretion of each agency regardless of a consent form. The agency's policies and procedures manual should provide guidance on agency specific limitations regarding email.
- CHD's are not allowed to email clients.
- This is covered in the Part A required CSN form.

Field Security

Job descriptions must document the authority to transport confidential information into the field. In addition:
- All confidential information taken into the field must be tracked, including who, what, when, why, where, and expected date of return.
- Information taken into the field is limited to what is needed to perform responsibilities.
- Prior permission must be obtained if information is not to be returned by close of business.
- Information must be safeguarded from unauthorized access.

Work Space
- Eligibility staff must be provided with office space that allows business to be conducted in a timely and confidential manner.
- If private office space with a door is not available, the provider must ensure all communications remain confidential.

Storage
- Offices and staff must maintain confidentiality of all data, files, and records, including client records related to the services: and shall comply with state and federal laws, including, but not limited to, sections 384.29,

392.65, and 455.667, F.S.
- Appropriate storage systems for hard copy client records are required.
- Storage systems include, at a minimum, file folders that are kept in locked file cabinets.

Client File Retention

- File retention must follow the Department of State, Bureau of Archives and Records Management, storage and disposition procedures as mandated in Chapters 119 and 257, F.S.
- File retention schedule for agencies contracted with Part A Grantee and the DOH is six years from the date of termination of a provider (contract) with Part A Grantee and the DOH or closure of the file.
- Upon completion or termination of the contract, the provider will cooperate with the department to facilitate the duplication and transfer of any said records or documents during the required retention period.
- In the event that a client file is closed, the file is retained at the agency for the minimum six years before disposing of said record.
- Documents must be shredded.

Electronic Files and Computers

The use of electronic files to gather and collect client information requires specific precautions to avoid a breach of confidentiality and protect the client's right to privacy. DOHP 50-10-07 includes, but is not limited to, the following guidance concerning electronic files and information:
- Computer monitors must be positioned to prevent unauthorized viewing.
- All computers, including laptops, that access and store confidential information must be password protected, and the data must be encrypted in accordance with DOH Information Security policies, protocols, and procedures.
- Laptops may be used for storing and accessing HIV/AIDS information with client identifiers if they adhere to the specific requirements in DOHP 50-10-07.
- Laptops containing confidential information must be returned to the secured area at the end of the working day, and never stored in an unsecured, unauthorized area. This directive includes storing laptops in the employee's car, car trunk, or home unless there is prior supervisory approval.
- Deleting files from a computer hard drive is not necessarily sufficient if the computer is to be stored. Hard drives must be wiped clean. If you are unsure how to do this or what it means, consult with your Information Technology staff.

Additional Information

- Agencies need to document that positions have "need to know" access in their written job descriptions.
- Unauthorized persons shall not be left unattended in areas where confidential or sensitive information is maintained.
- All visitors must sign in on a security log.

SECTION 3: Eligibility Personnel

This section describes personnel activities, responsibilities, training and documentation required for eligibility staff.

Eligibility Staff	Eligibility staff is authorized by the Ryan White Part A program and the DOH to determine eligibility for the HIV/AIDS patient care programs (including Part A services), and must have strong administrative, interviewing, and communication skills to ensure an applicant has been appropriately determined eligible or ineligible.
Supervisory Oversight	All eligibility staff must have an immediate supervisor for oversight of the eligibility process. Eligibility staff must have access to supervisors to ensure the final determination is fairly completed in accordance with the established procedures.

Supervisor Responsibilities

Supervisor responsibilities include, but are not limited to:

- Provide oversight to the overall eligibility process, including exception requests.
- Provide an interim supervisor when on leave or when a position is vacant.
- Monitor staff performance, and complete annual performance evaluations.

Staff Responsibilities

Responsibilities of eligibility staff include, but are not limited to:

- Determine and re-determine eligibility in conjunction with this manual and Chapter 64D-4 F.A.C.
- Maintain orderly files, document all activities relating to the eligibility process and provide accurate information.
- Provide referrals for services as appropriate.
- Have knowledge of federal, state and other local programs in order to refer clients.

PLEASE NOTE: Many CHDs and case management agencies have blended staff responsibilities to include eligibility and case management for more than one program. All staff completing eligibility must follow the established procedures in this manual, regardless of other roles.

Training Requirements

Eligibility staff, <u>including supervisors</u>, must complete the local Eligibility training as well as the DOH "Core Eligibility Training." A Certificate of Attendance must be maintained in the personnel file. DOH training schedules are posted on the Section of HIV/AIDS and Hepatitis web page. Trainings are conducted via WebEx. To register, go to the following link.

http://www.doh.state.fl.us/Disease_ctrl/aids/care/Core_Eligibility_Pre.html

Local Eligibility training will be scheduled by the Part A Grantee office.

SECTION 4: Eligibility Requirements

Following are the eligibility requirements for all clients seeking services for Ryan White Part A and the HIV/AIDS programs under Chapter 64D-4 F.A.C., including Consortia, ADAP, ADAP Premium Plus Insurance, and State HOPWA.

Who May Apply for Services	Any individual seeking services or their court appointed representative, legal representative, or legal guardian may apply for services.
Minors Seeking Services	Minors (13 years or older) may receive HIV/AIDS services without parental consent or notification in accordance with Chapter 384.30, F.S.
Eligibility Requirements	The following are the requirements that must be met for al clients seeking services under Ryan White Part A. • Proof of HIV. • Living in Palm Beach County. • Not participating in local, state, or federal programs where the same types of services are provided or available. This means a client can not have duplication in services. • Low-income which means a gross income less than or equal to four hundred percent (400%) of the Federal Poverty Level (FPL). Or lower according to the local Part A Eligibility Grid. • Willingness to cooperate and provide truthful information. Additional information regarding each program requirement can be found under the individual tabs.

SECTION 5: Eligibility Brochure/Application

The Application and Eligibility Requirements, #DH 150-884, is the official application for patient care services that is incorporated by reference in the eligibility rule. (Attachment C)

The applications are available at every CHD, and can be made available at other local venues such as lead agencies, case management agencies, and community-based organizations. The back of the application provides space for local addresses and phone numbers.

Brochure

The brochure is in a question and answer format and provides the following information:
- Eligibility requirements.
- Eligibility process.
- Programs and services covered and not covered.
- Rights and responsibilities.
- Enrollment requirements for Part B, ADAP, ADAP Premium Plus Insurance, and HOPWA.
- Client's recourse if determined ineligible.

Application

The Application to Receive Allowable Services for HIV/AIDS Patient Care Programs is divided into the following sections:
- Applicant Information.
- Living Arrangement.
- Medicaid Insurance and Other Programs.
- Household Monthly Income.
- Rights and Responsibilities.
- Last Section "For Eligibility Staff Only".

Rights and Responsibilities

- A client must be willing to cooperate during the eligibility process by signing and complying with all of the rights and responsibilities.
- The client must initial next to each bullet of the rights and responsibilities.
- If the client will not sign the application, staff must not proceed with the eligibility determination process.

Applicants' Rights

The rights and responsibilities are:
- To complete (to the best of their ability) and submit an application.
- Obtain and submit the required documentation for determination.
- Request assistance if needed.
- Be truthful and cooperative with eligibility staff.
- Acknowledge the rights and responsibilities as listed on the application, and confirm signature.

Frequency

- Completion of application is only required <u>once</u> upon initial enrollment unless the client's file has been closed for more than one a year.
- An additional application must be completed if a client has not received services in excess of one year.

Interpreters/ Illiteracy/ Illness

- The brochure portion is available in English, Spanish and Creole with the connecting application portion in English only.
- Eligibility providers should be available to assist persons unable to read and eligibility offices are responsible for obtaining interpreters as needed.

CAREWare

- The application must be completed, signed by the client, and scanned into CAREWare.
- This is done once unless the client file is closed for one year or more, then a new application should be completed.

SECTION 6: New Enrollment and Re-Determination

This section describes the activities for initial determination of a new applicant and re-determination every six months or sooner as necessary.

New Enrollment

A new client's first contact with the eligibility office or process may be:
- The application itself, which is available at CHD's and local HIV/AIDS community-based organizations.
- A referral from another social service program.
- A referral from the AIDS Hotline 1-800-FLA-AIDS (1-800-352-2437).
- An inquiry by mail or telephone.
- A walk-in to the eligibility office.
- A referral from a friend or another client.

Application Requirement

The eligibility staff member must have a face-to-face encounter with the applicant to process the enrollment. Certain circumstances may prevent face-to-face contact, and must be documented in the client's file with supervisory approval.

Initial Contact

Initial contact procedures may vary among eligibility providers, but each should include knowledgeable staff to provide the following minimum information:
- Eligibility requirements as stated in the brochure #DH150-884.
- Where to obtain the brochure/application.
- Policies regarding walk-ins.
- Application options to complete prior to or during the face-to-face eligibility interview with or without staff assistance.
- The services available from programs under 64D-4, F.A.C. and the local Part A.
- Time limits.

The application (Attachment C) requests general information from the client that may be obtained during the initial contact.
- Eligibility providers may have their own initial contact information sheet and procedures for obtaining initial information that can serve as a pre-screening tool for an eligibility office.
- Confidentiality issues could be a factor if other individuals in the client's household are unaware of the client's HIV status. It is very important to contact a client only in the manner instructed in Part 2 of the application.
- Not all eligibility inquiries will result in the client initiating the eligibility

process.

Time Limits

The eligibility rule establishes a time standard for processing the application.
- The application must be processed and a determination of eligibility made within 30 days from the date the application was received/dated.
- Mail-in applications are dated when received at the eligibility provider.
- Walk-in clients who submit a completed or partially completed application will have their application dated the same day.
- The time limit can be extended, with supervisory approval and documentation, if the requested information has not been received and delays the 30 days time standard.

Eligibility Staff Assessment Worksheet (Attachment D)

The Eligibility Staff Assessment Worksheet (Attachment D) is **required** for all <u>initial</u> determinations. The form must be:
- Included in each client's eligibility file or established client record.
- Used to ensure all eligibility requirements are included and are presented in the same chronological order as required.
- The local RW Part A requires Eligibility staff to use the Grantee Intake tool to complete clients' initial and re-determinations.

Required Documentation In Eligibility Chart

The following documentation must be included in the file and scanned into CAREWare under the Unique ID tab, attachment hyperlink. Please reference the Scanned Documents List (Attachment L) for allowable documents of each requirement:
- Eligibility application signed and dated by client (original).
- Proof of HIV.
- Proof of living in Palm Beach County.
- Documentation of income.
- Copies of any third party insurance card and/or policy (Medicaid, private insurance, etc.).
- Releases and consents signed by the client (CSN form).
- Clients Social Security card.
- Printout from the Grantee Intake tool stating Eligibility and other payer sources.

The following FORMS must be completed in CAREWare under the forms tab:
- Eligibility Staff Assessment Worksheet (initial enrollment only).
- Six Month Recertification Form (ONE every six months).
- Notice of Eligibility or Ineligibility, every six months (once completed, form must be printed, signed, and scanned into the Unique ID tab).
- Health Insurance Waiver Form (if applicable).

Re-Determination (Attachment E)	• Clients must be re-determined for eligibility at least <u>every six months</u> or sooner if circumstances have changed. • Clients will need to provide current information, especially as it relates to changes in income. • Eligibility staff must use the Six Month Re-Certification (Attachment E) to complete re-certification. • Information already in the file that has not changed does not need to be collected again.
Appointment Reminders	Eligibility providers are encouraged to provide appointment reminders for clients at least two weeks prior to the scheduled re-determination time. Each funded agency is required to have a written policy on an appointment reminder process.
Location of Eligibility File	• Only one eligibility/re-determination file per client is required. • A list of agencies responsible for eligibility and re-determination must be provided to the Program Manager, made available to all area providers, and updated as needed. • All Eligibility files are to be kept in the Grantee's client database (CareWare).

SECTION 7: Proof of HIV

An applicant is required to have documentation of a medical diagnosis of HIV disease with a labortatory test documenting confirmed HIV infection for their initial determination of eligibility.

Acceptable Proof	One of the following documents is considered acceptable proof: • A positive HIV antibody test result (Reactive IA/EIA/ELISA screening test) confirmed by Western Blot, Immunofluorescense Assay (IFA), Nucleic Acid Testing (Aptima), or Multi Spot by blood or oral fluid. • A positive HIV direct viral test such as PCR or P24 antigen. • A detectable HIV viral load (undetectable viral load tests are NOT proof of HIV). • A viral resistance test result. • A Project AIDS Care (PAC) Physician's Referral Form. • 4th Generation testing.
Use of PRISM	• PRISM (Patient Reporting, Investigation, and Surveillance Manager) is a web-based application used by the Sexually Transmitted Disease Program. • PRISM has been designed to receive electronic lab results from the public labs of the State of Florida. • Lab results from PRISM are considered acceptable documentation for proof of HIV, when presented by an applicant/client.
Exposed Infants	• Exposed infants of HIV-positive mothers can be served with documentation of the mother's HIV-positive status up to the age of 12 months. • Children 12 months or older must meet the same criteria for proof of HIV as listed above to continue services.
Not Acceptable Proof	The following are considered not acceptable proof: • A physician's or nurse's statement of HIV-positive status on a prescription or letterhead. • OraQuick. • Anonymous test results or a test result with the name missing. • An undetectable viral load test.

CAREWare Documentation

- Proof of HIV must be scanned and attached under the Unique ID tab, attachment hyperlink.
- Document must have an identifying name; use drop down box to select "Proof of HIV."
- The comment box is not required but is encouraged if needed.
- Proof of HIV only needs to be collected and scanned during the initial enrollment.

SECTION 8: Living in Palm Beach County

A client must be living in Palm Beach County (PBC).

Living in PBC Definition	• For purposes of eligibility, living in PBC refers to clients who make PBC their home.
	• A specific number of weeks or months in PBC are not required to be considered as living in PBC; however, a client's intent to remain in PBC is of interest, particularly for medical and treatment services.
	• Clients can have unusual circumstances, such as the unpredictability of migrant work, that require consideration.

Documentation

Documentation to verify a client's identification include:

One Photo Identification is not required, but encouraged (photo identification can be an old document if you are using it just to show photo identification; it must be current if you are also using it to show current living status.) This can include:

- Driver's license.
- Passport.
- School identification.
- Other state or local Florida photo identification.
- US Visa (immigrant and non –immigrant).

Other forms of client identification to show current proof of living in PBC may include, but are not limited to:

- Utility bill, with name and address.
- Housing, rent/mortgage agreement in client's name.
- Receipt of payment of rent with name, address, and signature of landlord.
- Recent school records.
- Letter from person with whom the client resides.
- Homeless shelter/social service agency letter signed by staff.
- Property tax receipt or W-2 form for previous year.
- Unemployment document with address.
- Current voter registration card.
- Prison records (if recently released).
- Current documentation from FLMMIS or MEVSNET with client's address.
- Department of Corrections offender search website photo print out.

- Current and valid proof of receiving Health Care District services.
- Recent postmarked letter mailed to the client at that address.

Photo identification should not be considered the only form of proof of living in PBC, especially if it is not current.

Homeless

Documentation can include:
- A statement from the shelter in which the client resides.
- Physical observation from eligibility. A written statement from the client (assistance can be provided from the eligibility staff) describing living circumstances that is signed and dated by the client.
- A statement from a social service agency or other applicable person attesting to the homeless status of the client.
- If the client does not have a living address (such as a shelter address) enter in CAREWare as "Homeless" with the city name and zip code (if available).

Immigration Status

- Citizenship of the United States and immigration status are not required as a condition of eligibility.
- Clients who are undocumented aliens do not have Social Security numbers and are identified using alternate pseudo numbers.
- Eligibility providers are not required to report undocumented aliens to the Immigration and Naturalization Services (INS).

Use of Social Security Number

A Social Security number is required for eligibility determination. If documenting a pseudo social security number, this can only be done under the following circumstances:
- Undocumented aliens.
- Non-citizen residents who do not have a Social Security number.
- Children 12 months or under whom do not have a Social Security number.

Creating Pseudo Identification Numbers

If staff must create a pseudo social security number, they must use the following format for consistency among all programs and enter it in the appropriate CAREWare field :
- First letter of client's first name, followed by
- First letter of client's middle name or "X" for persons with no middle name, followed by
- First letter of client's last name, followed by
- Client's six digit date of birth using the format (MM-DD-YY)

Example: If a client's name is <u>Joe Edward Smith</u> and he was born <u>October 5, 1945</u>, his alternate pseudo number would be <u>JES100545</u>.

**CAREWare
Instructions**

- Proof of living in PBC must be scanned and attached under the Unique ID tab, attachment hyperlink.
- Document must have an identifying name; use drop down box to select "Proof of Living in Florida."
- The comment box is not required but encouraged, especially if there is one type of document being used for various types of proof.

SECTION 9: Screening for Other Programs

Screening for other available programs is a required step in the eligibility process. Determining whether an applicant/client is already participating in local, state, or federal programs is necessary to eliminate duplication of services and adhere to federal requirements associated with the funding of the programs. This section provides information relating to specific circumstances that may arise during the applicant interview for this requirement.

Payer of Last Resort

A client may not be eligible for services from the Ryan White Part A or the HIV/AIDS patient care programs if the client is already receiving or is eligible for the same benefits/services from other programs. The services provided by Ryan White Part A, B, and the other HIV patient care programs may be used for HIV-related services only when no other source of payment exists.

A client may not access Ryan White Part A or other HIV/AIDS patient care programs when the client is receiving or is eligible to receive services in another local, state, or federal program. This requirement does not preclude an individual from receiving allowable services not provided by other local, state, or federal programs or pending a determination of eligibility from these other programs.

In order to ensure Ryan White Part A or other HIV/AIDS patient care programs are the payers of last resort, eligibility providers are required to print proof, at a minimum, from FLMMIS/Florida Access/Other Payers, which shows a client is not eligible for such services.

NOTE: Payer of last resort includes after Medicaid payment.

Exception: HRSA has allowed an exception for those persons able to access services under the Florida Department of Veterans Affairs (VA). See further details under the section regarding VA below.

Most Common Programs

Eligibility providers must be familiar with the other federal, state, and local assistance programs providing HIV/AIDS services for persons in PBC. A brief description of some common programs follows.

Medicaid

Medicaid is a state and federally-funded entitlement program. The Department of Children and Families (DCF) and/or the Social Security Administration (SSA) determine Medicaid recipient eligibility. Individuals who might be eligible for Medicaid include:

- Single parent household with children under age 18.

- Two parent household unemployed or underemployed.
- Disabled individuals as determined by the SSA or DCF.

Clients who are Medicaid eligible will not be eligible for Ryan White Part A or HIV/AIDS patient care programs where the same service is covered by Medicaid. Eligibility providers must have access to Florida Medicaid Management Information System (FLMMIS) or another Medicaid access program in order to verify current Medicaid enrollment. **This is a requirement**.

A copy of Medicaid eligibility must be scanned into CAREWare every six months for those currently on Medicaid to show current Medicaid status.

Medicaid Screening

All individuals potentially eligible for Medicaid benefits and not currently accessing some form of insurance **must** be prescreened for Medicaid eligibility using the Medicaid pre-screening tool.

Procedure for Prescreening Clients
1. Visit the following link: http://www.myflorida.com/accessflorida/
2. Click on "Medicaid Pre-Screening" link.
3. Complete the form and click the "Continue" button.
4. Verify the information and click the "Continue" button.

If the Medicaid prescreening tool determines the client is possibly eligible for Medicaid services, the client **must** apply for Medicaid. The form must be printed, the client's name and date of screening must be written on the form, and the documents must be scanned into CAREWare.

Clients who are deemed ineligible based on the prescreening also must have the form printed; the client's name and date of screening must be written on the form, and the document scanned into CAREWare.

Medically Needy (Share of Cost Medicaid)

- This program provides Share of Cost Medicaid for persons with high medical bills but whose income is too high to qualify for traditional Medicaid.
- DCF determines eligibility.
- Share of cost is based on the family's monthly income.
- To find additional information about this program visit http://www.dcf.state.fl.us/programs/access/medicaid.shtml#n.

Types of Medicaid

- Medicaid Qualified Medicare Beneficiary (QMB) – individuals who are eligible to have Medicaid pay for Medicare premiums (Parts A and B),

Medicare deductibles, and Medicare coinsurance within limits.

- Medicaid Special Low Income Medicare Beneficiaries (SLMB) – individuals eligible to have Medicaid pay Medicare directly for Medicare Part B premiums
- MEDS for Aged and Disabled (MEDS-AD) – entitles a limited group of aged or disabled individuals to receive full Medicaid coverage. A client must meet the requirements, and must NOT have Medicare Part A or B

**Medicare
Parts A, B and C**

- Medicare is a federally funded entitlement program administered by the Centers for Medicare and Medicaid Services (CMS).
- Health insurance for people aged 65 or older, under age 65 with certain disabilities and at any age with end-stage renal disease.
- Persons with disabilities are eligible for Medicare after two years of being determined disabled by the SSA.
- Most people receive Medicare health coverage in one of two ways: an original Medicare plan (Part A Hospital Insurance or Part B Medical Insurance), or a Medicare Advantage Plan, (sometimes referred to as Part C or MA Plans.) Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).
- Costs vary depending on the plan, coverage, and services used.
- Individuals who are eligible for Medicare must enroll in all coverage that is available.
- Additional information on Medicare can be found at http://www.medicare.gov/default.aspx

Medicare Part D

- Part D is prescription drug coverage for Medicare Part A and B recipients.
- Clients eligible to receive Part D must apply through the SSA in order to be eligible for HIV/AIDS patient care programs.
- Part D recipients are required to select a drug plan.
- Monthly premium costs vary depending on the plan selected.
- There are two ways to get Medicare prescription drug coverage:
  o Join a Medicare prescription drug plan that adds drug coverage to the original Medicare plan; or
  o Join a Medicare plan (like an HMO) that includes prescription drug coverage as part of the plan.
- Clients accessing Part D do not need to spend down pharmaceutical benefits prior to enrolling in ADAP; however, clients must apply for the Medicare Part D Low Income Subsidy.
- Additional information can be found at http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx

**Medicare Part D
Low Income
Subsidy
(Extra Help)**

Dual Eligible Clients:
- Have Medicaid and Medicare, and qualify for the Low-Income Subsidy (LIS) automatically. They do not need to apply.
- Must enroll in a Medicare Part D plan.
- Can switch plans every month; however, this is discouraged as it takes several weeks for the information to be finalized, and clients may have challenges accessing medications during this time.

Non Dual Eligible Clients
- Have Medicare only.
- MUST apply for the LIS, and be determined eligible or receive a denial letter.

Clients Eligible for LIS
- Must apply for a Medicare Part D Plan.
- May be enrolled in ADAP and will receive an information packet about the Pharmacy Benefits Manager. Access to drugs from the ADAP formulary will be through a local CVS or CVS Caremark.

Clients NOT Eligible for LIS
- If income is greater than 150% of the FPL, will most likely fall in the "donut hole" and not be eligible for LIS.
- Must meet the asset requirements for Medicare Part D, apply for the LIS and receive a denial letter.
- May apply for an ADAP waiver. Proof of LIS denial is a requirement.
- May be enrolled in ADAP, and will receive an information packet about the Pharmacy Benefits Manager. Access to drugs from the ADAP formulary will be through a local CVS or CVS Caremark.
- Must also enroll in a Medicare Part D plan for all non-ADAP medications.

**Patient Assistance
Program (PAP)**

A PAP provides for electronic claims adjudication and electronic payment of client cost-sharing such as co-pays and deductibles for prescription drug coverage available through an insurance plan.

- Patient Assistance Programs are available through pharmaceutical companies to provide access to free medications to people with limited income.
- Qualification guidelines vary among pharmaceutical companies.
- The following link has a list of all PAPs and information regarding criteria:
  http://www.doh.state.fl.us/Disease_ctrl/aids/care/waiting_list.html

Using the link above, click on "Comprehensive Cost Containment Guidance."

Pharmacy Benefits Manager (PBM)

- Medicare beneficiaries who have limited income and resources may qualify for extra help or LIS to pay for prescription drugs costs.
- Clients eligible for LIS will receive assistance paying monthly premiums, yearly deductibles, prescription coinsurance and co-payments and no gap in coverage
- Some people are automatically eligible for LIS: full benefit dually eligible clients (Medicaid and Medicare); SSI recipients with Medicare; and Medicare Savings Programs participants.
- Some people must apply through SSA. https://secure.ssa.gov/i1020/start

Medicare-eligible clients in need of TrOOP assistance for ADAP medications and meet the ADAP program qualifications are enrolled into ADAP Premium Plus Insurance and receive their ADAP medications through a network of retail or mail-order pharmacies.

ADAP Program Qualifications for Medicare-eligible clients:
- Must meet core eligibility requirements
- Must meet ADAP program qualifications.
- Must have and stay enrolled in a Medicare Part D plan.
- If eligible for LIS, applicants must apply for LIS.

Application Process:
- Apply for core eligibility.
- Contact your local County Health Department and speak with an ADAP staff member to schedule your client an ADAP appointment; or call the Florida HIV/AIDS Hotline:
  English: 1-800-352-2437 (1-800-FLA-AIDS)
  Espanol: 1-800-545-7432 (1-800-545-SIDA)
  Kreyol: 1-800-2437-101 (1-800-AIDS-101)
  TTY: 1-888-503-7118
- Work with your ADAP office for program eligibility determination.
- Re-determination must be completed every six months.

Expanded Access Program (EAP)

- EAP refers to the use of investigational drugs outside of a clinical trial by patients with serious or life-threatening conditions who do not meet the enrollment criteria for the clinical trial in progress. The Food and Drug Administration (FDA) has established medical criteria for enrollment. The drugs are provided free of charge and are only available to patients through participating physicians.
- Clients seeking assistance through EAP's should communicate with their physician.
- For more information visit http://www.aidsinfo.nih.gov/default.aspx

Clinical Trials
- Clinical trials are research studies that follow pre-defined protocols.
- Guidelines for all clinical trials can be researched at: http://www.aidsinfo.nih.gov/default.aspx, (click on the link for clinical trials) There is additional information at http://clinicaltrials.gov/

Medicaid Project AIDS Care (PAC) Waiver Program
- PAC Waiver program is a home and community-based program including a wide range of authorized services for clients.
- Clients must have a medical diagnosis of AIDS and be determined disabled according to the SSA (or in the process of applying for or appealing disability decision), and have income less than 200% of FPL.
- All clients participating in the PAC Waiver Program must have a case manager.
- PAC case managers are the primary and lead case managers and are responsible for accessing Ryan White Part B or other services.

Prescription Discount Card Program
- This plan is not insurance; it is a prescription discount program provided by various pharmaceutical companies.
- The card provides immediate discounts at the pharmacy. Upon presenting your card to the pharmacist, clients will pay the lower of a discounted price or the pharmacy's regular retail price.
- There are no claim forms to fill out, and no limit to the number of times client's can use the card. These discounts are available only at participating retail pharmacies.
- Apply online at http://www2.caremark.com/naco/index.htm

Temporary Assistance To Needy Families (TANF)
- The purpose of TANF, previously called Aid to Families with Dependent Children (AFDC), is to:
  - Provide assistance to needy families with children so that they can live in their own home or the homes of relatives;
  - End the dependency of needy parents on government benefits through work, job preparation, and marriage;
  - Reduce the incidence of out-of-wedlock pregnancies; and
  - Promote the formation and maintenance of two-parent families.

- Clients can apply for TANF through the Florida Department of Children and Families.
- Visit the following link for more information http://www.tanf.us/florida.html

Supplemental Nutritional
- Food stamp benefits are intended to supplement other household income and may only be used to purchase food. Other household items

Assistance Program (SNAP), previously Food Stamps

such as cleaning supplies, paper goods, clothes, and alcohol or tobacco products may not be purchased with SNAP benefits.

- To receive SNAP benefits, a household must meet certain conditions. Everyone in the household who is applying must have or apply for a Social Security number and be a U.S. citizen, U.S. national or have status as a qualified alien (documented alien with a green card).
- All those applying for or receiving Supplemental Security Income (SSI) payments, must take or send their food stamp applications to the local food stamp office or to any Social Security office where a food stamp representative works or online at ACCESS Florida.
- When interviewed, a client should have:
  - Identification such as a driver's license, state identification, birth certificate, or alien card;
  - Proof of income such as pay stubs, Social Security, SSI, or a pension for each member of your household;
  - Proof of how much you spend for child care;
  - Rent receipts or proof of your mortgage payments;
  - Records of your utility costs; and
  - Medical bills for those members of your household age 60 or older and for those who receive government payments such as Social Security or SSI because they are disabled.
- Visit the following link for more information http://www.dcf.state.fl.us/programs/access/

Veterans Affairs (VA)

- The VA is a state agency created to assist all former members of the Armed Forces of the United States and their dependents in preparing claims for and securing compensation, hospitalization and other medical benefits for eligible persons.
- Veterans will be issued documentation of VA eligibility or denial.
- Enrollment in VA services is not required in order to be eligible for patient care services funded by the Ryan White Part A or HIV/AIDS and Hepatitis Program. However, VA services provide comprehensive health care coverage for veterans while the Ryan White Part A or HIV/AIDS and Hepatitis Program only provides coverage for HIV-related services.

Children's Medical Services (CMS)

- The CMS program provides children with special health care needs with a family centered, managed system of care.
- Children with special health care needs are those children under age 21 whose serious or chronic physical, developmental, behavioral, or emotional conditions require extensive preventive and maintenance care beyond that required by typically healthy children.
- CMS provides a comprehensive continuum of medical and supporting services to medically and financially eligible children, and high-risk pregnant women.

- The continuum of care includes prevention and early intervention programs, primary care, medical care, and therapeutic specialty care and long-term care.
- Services are provided through an integrated statewide system that includes local, regional and tertiary care facilities and providers.
- Visit the following link for more information: http://www.cms-kids.com/

KidCare

Florida KidCare is the state's children's health insurance program for uninsured children under age 19, and includes four different parts, (or programs): MediKids, Healthy Kids, CMS, and Medicaid. When an individual applies, Florida KidCare will identify which program a child may be eligible for based on age and family income. Some of the services Florida KidCare covers are:

- Doctor visits, check-ups, shots, hospital, and surgery.
- Prescriptions.
- Emergencies.
- Vision, hearing, dental and, mental health.
- Visit the following link for more information: http://floridakidcare.org/

ADAP Premium Plus Insurance (previously AIDS Insurance Continuation Program (AICP)

ADAP Premium Plus Insurance requirements referenced in this section may be updated during the course of the contract year. Determining program qualifications for ADAP Premium Plus Insurance is not a part of the eligibility process and clients should be referred for ADAP Premium Plus Insurance program determination.

ADAP Premium Plus Insurance assists with insurance co-pays, deductibles and premiums as needed and available. To be referred to ADAP Premium Plus Insurance, a client must:

- Be determined eligible for HIV/AIDS patient care programs.
- Meet ADAP program qualifications.
- Have a current health insurance policy.
- Be willing to participate by providing their health insurance benefits package and explanation of benefits.

Social Security Disability Insurance (SSDI)

- A payroll tax-funded federal government insurance program managed by the SSA.
- Provides income to people who are unable to work due to a disability.
- To qualify, individuals must have a physical or mental condition that prevents them from engaging in "substantial gainful activity," the

condition is expected to last at least 12 months or result in death, and they are under the age of 65 and have worked 40 quarters (at least 10 years).

- To apply for SSDI or find more information visit:
  http://www.ssa.gov/disability/

Supplemental Security Income (SSI)

- A cash assistance program administered by the SSA.
- Provides financial assistance to aged, blind, or disabled individuals who have little or no income.
- Provides cash to meet basic needs for food, clothing, and shelter.
- To be eligible, a person must be a U.S. citizen, have resources no more than $2,000, and have an income less than $674 a month for an individual.
- Persons eligible for at least $1 in SSI automatically receive Medicaid.
- To apply for SSI or find more information, visit http://www.ssa.gov/ssi/ or http://www.dcf.state.fl.us/programs/access/medicaid.shtml

Local Assistance Programs

- Local indigent programs that have requirements more restrictive than the patient care programs under the HIV/AIDS and Hepatitis Program.
- Documentation of the local program income requirement and participation in the program are required to be eligible for the Ryan White Part A or HIV/AIDS patient care programs.

CAREWare Instructions

- Proof of third party insurance and/or screening for Medicaid must be scanned and attached under the Unique ID tab, attachment hyperlink.
- Document must have an identifying name; use drop down box to select "proof of third party insurance".
- The comment box is not required but encouraged if needed, especially if there is one type of document being used for various types of proof.

SECTION 10: Health Insurance

A client must access health insurance coverage when and if available.

Adequate Health Insurance

- All forms of health insurance are considered third party insurance. (i.e.: BC/BC, Medicare, etc)
- Clients with health insurance available from an employer or other private insurance must apply for and access the offered health insurance.
- Without health insurance, services from any of the patient care programs under the Ryan White Part A and HIV/AIDS and Hepatitis Program will only be considered under the following circumstances:
    - o Insurance is inadequate, and does not cover required medical care or pharmaceuticals.
    - o The co-pays or premiums are too costly for the client. Unaffordable co-payments mean:
        1. The client's monthly total out-of-pocket HIV medication costs are greater than $250 or 10% of household monthly income.
        2. The client's monthly total out of pocket costs is less than $250 a month but greater than 10% of client's monthly income.

Premiums may NOT be counted towards monthly out-of-pocket costs unless a client provides proof of being denied ADAP Premium Plus Insurance (formerly AICP).

Clients who meet the other eligibility requirements may be given a limited-time Notice of Eligibility pending a final assessment of the insurance policy if the circumstances are warranted. Supervisor and lead agency approval is REQUIRED under these circumstances.

Co-Pays and Premiums

If the client's insurance policy is assessed to have partial coverage or full coverage but co-pays, deductibles and premiums are too high, staff should:
- Determine if the client is eligible for ADAP Premium Plus Insurance and refer to the local ADAP Premium Plus Insurance provider for program eligibility determination.
- Assist with co-pays, deductibles, and premiums where necessary through local Part A or other dollars until client is enrolled in ADAP Premium Plus Insurance.
- Once enrolled in ADAP Premium Plus Insurance, enroll client into the special services program, if available.

Electing Not To Use

- If a client has an <u>adequate</u> employer-sponsored-insurance but has

elected NOT to use it, the client must be advised of the restrictions with public funding and that this is not an option.

- Clients who still choose not to use their insurance must be given a Notice of Ineligibility; the HIV/AIDS patient care programs are payers of last resort.

Pre-Existing Conditions and Waiting Periods

- Some insurance policies have pre-existing conditions that do not allow access for 6 to12 months from the date of enrollment.
- Some insurance coverage terms have a 30 to90 day waiting period before benefits begin. Pharmacy coverage is most commonly delayed for many plans.
- Clients must enroll for insurance coverage even under these circumstances.
- Eligibility staff should complete the Insurance Waiver Form (Attachment H), which identifies when the client will have access to their full insurance coverage.
- Clients may then be eligible for HIV/AIDS patient care program services until such time their insurance can be accessed. Eligibility staff must document on the Notice of Eligibility and in CAREWare, under Other Programs, when the client is able to access their insurance.

ADAP Premium Plus Insurance (previously AIDS Insurance Continuation Program (AICP)

ADAP Premium Plus Insurance requirements referenced in this section may be updated during the course of the contract year. Determining program qualifications for ADAP Premium Plus Insurance is not a part of the eligibility process and clients should be referred for ADAP Premium Plus Insurance program determination.

ADAP Premium Plus Insurance assists with co-pays, deductibles and premiums as needed and available. To be referred to ADAP Premium Plus Insurance, a client must:
- Be determined eligible for HIV/AIDS patient care programs.
- Meet ADAP program qualifications.
- Have a current health insurance policy.
- Be willing to participate by providing their health insurance benefits package and explanation of benefits.

Screening for Health Insurance

The following steps should be taken during the eligibility process to screen for health insurance:

Step 1 - Initial determination

- Ask the client if they currently have health insurance or determine if they are working for a company that offers health insurance.

Step 2A - If the client has insurance

- Obtain a copy of the insurance card and policy coverage, and maintain a copy in eligibility file.
- Determine if the coverage is viable, including pharmaceutical coverage. (Seek assistance from ADAP Premium Plus Insurance staff or the Grantee for assistance as needed.)

- Determine the premium cost to the client, and if help is needed with their portion to maintain coverage (not everyone needs assistance with premium payments).
- If assistance with premium payments is needed, refer the client (once determined eligible) to the ADAP Premium Plus Insurance provider.

Step 2B - If the client has no insurance
- Determine if the client is employed.
- If no, document that the client is not likely to have insurance or access to insurance. Proceed with eligibility.
- If yes, the client will need to provide proof of no access to insurance from their employer. This can be done in many ways. For example:
  o Letter from employer.
  o Personnel handbook that describes benefits.
  o PBC Insurance Verification form.

  NOTE: It is not acceptable to take a client's word they have no access to insurance when employed.

- If the client has no access to insurance, keep documentation in file and proceed with eligibility.
- If the client has access to health insurance, take the following steps:
  o Determine if they already have insurance and follow step 2A above.
  o Determine if the client will have access to insurance, and when access will be available (usually there is an open enrollment period).
  o If open enrollment is not immediate, complete the Insurance Waiver Form (Attachment H) stating the client will have access to insurance during open enrollment and document timeframe. Complete eligibility and issue a Notice of Eligibility for six months or until open enrollment can be completed, whichever comes first.
  o The client must access insurance during open enrollment and follow step 2A above.
  o Refusal to access insurance is justification to deny eligibility. The Ryan White Part A and HIV/AIDS patient care programs under the HIV/AIDS and Hepatitis Program are payers of last resort. Exceptions and waivers below detail exceptions to the rule.

Step 3 Exceptions/Waivers/Miscellaneous Information
- Insurance policies with poor pharmaceuticals coverage and/or high out-

of-pocket costs may be eligible for a waiver from ADAP.

- Clients who are in the process of completing COBRA may have a lapse in coverage for a period of 30 to 60 days. Application for COBRA should be completed as soon as possible (they have no more than 63 days from the end of their employment).
- Local consortia dollars may be used to pay for the drugs in the interim. ADAP does not provide interim drug coverage.
- Interim coverage for a premium payment (client does not need to apply for AICP) may be accessed through Part B in the health insurance line item. Please contact your lead agency for more information.

CAREWare Instructions

- All forms of third party insurance must be scanned and attached under the Unique ID tab, attachment hyperlink.
- Document must have an identifying name; use drop down box to select "proof of Insurance Coverage/Denials" or "proof of third party insurance."
- The comment box is not required, but encouraged if needed.

SECTION 11: Income

For the patient care programs within the HIV/AIDS and Hepatitis Program, the income eligibility requirement is defined as a gross household income (before taxes and deductions) at or below 400% of the Federal Poverty Level (FPL).

For the local Ryan White Part A, the Eligibility Grid determines FPL requirements for specific services. Remember to reference the Eligibility Grid (Attachment M) document when determining income eligibility for Ryan White Part A services.

Federal Poverty Guidelines (Attachment I)	The Federal Poverty Guidelines provide a measure of poverty. They are updated annually in the Federal Register by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds when determining financial eligibility for certain federal programs. For general questions about the FPL, visit http://aspe.hhs.gov/poverty. The FPL is used by the Ryan White Part A and HIV/AIDS and Hepatitis Program to determine the maximum amount of income allowed for eligibility. The FPL chart is made available on the HIV/AIDS patient care website at http://www.doh.state.fl.us/Disease_ctrl/aids/care/EligibilityAdRule.html.
Gross Income versus Net Income	Gross income is commonly defined as the amount of a company's or a person's income, before any deductions or taxes are taken, except that which is specifically excluded by the Internal Revenue Service. Section 61 of the Internal Revenue Code defines gross income as "all income from whatever source derived." Net income for an individual is gross income minus taxes, allowances and deductions. An individual's net income is used to determine how much income tax is owed. • In business, net income is what remains after subtracting all the costs (business, depreciation, interest and taxes) from a company's revenue. Net income is sometimes called the bottom line, also called earnings or net profit. **Gross income is the amount used when determining eligibility except where the client reports he/she is self-employed.**
Earned Income, Unearned Income	Earned Income is compensation earned from participation in a business, including wages, salary, tips, commissions, and bonuses, earnings from

and Deemed Income

self–employment, and royalties or honoraria.

Unearned Income is all income that is not earned, such as Social Security benefits, pensions, disability payments, unemployment benefits, interest income, property rental income, and cash contributions from relatives.

Deemed Income is all earned and unearned income from the client's spouse, if married and from the adults living in the home who are counted in the household size.

Step 1: Determining Household Size

A household is a domestic establishment that includes the client, members of his/her family and others who live under the same roof. The size of the household used in determining the client's FPL will not necessarily include everyone in the home.

Counted

Only specific individuals are counted when determining the household size for purposes of determining the client's FPL. Those counted in the household size are:

- Client (always).
- Spouse (always, if married).
- Client's children (always, if minors).
- Adults who live with the client in his/her home, and meet one or more of the following:
  - Claims the client as a dependent on a tax return.
  - Claims the client on a health insurance policy.
  - Has legal custody, or other legal arrangement or guardianship of the client.

Not Counted

Not counted in household size are:
- Roommate(s) with separate finances who share only in the cost of room and board. Room and board includes household expenses such as utility, cable, phone, rent or mortgage, and meals.
- Adults such as parents, adult siblings, adult children, significant others, and partners who live with the client, but have separate finances and/or share only household expenses.
- Live-in aides who receive payment for their services.
- Children who are not financially dependent on the client.

Step 2: Determining Household Income

- Household income is defined as income received by the client from all sources.
- Adults living outside of the household who provide money to the client on a daily, weekly or monthly basis are not included in the household size,

but the amount of financial support (allowance) is counted and
documented on the worksheet under "other sources of income."
* Income includes items that generate funds and may be counted as
income. *For example, a second home rented out generates income.*
* A list of items counted as income is included on the worksheet.

**Income Counted
(including
documentation)**

The total amount of income from <u>all counted household members</u> are
calculated on an annual basis and include, but are not limited to, the
following:

<u>Earned Income:</u>

* Pay stubs showing income before taxes and deductions. Enough pay
stubs should be collected to reasonably determine a person's annual
income to be able to project forward. Generally, at least two pay check
stubs would suffice.
* A signed and dated employer statement on company letterhead stating
name of client, rate and frequency of pay, a phone number and whether
client is currently receiving or is eligible to receive health benefits from
the employer. The PBC Insurance Verification form would suffice.
* 1040 Form or W-2 Form for previous year.
* If self-employed:
    o 1040 Form for previous year with corresponding attachments
    (Schedule C or Schedule SE).
    o W-4 Forms for previous year.
    o Company accounting books showing business revenue and
    expenses.
    o Self-employment tracking sheets (extenuating circumstances may
    call for supervisory approval).

<u>Unearned Income:</u>

* Retirement income statement from Social Security.
* OASI (Old Age and Survivors Insurance).
* Retirement pension statement from private or public fund.
* Trust fund income.
* Military/veteran pension benefits statement.
* A recent Third Party Query (TPQY) printout from Social Security.
* IRS 1040 Supplemental Income and Loss (Schedule E) for property
rental income (net income is counted in this circumstance).
* Unemployment benefit stubs.
* Alimony payments.
* Benefits from dependent children (i.e. survivor's benefits).
* Child support payments.
* Cash assistance by relatives and other individuals (included in Letter of

Support).
- Monthly Income from welfare agencies (public and private).
- Interest on investments.

Self-Employed (including documentation)

<u>Self-employment income</u> includes, but is not limited to:
- Small businesses, including proprietorships and partnerships
- Paid professional, paraprofessional, or occupational services such as lawn care, domestic work, handyman, landscaping, farming, or salesmen
- Royalty or honoraria from intellectual property or authorship.

Eligibility for a self-employed client is based on net income. Net income is obtained from the Federal Income Tax Return (IRS1040), and all applicable schedules and attachments:
- Schedule SE, entitled Self-Employment Tax.
  - Section A, Line 4, or Section B, Line 6, as applicable
- Schedule C, entitled Profit or Loss from Business, Line 31.

If this is not available or if the client has not been self-employed long enough to have filed taxes, the client can submit records of their monthly self-employment income for at least the past three months. Self-employment tracking sheets (Attachment J) mmay serve as proof of income in these cases. Extenuating circumstances may call for supervisory concurrence.

In such cases, subtract from gross self-employment income any allowable business expenses necessary and directly related to producing goods or services. Allowable self-employment expenses include, but are not limited to:
- Purchasing inventory.
- Space rental and utilities.
- Salaries for employees other than the client.
- Transportation expenses required for employment.
- Interest on loans for capital assets or durable goods.
- Income reinvested in a business, except for the purchase of real estate, is an allowable business expense. This includes the purchase of capital equipment, payment on the principal of loans and other expenses needed to produce goods and services.

NOTE: Capital equipment is equipment needed to produce self-employment goods (e.g. a printing press, copy machines, farm machinery, tools, sewing machines, tractors, tow trucks). If the expenses exceed the gross receipts, the self-employment income will be zero.

No Income

For no income:

(including documentation)	- A statement is provided as to how the client receives food, clothing, and shelter, also known as a letter of support. - A recent Summary Earnings Query (SEQY), or Work and Gain Economic Self Sufficiency (WAGES) printout or an income tax return from the previous year. - Federal Insurance Contribution Act (FICA) will establish prior work year income. **NOTE:** While SEQY, WAGES, or FICA printouts may verify only prior-year income, such information can be useful in helping to support the factual establishment of current income or claims of no income. - In cases where the client declares no income, documentation is required to validate his/her status. - A discussion of no income and unemployment is covered in this document when determining the household size. Some examples of questions to ask a client who has little or no income coming into the household include the following: - How does the client support him/herself without income or employment? - How are food, clothing, shelter and utilities being managed? - How long has the client been unemployed? - What is the client's previous work experience? - What are the client's educational qualifications? - Is the client underemployed? - Could the client find better employment? - Is the client currently looking for employment? - What is the reason for unemployment (medical, voluntary)? - If medical, what is the status of disability/SSI determination? - If voluntary, has payer of last resort been discussed? - Has there been any effort to find a job? - Is the client receiving Unemployment Compensation? The above list of questions reflects subject areas that can be explored on a case-by-case basis. Not all questions will be applicable.
Income Not Counted	Income that is not counted includes, grants, scholarships, fellowships, value of food stamp benefits, retirement benefits, Ricky Ray Hemophilia Relief funds, 401K if not accessed, and any other non-accessible income, such as trust funds.
State HOPWA Exception (please note, this	- Clients seeking assistance from State HOPWA must be determined eligible under Chapter 64D-4 F.A.C. - Clients who are not eligible based on the FPL limit should be assessed

**information has
been included to
alert staff of the
potential for some
clients to be
eligible for <u>State
HOPWA</u> even if
over 400% of the
FPL)**

- for a housing need.
- The State HOPWA Program qualification allows clients to be at 80% of the median income, which in some instances is greater than 400% of FPL.
- Under these circumstances, if all other criteria except FPL are met, clients who might have a housing need should be given a Notice of Eligibility with a notation for **HOPWA only** and referred to the State HOPWA Program. This step is very important.
- Individuals receiving a Notice of Eligibility Exception for HOPWA services are not a guarantee to receive HOPWA services. Additional programmatic requirements will need to be determined.
- The Sate HOPWA Program will assess for 80% of the median income.
- Not all clients who seek eligibility will have a housing need.

Refusal to Divulge

- Clients who refuse to divulge or document income will not be able to complete the financial eligibility assessment and will therefore be determined ineligible.
- This includes spouses and household members counted in the household size who refuse to provide the appropriate information.
- Under these circumstances clients must be given a Notice of Ineligibility with an explanation.

**How To Calculate
Income**

Calculating income can be a challenge. Below are some examples of how to calculate income. (Review the "Income Counted" section above for details.)

WEEKLY
- Gross amount X 52
- Example: $600.32 X 52 = $31,216.64 (annual income)

BI-WEEKLY (every two weeks/26 pay checks)
- Gross amount X 26
- Example: $1417.92 X 26 = $36,865.92 (annual income)

MONTHLY
- Gross amount X 12
- Example: $1,288.52 X 12 = $15,462.24 (annual income)

BI-MONTHLY (twice per month)
- Gross amount X 24
- Example: $1325.28 X 24 = $31,806.72 (annual income)

Circumstances may vary based on the availability of documentation.

- Year to Date (YTD) information can be used for established clients with salaried employment. For example, a June 30, 2011 pay stub reflects YTD $19,055, and the client is paid bi-weekly. Calculate the income by dividing the YTD income by the number of pay periods to date to determine bi-weekly pay, and then multiply by 26 pay periods to get annual income.

EXAMPLE: $19,055/13= $1465.77x 26= $38,110

**Step 3:
Calculating the
Federal Poverty
Level (FPL)**

- The FPL should be calculated to a specific number rather than a range.
- Calculate total annual household income.
- Calculate total household size.
- Calculate the FPL (Attachment I) using the most current FPL chart and the household size total.
- Document this on the financial worksheet.

Example: If a client's income is $24,000 annually and their spouse's income is $22,000 annually, add the total incomes together. Divide the total based on a family size of two using the amount in column A (100% FPL) to determine the specific FPL.

$24,000 + $22,000 = $46,000 divided by $15,130 = 304% FPL

**Final Income
Determination**

- The total amount of income from <u>all counted household members</u> is calculated on an annual basis.
- All of the earned and unearned income is documented on the worksheet and the grand total for the household income is tallied.
- This amount cannot exceed the client's FPL dollar amount which is determined in Step 3 above.

**CAREWare
Instructions**

- All forms of income must be scanned and attached under the Unique ID tab, attachment hyperlink.
- Document must have an identifying name; use drop down box to select "proof of income."
- The comment box is not required but encouraged if needed, especially if there is one type of document being used for various types of proof.

SECTION 12: Requests for Exception

The request for an exception is not allowed for Ryan White Part A services. Every applicant who fails to meet the eligibility requirements cannot be served with Part A dollars. Exceptions may be considered with approval from the DOH for their funded services only and under specific conditions for other funding services. Please refer to the Florida HIV/AIDS Eligibility Procedures Manual guidelines for their Exception process.

SECTION 13: Eligibility Determination

This section provides guidance for eligibility determination and required documentation.

Initial Eligibility

Eligibility determination requires the following documentation:
- Completed application (Attachment C)
- Completed Eligibility Staff Assessment Worksheet, at initial application or if the file has been closed for more than one year (Attachment D).
- Insurance Waiver Form (if applicable) (Attachment H)
- Required back-up documentation (proof of HIV, etc.)

Six Month Recertification and Notice of Eligibility

Eligibility providers are required by rule:
- To provide the client with written confirmation of the eligibility determination.
- Complete a Six Month Recertification Review Form (Attachment E) and Notice of Eligibility (Attachment F), which is valid for six months.

Staff must remind the client of their responsibility to advise the eligibility office of any circumstances that could impact their eligibility status.

Referrals and Linkage

The primary tasks of eligibility staff after a determination of eligibility include referrals and/or linkage to the following:
- Local case management services available.
- A choice of case management service providers in the area (if available) and make the appropriate referral. If the staff completing the eligibility process works at a case management agency, the client is still provided a choice of case management agencies in the service area.
- Allowable services based on availability, accessibility and funding of the service in the client's local area.

Referrals may be made directly to the HIV/AIDS patient care programs when indicated (Ryan White Part B, ADAP, ADAP Premium Plus Insurance, and HOPWA).

Ineligible

- A client may be deemed ineligible at any point during the eligibility process.
- Supervisory review is required of <u>all</u> cases considered for ineligibility <u>prior</u> to issuing a Notice of Ineligibility (Attachment G).

The following documentation will be reviewed for accuracy to determine ineligibility:
- Completed application.
- Completed eligibility staff assessment worksheet.
- Required documentation.

Notice of Ineligibility

The Notice of Ineligibility (Attachment G) is required by rule.

1. The Notice of Ineligibility is reviewed with the client, preferably during a face-to-face interview, and a copy is provided to the client. The Notice of Ineligibility may be mailed (certified only) if a face-to-face interview is not possible. All efforts are made to assist the client with understanding the reason for the decision.
   o The client is advised to contact the eligibility provider for a re-determination if circumstances change.
   o Referral information (name, address, and phone numbers) is provided to the client for possible assistance from other programs.

If the client is not satisfied with the explanation for ineligibility, the supervisor should assist. The Notice of Ineligibility requires the client's signature. If the client refuses to sign, document "Refuses to Sign" on the signature line of the Notice of Ineligibility. The eligibility staff person must also sign and date the NOE.

Closing the File

All active eligibility files must remain open until such a time circumstances change, for example, the client:
- Moves out of state or to another area.
- Is deceased.
- Has been incarcerated for six months or longer.
- No longer needs services.

For clients determined ineligible, the file is closed when a final determination of ineligibility is completed, and the referral and documentation material are assembled.

All closed files must follow the record retention policy located in Section 2.

CAREWare Instructions

- The Notice of Eligibility (NOE) and/or Notice of Ineligibility (NOI) MUST be completed under the forms tab. Once completed, it must be printed and signed by the eligibility staff member and the applicant/client.
- The signed NOE/NOI must be scanned with an identifying name; use the drop down box to select "Notice of Eligibility" or "Notice of Ineligibility".
- The comment box is not required, but encouraged if needed.

Section 14: PBCounty CAREWare Instructions

Entering Into PBC CAREWare	All eligibility forms and information under Rule 64D-4, F.A.C., must be entered into the PBC CAREWare, the statewide client level information database.
Database Access Restrictions	Access to CAREWare for eligibility will be determined by the Grantee and/or lead agency that contracts with providers. All personnel entering into CAREWare will have user accounts.
Information Security Requirements	All eligibility staff must attend confidentiality training annually and adhere to the rules established in DOHP 50-10-07, Information and Security Privacy Policy, Confidential Information, or their local policy similar to DOHP 50-10-07.

Domains and Sharing of Eligibility Data

Agency staff enters client information for eligibility into their unique domain (agency name). Clients may seek services from multiple providers (agencies). Clients can exist under multiple domains and this does not prevent different agencies from using CAREWare for that client.

The only shared eligibility data between agencies are the following tabs:
- Demographics.
- Annual Review.
- Unique IDs.

Each area is unique, so domains (name of agency as listed in State CAREWare) may vary. The Grantee determines local domains except for ADAP. All ADAP staff domains are their CHD's.

Paper Enrollment

Eligibility staff may use paper forms to determine eligibility for new clients if:
- The CAREWare database is not available due to server/network issues.
- You are conducting eligibility off site, and do not have access to the CAREWare database.

All paperwork must be entered and/or scanned into CAREWare once service has been restored or you have access to the database.
All information must be entered within two weeks of interviewing the client.

CAREWare Documents

The following documents must be completed in CAREWare under the forms tab:
1. Demographic form (at initial appointment and when information changes).
2. Eligibility Staff Assessment Worksheet (once at initial appointment or if the file is closed for more than a year).
3. Six Month Recertification Review Form (every six months after initial certification).
4. Notice of Eligibility or Ineligibility (every six months).
5. Insurance Waiver Form (as needed).

All forms are custom sub-forms. This means these forms are kept each time they are completed and will provide a history over time. You must check the box in the top left corner of the form to fill it in and save. When it is time to complete any of the documentation on the forms tab, you will add a new form. DO NOT edit any previous forms.

No signatures are required on the Eligibility Staff Assessment Worksheet, Six Month Re-certification Review Form or Insurance Waiver Form.

You MUST print the Notice of Eligibility or Ineligibility for signatures, scan the signed document, and save into CAREWare.

You must complete a new form for each six month recertification. You CANNOT edit an existing form. Doing so deletes the original form and the history provided by these forms.

Deleting Forms

Although forms completed under the "Forms" tab can be deleted, this should not occur unless a form is completed for the wrong client, under a different client's name or other unusual circumstance.

Forms will save by date and should be kept for tracking and auditing purposes.

Deleting Scanned Documents

Documents scanned and saved in the "Attachment" section under the tab "Unique IDs" should not be deleted, except under the following circumstances:
- The document is scanned under a different client name.
- The wrong type of document was scanned by accident.

Any deletions will not be allowed at the user level. Documents needing deletion will require an email to the Grantee office. CSD-CarewareSupport@pbcgov.org

Revised January 2013

**If you email staff a request it MUST be encrypted due to the
confidentiality of the information.**

**If the deletion can not occur immediately, you will be notified by
encrypted email (or generic email with no confidential information)
when the document has been deleted.**

The following staff can assist with deleting documents:

Sheron Hoo-Hing 561-355-4715

**Scanning
(Located under the
Unique IDs Tab)**

The following items MUST be scanned into CAREWare as proof of
documentation (see Eligibility Manual for acceptable proof/documents)
(Attachment L):
1. Proof of HIV.
2. Proof of living in PBC.
3. Proof of income.
4. Proof of any third party insurance (Medicaid, Medicare, private
    insurance, Veterans Benefits, etc.)
5. Copy of the **signed** application (both sides).
6. Copy of the **signed** Notice of Eligibility or Notice of Ineligibility.
7. Copy of the Insurance Waiver Form (if applicable).
8. Copy of the **signed** releases/consent forms.
9. Other identified documents as part of file (if applicable).
10. Social Security card.
11. Grantee Intake tool printouts.

When scanning documents, you must select an item from the drop down
menu. Specifics about the document should be noted in the Comments
section. All documents should be saved individually rather than combining
them, even if they represent one category (i.e. proof of living in PBC such as
driver's license and utility bill).
Example: A copy of a client's utility bill may be used as proof of living in
PBC. Select from the drop down box "Living in Florida" and in the comment
box type "utility bill". You are not able to type free text in the drop down
menu.

NOTE: File uploads (scanning) are limited to 1 MB or smaller. Anything
larger will cause problems with the system.

**Scanning for Six
Month
Recertification**

Updated information must be scanned during EACH six month
recertification. Certain documents do not need to be rescanned.

1. **Proof of HIV** - do not re-scan. This only needs to be done during the
    initial enrollment.

2. **Proof of living in PBC** – if the client has moved or has new living circumstances, the new documentation must be scanned. If there are no changes, do not re-scan any documents.
3. **Proof of income** – Verification of earned income (i.e.: pay stubs) are <u>ALWAYS</u> required at the six month recertification. All other documents only need to be scanned if there is a change, such as award letters for SSI, SSDI, VA, etc., where there has been an increase in benefits. If there is no change, do not re-scan any documents.
4. **Proof of third party insurance** (Medicaid, Medicare, private insurance, Veterans Benefits, etc.) – any new information on insurance <u>must</u> be scanned. Medicaid information must be scanned every 6 months.
5. Copy of the **signed** Notice of Eligibility or Notice of Ineligibility – <u>ALWAYS</u> scan the new Notice of Eligibility or Notice of Ineligibility with the client's signature.
6. Copy of the Insurance Waiver Form (if applicable).
7. Copy of the updated **signed** releases/consent forms (if applicable).
8. Other identified documents as part of file (if applicable).

Saving Scanned Documents

Scanned documents attached in CAREWare should be deleted from networks or desktops routinely, at least at the end of each day.

Agencies should determine a central location where all scanned documents are stored. It is preferable that these documents all be scanned to one file/location, and then be deleted each night for security purposes.

Display Settings

If you have issues viewing and/or printing a form, you might need to adjust your display settings. Please look at your DPI by going to Control Panel, Display, Settings, Advanced, DPI Setting. Make sure your setting is at normal size (96 DPI).

Client File (Hard Copy)

Until further notice, all CAREWare documents must be printed or available to print and be placed in the client record along with the documentation of proof for eligibility requirements.

It is the intent that all records will go electronic in the near future. Until then, hard copy records must be kept or available to print during a monitoring.

Attachments

Attachment	Name	Requirement
Attachment A	Ryan White Program Service Definitions	N/A
Attachment B	Coordinated Services Network (CSN) form	**Required**
Attachment C	Brochure and Application	**Required**
Attachment D	Eligibility Staff Assessment Worksheet	**Required**
Attachment E	Six Month Re-certification Review Form	**Required**
Attachment F	Notice of Eligibility	**Required**
Attachment G	Notice of Ineligibility	**Required**
Attachment H	Insurance Waiver Form	**Required**
Attachment I	Annual Federal Poverty Guidelines	N/A
Attachment J	Self Employment Tracking Sheet	**Required**
Attachment K	Grantee Intake Tool Printout	**Required**
Attachment L	Scanned Documents List	N/A
Attachment M	PBC Part A Eligibility Grid	N/A

PALM BEACH COUNTY HIV CARE COUNCIL
PART A - RYAN WHITE CARE ACT GRANT

SERVICE CATEGORY DEFINITIONS

CORE MEDICAL SERVICES

1. **Medical Care**
  a **Outpatient/Ambulatory Medical Care**

Provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, registered nurse, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

  b **Laboratory Diagnostic Testing**

HIV viral load testing, CD4/CD8, CBC with diff., blood chemistry profile, & other FDA approved routine tests for the treatment of patients with HIV disease. In addition, routine tests pertinent to the prevention of opportunistic infections (VDRL, IGRA, AFB, pap smear, toxoplasmosa, hepatitis B, & CMV serologies) & all other laboratory tests as clinically indicated (e.g. HCV serology) that are generally accepted to be medically necessary for the treatment of HIV disease & its complications and have an established Florida Medicaid or Medicare reimbursement rate, as well as new tests that may not have an established reimbursement rate.

  c **Drug Reimbursement Program**

Local Supplemental Drug Program
Provision of injectable and non-injectable prescription drugs, at or below Public Health Service (PHS) price, and/or related supplies prescribed or ordered by a physician to prolong life, improve health, or prevent deterioration of health for HIV+ persons who do not have prescription drug coverage and who are not eligible for Medicaid, Health Care District, or other public sector funding, nor

1

have any other means to pay. This service area also includes assistance for the acquisition of non-Medicaid reimbursable drugs.

ADAP Supplemental Drug Program
Program to expand Florida AIDS Drug Assistance Program (ADAP) locally by paying for FDA approved medications on the State of Florida ADAP formulary when the Florida ADAP is unable to pay for such medications for patients enrolled in the Florida ADAP program & patients are ineligible for other local health care programs which pay for these medications. Medications purchased under this program must be purchased at Public Health Services prices or less.

Nutritional Supplements
Provision of nutritional supplement prescribed as a treatment for diagnosed wasting syndrome. Counseling linked to Primary Medical Care, Nurse Care Management or Human Services Management.

d   Specialty Outpatient Medical Care

Short term treatment of specialty medical conditions and associated diagnostic procedures for HIV positive patients based upon referral from a primary care provider, physician, physician assistant, registered nurse. Specialties may include, but are not limited to, outpatient rehabilitation, dermatology, oncology, obstetrics and gynecology, urology, podiatry, pediatrics, rheumatology, physical therapy, speech therapy, occupational therapy, developmental assessment, and psychiatry.

e   Oral Health Care

Diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Service caps approved by the CARE Council must be adhered to. Clinical decisions must be informed by the American Dental Association Dental Practice Parameters.

f   Early Intervention Services (EIS)

Includes counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals to appropriate services based on HIV status; linkage to care and education and health literacy training for clients to help them navigate the HIV care system; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Services shall be provided at specific points of entry. Coordination with HIV

prevention efforts and programs as well as prevention providers is required. Referrals to care and treatment must be monitored. Grantee may modify targeted areas to include additional key points of entry.

g Nurse Care Coordination

A range of client-centered services provided by a registered nurse and coordinated with the client's primary outpatient healthcare provider, providing the Ryan White patient's main link with ongoing medical services.

Key activities include: 1)provides primary care as part of the clinical team, 2)triage for new problems, 3)provide health education and self-care education, 4) coordinate medical plan and specialty referrals, 5) implement and monitor home-based service plans, including home visits if necessary, 6) facilitate access to clinical trials, 7) guarantee patient access to clinical care five days per week, 8)coordinate in-patient and out-patient care, 9) conduct chart reviews for evaluation of services to Ryan White funded patients.

h Health Insurance Premium & Cost Sharing Assistance

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

An annual cost benefit analysis that includes an illustration of the greater benefit of using Ryan White funds for Insurance/Costs-Sharing Program vs. having the client on ADAP. Documentation of the low-income status of the client must be available. Insurance programs must cover comprehensive primary care services and a full range of HIV medications. Funds may not be used for social security.

i Home Health Care

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

j Home and Community-Based Health Services

Includes skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are NOT included.

k   Hospice Services

Includes end-of-life care provided to clients in the terminal stage of illness. Includes room, board, nursing care, counseling, physician services, and palliative therapeutics. Services may be provided in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services.

l   Mental Health Services

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

m   Medical Nutrition Therapy

Provided by a licensed registered dietitian outside of a primary care visit. The provision of food, nutritional services, and nutritional supplements may be provided pursuant to a physician's recommended and nutritional plan developed by a licensed, registered dietician.

n   Medical Case management services (including treatment adherence)

A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Case Management providers must be PAC Waiver providers or demonstrate that they have begun the PAC Waiver application process.

Medical Case Management services exclude determining/re-determining clients' eligibility.

Peer Mentor Program

4

The goal of the Peer Mentor program is to improve HIV-related health outcomes and reduce health disparities for at risk communities through HIV peer education. Peers shall be persons living with HIV from the community, not working as licensed clinical professionals, who share key characteristics with target population which shall include: a. community membership, gender, race/ethnicity, b. disease status or risk factors, c. sexual orientation, d. salient experiences, e.g. former drug use, sex work, incarceration. The Peer Mentor will use shared characteristics/experiences to act effectively as a trusted educator, mentor for adopting health behavior, role model, and empathic source of social and emotional support.

The contributions of HIV-positive peers shall include: adherence to medical care (keeping appointments, responding to physician referrals, and picking up medications); linking to medical care and support services; self-management of disease; emotional support and reduced risk behaviors.

Treatment Adherence

Treatment adherence counseling to ensure readiness for and adherence to, complex HIV/AIDS treatment.

o **Substance Abuse Services-Outpatient**
Provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

SUPPORT SERVICES

2. Case Management (non-Medical)

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

Excludes determining/re-determining clients' eligibility.

Determining Eligibility
Provision of eligibility screenings for clients.

3.Referral for Health Care/Supportive Services
The act of directing a client to a service in person or through telephone, written, or other type of

communication. Referrals for health care/supportive services that were not part of Outpatient/Ambulatory services or case management services (medical or non-medical) should be reported under this item.

4.Housing Services
Provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

5.Substance Abuse Services- residential
Provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Provides room and board, substance abuse treatment and counseling, including specific HIV counseling in a secure, drug-free state-licensed residential (non-hospital) substance abuse detoxification and treatment facility. This treatment shall be short term. Anyone providing direct counseling services must under the supervision of staff possessing postgraduate degree in the appropriate counseling-related field, or a Certified Addiction Professional (CAP). Part A funds may not be used for hospital inpatient detoxification.

6.Food Bank/Home Delivered Meals
Provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

7.Emergency Financial Assistance (EFA)
Provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. EFA funds are only to be used as a last resort. Clients may receive up to 12 accesses per year for no more than a combined total of $1,000 during the grant year.

8.Medical Transportation Services
Includes conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Records must be maintained that track both services provided and the purpose of the service (e.g., transportation to/from what type of medical or support service appointment). Clients shall not receive direct payment for transportation services.

9.Treatment Adherence Counseling

Provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

10. Outreach Services
Programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding). Outreach services does not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

11. Legal Services
Provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

12. Health Education/Risk Reduction
Provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

13. Psychosocial Support Services
Provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

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

15. Linguistics Services
Provision of interpretation and translation services. Types of linguistic services to be provided

include oral interpretation and written translation as needed to facilitate communications and services delivery. Training and qualifications based on available State and local certifications are required.

16.<u>Child Care Services</u>
Provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training. NOTE: This does not include child care while a client is at work.

17. <u>Respite Care</u>
Provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION AND PRIVACY AND SECURITY OF YOUR CLIENT RECORDS

AGENCY NAME: ___(AGENCY NAME)_____

This document is intended to provide you with information regarding our disclosure of confidential information, and our privacy and security practices.

The Coordinated Services Network (CSN) is a partnership of medical and support service providers including but not limited to the following list of providers.

1		Compass, Inc.	8		PBC Department of Community Services
2		Comprehensive AIDS Program of PBC. (CAP)	9		PBC Health Care District
3		FoundCare	10		Palm Beach County Health Department
4		Gratitude House, Inc.	11		Private Physician:
5		Health Council of Southeast Florida	12		OTHER*:
6		Legal Aid Society of PBC	13		OTHER*:
7		Minority Development & Empowerment Inc.	14		OTHER*:

If initialed, an agency must be identified.

Services provided by members of the Coordinated Services Network are funded by Ryan White Part A, Ryan White Part B, Florida Project AIDS Care (PAC), Bureau of HIV/AIDS Patient Care Programs, AIDS Insurance Continuation Program, Palm Beach County Department of Community Services, Health Council of Southeast Florida, Florida AIDS Drug Assistance Program (ADAP) and other local, state or national funding sources that directly pay for your care (including private health insurance).

The Coordinated Services Network is committed to ensure that the information maintained in your client records remains confidential, secure and can be accessed only by individuals authorized to do so.

(AGENCY NAME) has entered into an agreement with the Coordinated Services Network to provide a comprehensive and coordinated level of care.

We use a shared data collection software product known as "CAREWare".. **Your information will be maintained securely and is only shared with your consent.**

The medical and support service providers (listed above) will disclose to funding and specified service providers (referenced above) the required data base demographic and Personal Health Information (PHI) about you (including medical, dental, HIV test results_____, substance abuse prevention, psychiatric/psychological, and case management). Disclosure is for the purpose of coordinating payment for care, treatment, health care operations, and to demonstrate that the quality of care provided is in accordance with accepted standards.

Client Signature: _____

CLIENT NAME:_____

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

➢ You maintain control of the personal health information that is shared with others providing services and treatment by signing the attached release of information form.

➢ You will receive notice of any changes made to our privacy and security practices.

➢ CSN providers receiving information from us may not release your PHI to outside agencies or organizations.

➢ You may provide other means of communication. Each form of communication presents unique risks for unintentional disclosure. I authorize you to optionally contact me for appointment reminders and other medical or dental matters by the below method(s):

Initials
_____ mailed to this address: _____,

_____, _____, zip _____

_____ by a phone call to one of these numbers: #_____-_____-_____, #_____- _____-

_____, Cell Phone #_____- _____-_____

_____ other means of communication:_____

_____ **TEST** Results (excluding HIV, or minor family planning) may be mailed to me at home

or the above addresses.

_____ **FAX --** I authorize my PHI to be faxed to others for payment or healthcare operations.

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 Records:

As a recipient of medical and supportive services through a member agency of the Coordinated Services Network, your records are maintained on a secure computer system known as "CAREWare".. The system requires each individual to enter his or her personal user ID and Secret Password to authenticate identity and establish the specific records and information the user is authorized to view. Passwords expire every ninety days and must be changed for continued access to the database.

➢ All of our electronic client records are stored in a highly secure location separate from where you receive services.

➢ A secure backup is made daily. This is done to provide disaster recovery in the event of difficulties at the main computer location.

CLIENT NAME:_____

Staff Training:

The staff of this agency undergo training as new employees and annually. This training ensures that each staff member is introduced to privacy and security policies and practices.

Acknowledgement of receipt of this form:

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

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

_____   _____
Patient-Client / Representative or Guardian's Signature   Date

_____   _____
Patient- Client Representative / Guardian's Relationship   Agency Representative and Date

                                             _____
                                             Printed Name of Agency Representative

THE ORIGINAL SIGNED COPY OF THIS FORM IS FILED IN THE PATIENT/CLIENT'S MEDICAL RECORD

WITHDRAWAL OF CONSENT

I, _____ hereby WITHDRAW THIS CONSENT, effective

_____ .
Date of withdrawal
_____
Client/Representative Signature Date

_____   _____
Signature/Date   Client Signature

_____   _____
Witness   Client ID

                                                _____
                                                Client Date of Birth

                                                _____
                                                Date Signed

CLIENT NAME:_____

PATIENT CONSENT/OPT OUT

For sharing of patient information among providers for persons using Ryan White CAREWare Electronic Health Records

(AGENCY NAME) is mandated to collect certain personal information that is entered and saved in a database system called CAREWare. CAREWare records are maintained in an encrypted statewide database, in a secure server by the State of Florida Department of Health. CAREWare aggregate reports may be used for advocacy, both statewide and federally, and any client information used will be done so without revealing names or other information that would identify any specific client.

The CAREWare database software allows for certain medical and support service information to be shared among providers involved with your care. This includes but is not limited to medical visits, lab results, medications prescribed, emergency financial assistance, nutritional supplements, case management, transportation, substance abuse and mental health counseling.

You have a right to opt out of this electronic sharing; however, you will be personally responsible for payment for services received when payor sources cannot access your health records to verify receipt of services.

(1) I _____ (Print Name) hereby provide my consent and authorization for (AGENCY NAME) to enter my client-specific health, treatment, and support service information in the encrypted CAREWare database. This authorization allows the disclosure and sharing of the information entered into the CAREWare database to any provider or funder within the Coordinated Services Network.

_____   _____
Client Signature   Date

_____   _____
Witness Signature   Date

<u>**NOTE: THIS AUTHORIZATION AUTOMTICALLY EXPIRES THREE YEARS FROM DATE OF SIGNING.**</u>

Application to Receive Allowable Services for HIV/AIDS Patient Care Programs:

- AIDS Drug Assistance Program (ADAP)
- AIDS Insurance Continuation Program (AICP)
- State Housing Opportunities for Persons with AIDS (HOPWA)
- Ryan White Title II Consortia and other Bureau HIV/AIDS Patient Care Programs

PART 1. Adult Applicant Information: **HIV positive is an eligibility requirement. Check if you are HIV Positive.**
__Y ____N ____Unknown. **Provide a copy of an HIV Laboratory Test which shows your HIV status.**

Name: _____
First   M.I.   Last   Date of Birth (MM/DD/Year)

Male___   Female___   Transgender___   Race_____   Language_____

Check if you receive HIV/AIDS services from any of the following program(s):

ADAP__   AICP___   HOPWA___   TITLE II____   TITLE I ____   COUNTY HEALTH DEPARTMENT____   Other_____

If you have a Case Manager, please provide the name & agency: _____

Are you a Veteran? Yes ___No____   **Have you served in the Armed Forces?** Yes___ No___

Are you Pregnant? Yes ___No____ Don't Know_____

Do you have a housing need? Yes___ No___   **Do you rent?** Yes___ No___   **Do you own your house?** Yes___ No___

How much is your monthly mortgage $_____ or rent $_____

Are you taking a prescription drug(s)? Yes___ No___If you can, please name or bring your prescriptions to your appointment
_____

PART 2. Living Arrangements

Address Where You Currently Live: _____
Number   Street   Apt. Number

_____FL_____
City   State   Zip   County

Mailing Address: _____
(if different)   Number   Street   Apt. Number

_____FL_____
City   State   Zip   County

Home Telephone: _____ Other Contact Telephone: _____

Work Telephone: _____ Name of Employer(s): _____

Email: _____

How many adults live with you? ____ (Spouse/Parents/Adult Children/Partner/Roommate, etc.)
How many children live with you?____ (Under 18 years of age)

Check how you prefer staff contact you:
HOME PHONE____ WORK PHONE____ OTHER CONTACT PHONE____ EMPLOYMENT PHONE____ MAIL____ OTHER____

PART 3. Medicaid Insurance and Other Programs:

Check if you receive services from the following programs:

Medicaid ___   Medicare ___   Project AIDS Care ___ Veterans Administration _____   Children's Medical Services (CMS) ____

Other ____ (Name)_____

Are you currently receiving HIV/AIDS services from another local, state or federal public assistance program?
Yes___ No____ If yes, which one(s):_____

Do you have an existing health insurance policy? Yes ___No____   **If Yes, is it through an employer?** Yes ___No___

If NO, does your employer offer health insurance as a benefit? Yes ___No____

A8

READ THE FOLLOWING BEFORE YOU COMPLETE **PART 4 & 5**
PLEASE CHECK 4 IF YOU ARE PARTICIPATING IN ONE OF THE FOLLOWING PROGRAMS AND BRING THE AWARD OR ELIGIBILITY LETTER OR CARD AS PROOF.

__Medicaid   __Temporary Assistance for Needy Families (TANF)
__Project AIDS Care (PAC)   __Women, Infants and Children (WIC)
__Food Stamps   __Name Other:_____

SKIP PARTS 4 & 5 IF YOU HAVE PROOF OF ELIGIBILITY FOR ONE OF THE ABOVE PROGRAMS.

PART 4. Household Monthly Income

Household Income means gross income from all sources received by the applicant and the applicant's spouse (if married). This includes other adult persons living in the home, if they have joint financial arrangements with the applicant, such as banking (checking and savings) accounts, mortgage agreements, business or other personal finances.**DO NOT INCLUDE,** adults in the home with separate finances, live-in aides or persons under 16 years of age.

HOUSEHOLD MONTHLY INCOME BEFORE TAXES AND DEDUCTIONS

Name (First & Last)	Relationship of person to you	Monthly Work Income $	Monthly Social Security $	Monthly SSI Retirement Income $	Unemployment Child Support, Public Assistance, Other $	Monthly Totals $	Check if No Income*
	Applicant						
Total Monthly Household Income					$_____		

*If you checked NO INCOME provide a statement as to how food, clothing and shelter are being provided for you.

PART 5. Cash and Items of Value

Do you have a checking bank account? Yes___ No_____ **If yes, how much?**$_____
Do you have a savings bank account? Yes___ No_____ **If yes, how much?**$_____ **How many cars do you have?** ____
Do you have more than 1 home? Yes___ No_____ **Do you own property (other than your personal residence)?** Yes___ No_____
Do you own a business? Yes___ No_____ **Name and Address:**_____
List other items of value such as Certificates of Deposits, Treasury Bills Other:_____

PART 6. Rights and Responsibilities (Please Initial by Each Item Below)

☐ I understand that I am responsible for giving truthful and correct information on this application and during the application process to the best of my knowledge and failure to be truthful may prevent or delay a determination of eligibility to receive services.

☐ I understand if I knowingly give information that is not true or withhold information and receive services that I am not eligible to receive, I may be lawfully punished and have to pay the Department of Health back for services.

☐ I understand the information I provide may be verified, which may include computer matching and the information I give about my income may be checked,

☐ I understand that the information will be kept confidential in accordance with Florida and Federal law.

☐ I understand not all services I am eligible to receive may be available, accessible or funded, and I may not meet specific Program Qualifications for some programs.

☐ I understand that at any time during the application process I can be denied eligibility if my actions are uncooperative, disruptive of office procedures, threatening or hostile towards staff.

☐ I understand the Department of Health, eligibility staff cannot discriminate because of race, color, sex, age, disability, religion, nationality or political beliefs.

☐ I understand I have the right to ask for a Fair Hearing if I think the decision on my case was unfair or incorrect.

SIGNATURE REQUIRED_____ Date_____

FOR ELIGIBILITY STAFF ONLY

Date Stamped Receipt of Application:_____ Walk-In____Mail____ Other_____
Date of Appointment: _____ Eligibility Staff: _____
Date Determined Eligible:____ Date Referred to: Case Management ___ ADAP____ AICP____ HOPWA ___ Other:____ Date_____
Date Determined Ineligible:____ Date Supervisory Review: _____ Fair Hearing Information Provided _____

A8

Eligibility Staff Assessment Worksheet

To be completed by eligibility staff to document applicant's eligibility status during enrollment.

Applicants Name	Address

Name of Agency	Address

Eligibility Staff	Phone Number

Proof of HIV: An applicant must have documentation of a medical diagnosis of HIV disease. A laboratory test documenting confirmed HIV infection is required. Check the appropriate box.

A confirmed positive HIV antibody test result (Reactive EIA/ELISA screening test confirmed by Western Blot or Immunofluorescense Assay (IFA) or Nucleic Acid Testing (Aptima) by blood, oral fluid or urine.	☐
A positive HIV direct viral test such as PCR or P24 antigen.	☐
A positive viral culture result.	☐
A detectable HIV-viral load or viral resistance test result.	☐
No Documentation - Do not proceed, applicant is not eligible	☐

Living in Florida: An applicant must be living in Florida. Photo ID is not required but encouraged. One form of documentation other than photo ID must be obtained.

No: ☐ Do not proceed, applicant is not eligible. Yes: Check all applicable items below.	☐
Drivers License	☐
Voters Registration	☐
Lease or Mortgage Statement	☐
Utility Bill	☐
Letter of Support	☐
Other: (specify)	☐

Screening for Other Programs: An applicant cannot be receiving services or be eligible to participate in local, state or federal programs where the same type service is provided. Check if the applicant is receiving or has been screened for any of the following:

Medicaid: (specify type)	☐
Project AIDS Care	☐
Medically Needy (list share of cost)	☐
Medicare (specify which parts applicant receives)	☐
Private Health Insurance (list type of insurance)	☐
Veterans Benefits	☐
Low Income Subsidy (Other Help, Medicare Part D)	☐
Other: (Specify)	☐

Income: An applicant must have low income (FPL below 400%).
Determining Financial Waiver for income – If an applicant has any of the following they may be waived for the income portion of the application with appropriate documentation. If yes, skip the next section.

Medicaid	☐
Project AIDS Care	☐
Food Stamps	☐
SSI (Supplemental Security Income)	☐
TANF (Temporary Assistance for Needy Families)	☐
WIC (Women, Infant and Children)	☐
Local Indigent Program	☐
Other (specify):	☐

Determine Household Size: List all household members and whether they are counted or not counted in Household Size. (Applicant, Spouse and Dependent are always counted in the Household Size)

Name	Relationship	C	NC
		☐	☐
		☐	☐
		☐	☐
		☐	☐
How many adult household members are counted (including applicant):			
How many of the applicant's dependent children are in the home.			
Total Household Size			

Household Monthly Income: For applicants and COUNTED Household Members (HM) only.
Determine the <u>applicant's</u> household income and the <u>counted</u> household members income named in the step above. If the applicant is unemployed, use additional paper to document responses to the applicable "no Income/unemployed" questions. Complete the list as either annually or monthly, but not mixed.

Income	Applicant	Counted Member
Unemployed ☐ (explain in narrative how person is living)		
Employment (where)		
Self Employed		
Checking Account		
Savings Account		
Investment income (Ex: rental properties)		
Retirement Income (if accessed)		
Disability Benefits		
Alimony		
Child Support		
Other (specify)		
Total Household Income		

Eligibility Staff Assessment Worksheet

FLORIDA DEPARTMENT OF HEALTH

Calculating the Federal Poverty Level: Using the most current FPL chart and the household size total, determine the $ and FPL for the applicant. <u>Calculate actual FPL instead of range.</u> Use the total household income based on family size and divide by dollar amount in Column A of the FPL chart. You must use the annual income chart to arrive at the correct FPL. (See section 11 for calculating FPL)

Total Household Income	Total FPL%

The applicant meets the income requirements.	☐
The applicant does not meet the income requirement and is not eligible.	☐

Rights and Responsibilities: An applicant must be willing to cooperate with eligibility staff during the eligibility process and sign and comply with the Rights and Responsibilities established in the application.

The applicant has initialed each requirement in the Application, provided the required signature and complied with the requirements during the eligibility process.	☐
The applicant has not complied with this requirement. (Explain)	☐

Final Determination: Based on eligibility interview, application and required documentation the applicant is:

Eligible	☐	**Date:**
Not Eligible	☐	**Date:**

Eligibility Staff Printed: _____

Eligibility Staff Signature: _____

Date: _____

Six Month Recertification Review Form

To be completed by Eligibility staff to document applicant's re-determination.

Re-determination Date   Eligibility Staff Name

Client's Name   Address

Please indicate any changes that have occurred and attach appropriate documentation:

	Change	No Change
Living in Florida	☐	☐
Participating in Other Social Service Programs	☐	☐
Income	☐	☐

The client has provided updated documentation for any items marked "change" and/or updated income information where necessary. ** All employment income must be verified every six months.

Fill in the following information based on the re-determination.

Household Size	
FPL	
Income	
Other Programs (list all that apply)	

Eligibility Staff Printed: _____

Eligibility Staff Signature: _____

Date: _____

Notice of Eligibility

FLORIDA DEPARTMENT OF
HEALTH

Date	Clients Name

Client's Address

It has been determined that you comply with the required eligibility requirements to receive allowable services from the Department of Health, Division of Disease Control, Bureau of HIV/AIDS, Patient Care Programs. Allowable services are based on availability, accessibility, funding and program qualifications for the AIDS Drug Assistance Program (ADAP), the AIDS Insurance Continuation Program (AICP), and the state Housing Opportunities for Persons with AIDS (HOPWA) specialty programs.

Your eligibility status for receiving allowable services from the HIV/AIDS Patient Care Programs is valid for 6 months from the date of this correspondence. You must have a new determination for eligibility no later than the expiration date provided below in order to continue services. You must advise the originating eligibility staff when there are changes which affect your eligibility status.

Your signature below acknowledges your understanding of the following:
- I have received a copy and verbal explanation of this notice.
- I understand the requirements for receiving HIV/AIDS services.
- I verify that I have complied with all of the Rights and Responsibilities in the Application as verified by my signature on the application.

Client's signature:_____ Date:_____

Eligibility staff signature: _____ Date:_____

Re-determination Date Due No Later Than	

Eligibility Staff Name	Phone

Address

Household Size	
FPL	
Income	
Other Programs (list all that apply)	

Keep this notice of eligibility in a safe place. Bring this notice along with photo identification when meeting with an ADAP, AICP, HOPWA, or case management representative about services.

Notice of Ineligibility

Date   **Client's Name**

Client's Address

It has been determined by that you are ineligible to receive allowable services from the Department of Health, Division of Disease Control, Bureau of HIV/AIDS, Patient Care Programs for the following reason(s):

You are not HIV positive	☐
Your gross income is above 400% of the federal poverty line	☐
Your are not living in Florida	☐
You are unwilling to sign all forms and provide the appropriate eligibility information.	☐
You are not willing to utilize your private or other third party insurance	☐
Other (specify):	☐

Please contact this agency with the appropriate documentation for a re-determination, if you have any changes in the above eligibility factors.

Your signature below acknowledges your understanding of the following:

- I have received a copy and verbal explanation of this Notice of Ineligibility.
- I have received referrals by eligibility staff for possible participation in other programs.
- I have been given a copy of the Notice of Rights, which is attached to this Notice.

(Chapter 64D-4, F.A.C.)

Client's signature:_____   Date:_____

Eligibility staff signature: _____   Date:_____

Eligibility Staff Name   **Phone**

Address

Household Size	
FPL	
Income	
Other Programs (list all that apply)	
Other Programs (list all that apply)	

Keep this notice of ineligibility in the applicant's file.

Insurance Waiver Form

Date   **Clients Name**

Client's Address

Eligibility Staff Name   **Phone**

Address

Patient Care Programs under Chapter 64D-4 are payor of last resort. As such, any applicant/client eligible to receive health insurance through employment or COBRA, must access the insurance. Exceptions can be granted if the insurance policy is considered not viable. (See section 10 of eligibility manual for details).

Please check the appropriate box: **Date of open enrollment**

☐ | Applicant/client has available insurance during open enrollment |

Applicants/clients can be served while waiting for open enrollment. After the date listed above, applicants/clients are not eligible for services if they did not access the insurance.

☐ | Applicant/clients insurance is not viable.

Applicants/clients are eligible if the insurance policy is deemed not viable. This would include ADAP.

Proof of availability of insurance or policy description must be in the file. Refer to Section 10, Health Insurance for details.

Eligibility Staff Printed: _____

Eligibility Staff Signature: _____

Date: _____

* This form must be placed in the client file.

Poverty Guidelines 2013

Household Size		A 100%		B 101-150%	Medicare 135-150%		C 151-200%		D 201-250%		E 251-300%		F 301-350%		G 351-400%
1		$11,490	<	$11,605	$15,512	<	$17,350	<	$23,094	<	$28,840		$34,584	<	$40,330
1	<			$17,235	$17,235		$22,980		$28,725		$34,470	+	$40,215		$45,960
2		$15,510	<	$15,665	$20,939	<	$23,420	<	$31,174	<	$38,930		$46,684	<	$54,440
2	<			$23,265	$23,265		$31,020		$38,775		$46,530	+	$54,285		$62,040
3		$19,530	<	$19,725	$26,366	<	$29,490	<	$39,254	<	$49,020		$58,784	<	$68,550
3	<			$29,295	$29,295		$39,060		$48,825		$58,590	+	$68,355		$78,120
4		$23,550	<	$23,786	$31,793	<	$35,561	<	$47,335	<	$59,111		$70,885	<	$82,661
4	<			$35,325	$35,325		$47,100		$58,875		$70,650	+	$82,425		$94,200
5		$27,570	<	$27,846	$37,220	<	$41,631	<	$55,415	<	$69,201		$82,985	<	$96,771
5	<			$41,355	$41,355		$55,140		$68,925		$82,710	+	$96,495		$110,280
6		$31,590	<	$31,906	$42,647	<	$47,701	<	$63,495	<	$79,291		$95,085	<	$110,881
6	<			$47,385	$47,385		$63,180		$78,975		$94,770	+	$110,565		$126,360
7		$35,610	<	$35,966	$48,074	<	$53,771	<	$71,575	<	$89,381		$107,185	<	$124,991
7	<			$53,415	$53,415		$71,220		$89,025		$106,830	+	$124,635		$142,440
8		$39,630	<	$40,026	$53,501	<	$59,841	<	$79,655	<	$99,471		$119,285	<	$139,101
8	<			$59,445	$59,445		$79,260		$99,075		$118,890	+	$138,705		$158,520
9		$43,650	<	$44,087	$58,928	<	$65,912	<	$87,736	<	$109,562		$131,386	<	$153,212
9	<			$65,475	$65,475		$87,300		$109,125		$130,950	+	$152,775		$174,600
10		$47,670	<	$48,147	$64,355	<	$71,982	<	$95,816	<	$119,652		$143,486	<	$167,322
10	<			$71,505	$71,505		$95,340		$119,175		$143,010	+	$166,845		$190,680

Any patient whose household total gross annual income is above the amount shown in Column G is not eligible.

Attachment I

Self Employment Tracking Sheet

NAME: _____

DATE	AMOUNT MADE	TYPE OF WORK

_____   _____

SIGNATURE   DATE

Documents to be Scanned into CAREWare Unique IDs Tab	
Eligibility Application signed and dated by client *(new clients or closed for one year)*	
Social Security Card	
Coordinated Services Network form (*CSN*)	
Proof of HIV	
Western Blot or Immunofluorescense Assay (IFA) or Nucleic Acid Testing (Aptima) by blood, oral fluid or urine.	A positive HIV direct viral test such as PCR or P24 antigen
PAC Physician Referral form	A detectible HIV Viral Load or viral resistance test result
If client is an exposed infant (up to 12 months), document mother's HIV status	PRISM Reports
4th Generation testing	
Proof of Living in Palm Beach County	
Unemployment documentation with address	Recently postmarked letter mailed to client at 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 address	Documentation of homelessness with client signature & date
Prison records (if recently released)	PBC Insurance Verification form (for clients who cannot get paystubs)
Verification of Income/No Income	
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 Income (SSI, other)
Letter of Support (if no income explain)	Military/Veteran Pension
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 (3 months of tracking) or DCF Work Calendar	Alimony/Child Support/Survivor Benefits
SEQY (if no income- required annually, or as necessary)	
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
Insurance Waiver Form	Medicaid PAC
Veteran's Administration	Children's Medical Services
Documentation from Employer	Patient Assistance Programs (PAP's)
PBC Insurance Verification form (for clients who cannot get letter from Employer)	
Notice of Eligibility or Ineligibility (with signatures)	
Insurance Waiver (if necessary)	

Revised: 2/21/13

Eligibility Criteria for Palm Beach County HIV/AIDS Services Provided by Ryan White Part A

Outpatient Primary Medical Care*	HIV+ or exposed infant up to 1 year old	At or below 400% FPL	Does not have access to another payer source		
Lab*	HIV+ or exposed infant up to 1 year old	At or below 400% FPL	Does not have access to another payer source		
Nurse Care Coordination*	HIV+ or exposed infant up to 1 year old	At or below 400% FPL	Does not have access to another payer source		
Specialty Medical Care*	HIV+ or exposed infant up to 1 year old	At or below 400% FPL	Does not have access to another payer source		
Health Insurance*	HIV+ or exposed infant up to 1 year old	At or below 400% FPL	Does not have access to another payer source		
Drug Reimbursement*	HIV+ or exposed infant up to 1 year old	At or below 400% FPL	Does not have access to another payer source		
Oral Health*	HIV+ or exposed infant up to 1 year old	At or below 400% FPL	Does not have access to another payer source	Maximum of 24 visits per client annually	
Home Health Care/Home and Community Based Health Services	HIV+	At or below 400% FPL	Does not have access to another payer source	Home Health services (including Durable Medical Equipment) authorized by physician prescription	
Early Intervention Services/Outreach	Local EIIHA & Disproportionately Impacted populations				
Treatment Adherence	HIV +	At or below 400% FPL	Does not have access to another payer source		
Substance Abuse Outpatient	HIV+	At or below 400% FPL	Does not have access to another payer source	Evaluation by Certified Addiction Professional (CAP) determining outpatient treatment is necessary	
Substance Abuse Residential Treatment	HIV+	At or below 400% FPL	Does not have access to another payer source	Evaluation by Certified Addiction Professional (CAP) determining residential treatment is necessary	

Service	Eligibility	Income	Other Requirements		
Peer Mentor Program	HIV+	At or below 400% FPL	Does not have access to another payer source		
Medical Case Management Services	HIV+	At or below 400% FPL	Does not have access to another payer source		
Non Medical/Support Case Management Services	HIV+	At or below 400% FPL	Does not have access to another payer source		
Food Bank/ Home Delivered Meals	HIV+	At or below 150% FPL	Resources resulting in $100 in food stamps per person per household a month or less	Must apply for and maintain enrollment in Food Assistance Program (food stamps)	
Medical Transportation	HIV+	At or below 150% FPL	No other available transportation resources and Palm Tran Connection denial or pending	Must be enrolled in medical and/or support services	
Mental Health Services	HIV+	At or below 400% FPL	Does not have access to another payer source	Evaluation by Licensed professional determining treatment is necessary	
Legal Services	HIV+	At or below 400% FPL	Does not have access to another payer source		
Emergency Financial Assistance	HIV+	At or below 400% FPL	Does not have access to another payer source	Up to 12 accesses/year for no more than a combined total of $1,000 during grant year	Documented need for assistance based on income/ expense ratio
Housing Services	HIV+	At or below 400% FPL	Does not have access to another payer source	Up to 120 days of emergency housing services	

* Clients over 400% FPL who are currently receiving medical services may continue to do so until June 30, 2012, at which time they will no longer be eligible.

Prepared by the Ryan White Part A Grantee Office, 810 Datura Street, West Palm Beach, 561-355-4730.

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