HIV COMMUNITY SERVICES PROGRAM

Support Services Guide

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SECTION 1: PROGRAM POLICIES

PROGRAM PRIORITIES

The program follows the core medical services requirement of the HIV/AIDS Bureau (HAB) of the Health Services and Resources Administration (HRSA), the federal administrative agency of the Ryan White HIV/AIDS Treatment Extension Act of 2009. HRSA requires that Ryan White Program grantees assure that the core medical services are adequately met before spending resources on other support services. Per HRSA policy, remaining funds may be spent on support services. See below for a list of the HRSA service categories funded by Oregon's Part B and discussed in more detail throughout this guide.

Core Medical Services	Support Services
• AIDS Drug Assistance Program Treatments • Health Insurance Premium and Cost Sharing Assistance • Home and Community Based Health Services • Home Health Care • Medical Case Management, including Treatment Adherences • Medical Nutritional Therapy • Mental Health Services • Oral Health Care • Substance Abuse Outpatient Care	• Emergency Financial Assistance • Food Banks/Home Delivered Meals • Housing • Linguistic Services • Medical Transportation • Non-Medical Case Management • Substance Abuse Services (residential)

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

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

CAREWARE

It is required that all demographic, case management and support service units, and clinical fields related to each actively enrolled client must be entered into the CAREWare data system within 30 days of service or receipt of information in the county-based service model and 72 hours in the regional based service model, per the Oregon CAREWare User Guide located at located in the CAREWare section at www.healthorgeon.org/hiv.

GENERAL PROGRAM REQUIREMENTS

1. Services must be provided in accordance with OAR 333-022-2000, which can be located at www.healthoregon.org.
2. Ryan White Program funds must be used as dollars of last resort. No expenditures will be incurred with Ryan White Program funds for any item or service which can be reasonably paid through medical insurance, or other state, federal or private benefits programs. However, use of Ryan White Program funds may be allowable when significant access or other barriers are identified and documented in the client file. Veterans and Native Americans are exempt from the payer of last resort policy. They are not required to seek medical services from the entitlement programs they qualify for (i.e. VA and Indian Health Services) and may receive eligible medical services through the Ryan White Program.
3. Affected family members or partners of HIV positive clients are eligible for some services in the following circumstances:
    - The service's primary purpose enables the non-infected individual to participate in the care of someone with HIV disease or AIDS.
    - The service enables the infected individual to receive needed medical or support services by removing an identified barrier to care.
    - The service promotes family stability for coping with the unique challenges posed by HIV/AIDS.
4. No charges are imposed for HIV case management services. It is the intent of the program to ensure access and retention in services necessary to maintain HIV medical care for all low income people living with HIV.
5. Use of Ryan White Program funds for emergency assistance, known as Emergency Financial Assistance (EFA), must be for limited amounts, limited use, and limited periods of time: provider(s) will be expected to establish clear eligibility standards for access to assistance and a limit for the amount of assistance a client may receive. Generally, emergency assistance should not be provided for more than 3 months total in a Fiscal Year (July 1 – June 30), and one-time only within a Fiscal Year (July 1 – June 30) for Emergency Housing or Utility Assistance. Once this limit has been reached, services should be paid for out of the appropriate non-EFA service category and documented in the client's most recent care plan.

6. Clients with unconfirmed diagnosis or whose eligibility hasn't been determined, are only eligible for Ryan White funded medical case management, non-medical case management, psychosocial case management/care coordination and Emergency Financial Assistance (EFA) necessary to connect with medical care or HIV Case Management in order obtain confirmation of a HIV diagnosis. These services are allowable until HIV confirmation has been received and eligibility is complete, but no longer than 30 days from the CAREWare enrollment date. In extenuating circumstances, and upon approval by HIV Community Services, additional financial support services may be necessary.
7. In no case may Ryan White Program funds be used to make direct payments of cash or checks to a client. Where direct provision of the service is not possible or effective, stored value cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Stored value cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the Ryan White Program are allowed as incentives for eligible program participants. RWHAP recipients are advised to administer voucher and stored value card programs in a manner which assures that vouchers and stored value cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and stored value cards. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment.
8. Stored value cards and other items allowed per this guidance may be purchased in bulk and dispersed to clients as needed. Bulk purchases are intended to be utilized in the same fiscal year they are purchased. Therefore, quantity projections must be considered when making bulk purchases. Any remaining items left over at the end of the fiscal year must be reported to the program on the Quarter 4 Administrative Fiscal Form, under the section explaining discrepancies between total expenditures reported and the data entered in CAREWare. If purchasing items in bulk, the service should be recorded in the client's CAREWare record at the time provided, including the cost of the service provided.
9. The Ryan White Program is a needs-based program; clients with the highest needs receive the greatest amount of service. Additionally, clients are not required to participate in case management if they do not require any Ryan White Program services. The Ryan White Program is not a federal entitlement program.
10. Clients receiving only CAREAssist services are not required to be in case management unless specifically required by the CAREAssist program. However, clients receiving Oregon Housing Opportunities in Partnership (OHOP) housing assistance services must be enrolled in case management as a requirement of program eligibility.
11. Service expenditures are expected to meet the minimum assessed need for the client. If the HIV case manager is faced with authorizing a basic service/item versus a costlier

service/item that serves the same purpose, the HIV Case Manager should select the basic service/item.

12. Ryan White Program funds may not be used to pay for professional licensure or meet program licensure requirements.
13. Payments can be made on past due bills if it is a current barrier to housing; client was eligible for services at the time of payment; there is documentation of how it addresses a barrier(s) to HIV Care & Treatment, such as housing, utilities, etc. If a bill has gone to collections, or is over 12 months old, contact OHA for prior approval.
14. Ryan White Program funds may not be used to pay for off-premise social or recreational activities (i.e. movies, vacations, gym membership, parties, or retreats).
15. Every Ryan White Part B Program must be in compliance with the State requirements for a Release of Information (as required under ORS 192.518-192.524) in which a client authorizes in writing the disclosure of certain information about their case to another party (including family members).
16. All support service payments must be directly linked to documented need. Authorizing support service payments for one service to offset the client-identified need, which is either a disallowed service or for which the client has reached the service category cap, is not allowed. In other words, cost-shifting client expenses to offset a disallowed or "maxed" out service is not allowed.
17. Ryan White support services may only be provided to persons incarcerated in a local, State or Federal correctional facility if the client is expected to be eligible for support services upon their release, and the support service is to ease re-entry . Case management and/or care coordination for purposes of transition into the community is allowable, per HIV Case Management Standards of Services, Case Management for Reentry to Community Section (Regional and County-Based Standards).
18. Eligible clients can receive services regardless of immigration status.
19. Per HRSA policy, funds awarded under the Ryan White Part B Program may NOT be used for:
    - Inpatient Hospital Services: Funds may not be used to assist with inpatient care.
    - Clinical Trials: Funds may not be used to support the costs of operating clinical trials of investigational agents, treatments (to include administrative management or medical monitoring of patients) or the cost of transportation and travel for a client's participation.
    - Pre-Exposure Prophylaxis: Funds may not be used to purchase antiretroviral medication for HIV negative people.
    - Clothing: Purchase of clothing.
    - Detox: Inpatient detoxification in a hospital setting (Detoxification offered in a separate licensed residential setting is allowed, including a separately-licensed detoxification facility within the walls of a hospital, see Substance Abuse Services).
    - Funerals: Funeral, burial, cremation, or related expenses.
    - Household Appliances: Household appliances.
    - Mortgages: Payment of private mortgages.

- Medical Marijuana: For application fees, or any other cost associated with prescribed medical marijuana.
- Pets: Pet foods, products or veterinary visits.
- Taxes: Paying local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Vehicle Maintenance: Direct maintenance expense (tires, repairs, etc.) of a privately-owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees.
- Water Filtration: Installation of permanent systems of filtration of all water entering a private residence. Water filtration/purification devices (either portable filter/pitcher combinations or filters attached to a single water tap) are allowable under Food Bank/Home Delivered Meals, in communities/areas where recurrent problems with water purity exist and are documented. Such devices, including their replacement filter cartridges, purchased with Ryan White HIV/AIDS Program funds must meet National Sanitation Foundation standards for absolute cyst removal of particles less than one micron.

CLIENT ELIGIBILITY

1. Client must have a verified HIV diagnosis.
2. Client must reside in the Ryan White Part B HIV case management service area where the client is seeking services, unless authorized by the HIV Community Services Program.
3. To qualify for Ryan White Program case management (medical and non-medical) a client must be enrolled in HIV case management and their gross income must be verified at **or below 550% of Federal Poverty Level (FPL)**.
4. To qualify for Ryan White Program financial support services, a client must be enrolled in HIV case management and their gross income must be verified at **or below 300% of Federal Poverty Level (FPL)**.

At intake and annually thereafter, every client is required to complete a Client Eligibility Review form.

Verification of HIV Diagnosis

Proof of an HIV diagnosis is only required at the INITIAL Intake and must be verified within 30 days of intake.

1. Documentation of HIV status must include at least one of the following:
    a. A current CAREAssist card, CAREAssist HIV Verification form or a copy of the CAREAssist Eligibility Report in the client file.
    b. Written verification of test results that confirm an HIV diagnosis sent directly from a lab or physician.
    c. Lab results at any time during the client's lifetime that show detectable HIV RNA

sent directly from a lab or physician.

d. Written verification from another HIV Case Manager who has one of the above documents in the client's file.
e. Written verification of a test result that shows an unconfirmed preliminary positive HIV test result.

In accordance with the HIV Testing Policy and Procedures, documentation of 2 Rapid HIV tests used for preliminary and confirmatory HIV verification must meet the following criteria:

a. The rapid test kits are produced by different manufacturers;
b. The rapid test used for confirmatory testing has an equivalent sensitivity.

For clients with an unconfirmed preliminary diagnosis:

a. HIV Case Management contractors should have a memorandum of understanding or agreement with key medical providers in their service area to facilitate the timely linkage of clients into HIV medical care. The receiving medical practice must be informed of the individual's unconfirmed preliminary positive HIV test and the urgent need for confirmation.
b. The client should be counseled about the likelihood of infection and real (though small) possibility of a false positive result.
c. Written verification of a confirmed HIV diagnosis must be included in the client file when obtained.

Verification of Identity

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

(a) State Driver License[1];
(b) Tribal identification (ID);
(c) State ID card[2];
(d) Military ID;
(e) Passport;
(f) Student ID;
(g) Social Security Card;
(h) Citizenship/Naturalization documents;
(i) Student visa;
(j) Oregon Learner's Permit or Temporary License;
(k) Birth certificate;
(l) Mugshot (police booking photo) or;
(m) Other form of verification with OHA HCT program approval.

[1] Only Oregon State Driver Licenses can also be applied to verify residence for potential client. All other state driver licenses do not meet residency requirements.
[2] Only Oregon State ID cards can also be applied to verify residence for potential client. All other state driver licenses do not meet residency requirements

Verification of Residence

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

- Copy of the CAREAssist Eligibility Report
- Unexpired Oregon State driver license**,** Tribal ID or Oregon State ID
- Utility Bill (including cell phone)
- Lease, rental, mortgage or moorage agreement/document
- Current property tax document
- Current Oregon Voter Registration card
- Letter from lease holding roommate (must include the lease holder's name, address that matches the CAREAssist Application and/or HIV Community Services Intake Form, relationship to the client and the lease holder's phone number)
- Copy of public assistance/benefits letter/documentation (SSI, SSDI, TANF, etc.)
- Paystubs
- Court Corrections Proof of Identity
- Homeowner's association statement
- Military/Veteran's Affairs documents
- Oregon vehicle title or registration card
- Any document issued by a financial institution that includes residence address, such as, a bank statement, loan statement, student loan statement, dividend statement, credit card bill, mortgage document, closing paperwork, a statement for a retirement account, etc.;
- Approved letter from Oregon State Hospital, homeless shelter, transitional service provider or halfway house
- Letter on company letterhead from an employer certifying that the client lives at a non-business residence address owned by the business or corporation.
- Residency affidavit

Verification of Insurance

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

- CAREAssist (CAREAssist Card and/or a copy of the CAREAssist Eligibility Report)
- Qualified Health Plan (QHP)
- Medicare

    - Part A
    - Part B
    - Part D
    - Low Income Subsidy
    - Qualified Medicare Beneficiary
- Oregon Health Plan (Medicaid)
- Private
    - Purchased outside Health Exchange
    - Group Policy (employer or spouse/parent's employer)
    - COBRA
    - Dental Insurance
- Other Public
    - VA Benefits[3]
    - Indian Health Services[4]
- No Insurance

Verification of Income

Income means the monthly average of any and all monies received on a periodic or predictable basis, which the family relies on to meet personal needs.

To be eligible for case management/care coordination services household income must be at or below 550% of the Federal Poverty Level. To be eligible for any other core medical or support services, household income must be at or below 300% of the Federal Poverty Level. An individual must submit appropriate income verification documentation for all family members and from all sources to determine total monthly income for a family.

There are 5 steps to determining income eligibility.

Topic	Guidance
Step #1: Determine whether client is pre-qualified	If a client is active in CAREAssist, and CAREAssist has determined client's income is at or below 550% of the FPL, they are pre-qualified. To be pre-qualified, proof of current participation in the CAREAssist Program must be obtained during the original Intake.
Step #2: Determine family members	A family is defined as a group of two or more persons related by birth, marriage, adoption, or a legally defined dependent

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

	relationship (see "Dependent Status Policy" below). Life partner, significant other, legally registered Domestic Partner, or roommate (with no children in common) is not counted as family for purposes of income verification. Please note CAREWare uses the term "household" for the family definition described above. Also, the family/household definition described here is not the same as the definition of household used by the OHOP program.
Step #3: Determine allowable documentation	See chart below
Type of Income:	**Required Documentation:**
No Source of Income	Complete the "Income Affidavit"
Other household income from Spouse, or Partner living with client with a shared legal child; and/or Legal Dependent Income	See below required documentation based on type of income
Work income (wages, tips, commissions, bonuses)	2 months current, **consecutive** paystubs or earnings statements for **all** jobs
Self-employment Income	Most recent federal tax return, including Schedule C (if filed) **AND** Previous 6 months of bank statements **OR** if not available: Business records for 6 months prior to enrollment/recertification
Social Security: Retirement, survivor's benefits, SSI, SSDI	Annual benefit award letter
Private/Employer Pension or retirement income (*not Social Security*)	Annual benefits award letter/statement
Unemployment benefits	Compensations stubs
Employer Disability benefits: Short Term (STD) Long Term (LTD)	Compensation stubs **OR** Benefit award letter/statement
Veterans benefits	Annual benefit award letter
Stocks, bonds, cash dividends, trust,	Documentation from financial institution showing income received, values, terms and conditions.

investment income, royalties	
Alimony or Child Support (*received on a periodic of predictable basis*)	Benefit award letter/statement **OR** Official document showing amount received regularly
Rental income	Most recent federal tax return, including Schedule E (if filed) **AND** Previous 3 months bank statements
Other:	Document:
Step #4: Calculate Gross Income	In most circumstances, gross income is used to determine eligibility. Gross Income is total income BEFORE any taxes or other withholdings are deducted. Net Income is also known as "take home" income, or income AFTER taxes and withholdings are deducted. Net income may only be used when: (i) A self-employed individual or the individual's family member files an Internal Revenue Service, Form 1040, Schedule C in which case the agency will allow a 50 percent deduction from gross receipts or sales; or (ii) An individual or individual's family member has income from rental real estate and provides a copy of the most recent year's IRS Form 1040 (Schedule E). In this case the agency may use the total rental real estate income, as reported on the Schedule E. If the Schedule E shows a loss, the applicant or applicant's family member shall be considered to have no income from this source. Because annual income will vary based upon whether or not the client is paid hourly, weekly, bi-weekly, or twice a month, see "Gross Monthly Income Determination" below for instructions on annualize.
Step #5: Identify the Federal Poverty Level	Determine an applicant's income by adding together all sources of family income and dividing that number by the applicable FPL. The resultant sum is the applicant's percentage of the FPL. To be eligible for case management/care coordination services household income must be at or below 550% of the Federal Poverty Level. To be eligible for any other core medical or support services, household income must be at or below 300% of the Federal Poverty Level.

	Please note: the CAREWare database will be updated after the poverty level changes take effect each year (March 1); however, it can take some time to do so.

Dependent Status Policy

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

- Dependent relationships include legal adoptions and guardianships.
- Dependent child status shall not extend beyond age 18, except when the dependent child is enrolled as a full-time student (min. 12 credit hours). In the case of student status, the age at which the dependent child status shall end is age 26. The client must attach documents to show that the child is enrolled in an educational institution and must be submitted with re-assessment.
- The client's most recent year Federal and State Income Tax Return can be utilized as a resource when claimed dependents is in question.
- Clients may not claim dependent status for individuals who reside outside the United States, unless those persons are listed on the clients most recent Federal Tax Returns filed; and there is a judicial ruling in the United States that defines a legal relationship and dependent status.
- All persons 19 or older (who are not covered by the student status extension, and whom the head of household is claiming dependent status) must be named specifically in a legally defined Guardianship Relationship approved by a U.S. Judicial proceeding. NO exceptions will be made to this requirement. Notarized copies of documents must be made available upon request to the program.
- Adults (i.e. elderly parents, disabled adult child, etc.) are approved dependents if the client has verifiable legal guardianship.
- In cases of joint custody, a child must live with the client 51% of the time in order to be included in the household.

Allowable Sources of Income

Income is the monthly average of any and all monies received on a periodic or predictable basis, which the family relies on to meet personal needs. For required documentation based on type of income see the chart on page 11, step 3.

Gross Monthly Income Determination

The following are program criteria for determining gross monthly income:

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

• If in the same job since the beginning of the year:	Refer to the year-to-date (YTD) total, then divide by the months, and percent of partial months, represented on the pay stub.	Example: Client X has a pay stub showing a pay date of June 15 and a YTD of $10,000. Divide the YTD amount by 5.5 months: *$10,000 divided by 5.5 months equals $1,818.18 per month.*
• If there is an hourly rate:	Calculate both the monthly income based on the YTD amount listed on their pay stub, described above, and annualize the hourly rate to find the monthly income to the client's best advantage.	Example: Client X makes $11 per hour. Calculate BOTH a YTD total AND multiply $11 x 2080 work hours per year which equals an annual income of $22,880. Then divide the annual income of $22,880 by 12 months which equals $1,906.67 per month.
• If the client has received a one-time, annual bonus:	This should be included in the ANNUAL salary (not YTD). To determine monthly income of total, divide by 12 months. Proof of the one-time status of the bonus may be necessary.	
• If the client is paid twice-a-month	Carefully check the pay stub to determine which factor to calculate when determining annual income –	

OR every-other-week:	24 pay periods per year for twice-a-month and 26 pay periods per year for every-other-week.	
• If there is a discrepancy between the monthly rate based upon YTD and the monthly rate stated on the pay stub or by client:	The monthly rated based upon YTD is calculated by dividing the YTD amount on the pay stub by the number of months in the total pay period. If this monthly rate is different from the monthly rate stated on the pay stub or if the client stated a different pay rate, further investigation will be warranted. This usually indicates a change in client status. They may have experienced a reduction in hours, began working part-time or were laid off - if the YTD monthly is less than the stated monthly. They may have worked some extra overtime or had a special circumstance which is not going to continue - if the YTD monthly is more than the stated monthly.	

- **Seasonal work:** Annual income based on documented seasonal trending is used for clients who can prove seasonal employment. Per OAR language, seasonal employment occurs when the applicant performs work cyclically during the year and most often the work is defined by seasons and typically defined by the calendar year. Again, the client's ability to document their earning "trend" is important and can be verified by looking at the client's previous year's federal income tax return.

- **Self-employed clients:** Net rental income will be used when the client submits the most recent year's IRS Form 1040 Schedule E. The client's ability to document their earning "trend" is important and can be verified by looking at the client's previous year's federal income tax return. A self-employed applicant or the applicant's family member should provide a copy of the most recent year's IRS Form 1040 (Schedule C) in which case the Authority may allow a 50 percent deduction from gross receipts or sales.

- **Rental income:** Net rental income will be used when the client submits the most recent year's IRS Form 1040 Schedule E, Line 26. If net income on the Schedule E is a negative

amount, consider this as zero income from this source. Without a Schedule E, gross rental income will be used.

- **Change in income or where there are no trends in income:** Annual income shouldn't be used for clients who experience frequent changes in income. Within reason, the program attempts to "look forward" in income assessment. The current monthly income should be used to determine eligibility.

Deductions to Income

- Do not take into account garnished wages, liens, child support payments and the monies garnished from monthly SSDI awards, to include reimbursement of previous Social Security overpayments.

- Gross income includes the amount that is deducted from Social Security checks for Medicare Part B.

- Food stamps are not considered income.

Verification of Residence
If the client's address has changed, enter the new address and attach approved documentation. Approved documentation to verify residence can be found in the client eligibility section (p. 6).

Verification of Income
If the client's income has changed, enter the new income and attach approved documentation. For required documentation based on type of income see the chart on page 11, step 3.

Verification of Insurance
If the client's insurance has changed, check the appropriate box and attach current insurance card. If client currently has or requests CAREAssist assistance with insurance premiums, a copy of the current premium statement must be requested to submit to CAREAssist. Failure to provide the insurance premium statement can result in loss of insurance. When insurance is terminated due to non-payment, individuals cannot reapply for private insurance coverage unless they experience a qualifying life event (QLE) that makes them eligible for a Special Enrollment Period, documentation of QLE will be required.

SECTION 2: CASE MANAGEMENT SERVICES

MEDICAL CASE MANAGEMENT, INCLUDING TREATMENT ADHERENCE

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

Key activities include:
- Initial and annual/ongoing assessment of service needs
- Development of a comprehensive, individualized care plan to be in compliance with the requirements under "Acuity Scale," within the HIV Case Management: Standards of Services
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

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

Program Guidance:
The objective of Medical Case Management services is improving health care outcomes, whereas the Non-Medical Case Management Services' objective is providing guidance and assistance in improving access to needed services. Case management activities under this category are provided by a Licensed Registered Nurse, or Nurse Practitioner. Telephone voicemail left for clients are not reportable as medical case management service visit and should be reported as a "RN Attempt Clt. Contact" service.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
MEDICAL CASE MANAGEMENT	MULTIPLE SUB-SERVICES—SEE CAREWARE QUICK GUIDE	15 MINUTES
NON CARE ACT SERVICE CATEGORY	RN ATTEMPT CLT. CONTACT	15 MINUTES

Report in CAREWare under Medical Case Management sub-services.

NON-MEDICAL CASE MANAGEMENT

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

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

Program Guidance:
The objective of Non-Medical Case Management Services is providing guidance and assistance in improving access to needed services, whereas the Medical Case Management services' objective is improving health care outcomes. Activities provided by someone who is recognized as a Case Manager or care coordinator, but who does not meet a "Nurse" definition, includes any case management contact and/or activity with or on behalf of the client. This includes phone contacts with the client and/or their representatives and contact of any kind with social service providers on behalf of the client. Ancillary activities related to the case management performed for a client, include, but are not limited to, visit preparation, chart notes, data entry, and written referrals, are reported here. Telephone voicemail left for clients are not reportable as a non-medical case management service visit and should be reported as a "Non-RN Attempt Clt. Contact" service.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
CASE MANAGEMENT (NON-MEDICAL)	MULTIPLE SUB-SERVICES—SEE CAREWARE QUICK GUIDE	15 MINUTES
NON CARE ACT SERVICE CATEGORY	NON-RN ATTEMPT CLT. CONTACT	15 MINUTES

SECTION 3: SUPPORT SERVICES

EMERGENCY FINANCIAL ASSISTANCE (EFA)

Recommended Service Cap (per Fiscal Year, July-June): $2200 per client per year total for all sub-services in this category

Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries and food vouchers), transportation, and full cost medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Use of Ryan White Program funds for emergency assistance must be for limited amounts, limited use, and limited periods of time: provider(s) will be expected to establish clear eligibility standards for access to assistance and a limit for the amount of assistance a client may receive. Generally, emergency assistance should not be provided for more than 3 months total in a Fiscal Year (July 1 – June 30), and one-time only within a Fiscal Year (July 1 – June 30) for Emergency Housing or Utility Assistance.

Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance and should be documented in the client's care plan.

Sub-services:

EFA FOOD VOUCHER

Description:
A card/voucher that cannot be converted to cash, allowing a client to purchase food products and groceries (including hygiene products) necessary to maintain health for the client with an emergent need in a short-term manner.

Program Guidance:
Documentation that clients have exhausted other food services prior to authorization (i.e. food banks, food stamps) must be in the CAREWare referral tab and case note. The voucher should clearly state that purchase of alcohol and tobacco products are not allowed. A voucher can also be defined as a payment to a store on behalf of a client.

For clients who have been assessed by a RN to have a nutritional need for food assistance please refer to Nutritional Support – RN Authorized, under Food Bank/Home Delivered Meals or Medical Nutrition Therapy.

If the need for food assistance persists beyond a short-term basis, please refer to guidance under Food Bank/Home Delivered Meals, Food Voucher.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
EMERGENCY FINANCIAL ASSISTANCE	EFA-FOOD VOUCHER	CARD OR VOUCHER

EFA HOUSING

Description:
Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Assistance with EFA Housing funds may only occur one-time in a Fiscal Year (July 1 – June 30). Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services, such as application fees.

Eligible housing can include either housing that:

- Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or
- Does not provide direct core medical or support services but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.

Program Guidance:
Use of Ryan White Program funds for short-term or emergency housing must be linked to medical and/or health care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment and may only occur one time within a Fiscal Year (July 1 – June 30).

Ryan White Program Housing funds may not be distributed as direct cash payments to recipients for services. Additionally, Housing funds may not pay for: mortgage payments,

recreational vehicles (RV), or any item that would increase the property value of the home (hot water heater, centralized heating and air conditioning, roof, vinyl siding, renovations, etc.).

If the client's housing needs persist beyond a one-time basis, please refer to guidance under Housing Services.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
EMERGENCY FINANCIAL ASSISTANCE	EFA-HOUSING ASST.	PAYMENT

EFA MEDICAL TRANSPORTATION

Description:
Medical transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services, including access to appointments that support health outcomes (such as social security, SNAP, insurance, psychosocial and/or medical services), self-management trainings, education groups, or during a housing search period for permanent stable housing.

Program Guidance:
Ryan White Program Transportation funds may not be distributed as direct case payments or cash reimbursements to clients. Additionally, Transportation funds may not pay for: direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle, or any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

If Medical Transportation assistance is needed beyond a short-term basis, please refer to guidance under Medical Transportation Services.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
EMERGENCY FINANCIAL ASSISTANCE	EFA-MEDICAL TRANSPORTATION	TRIP, CARD OR PAYMENT

EFA OVER THE COUNTER (OTC) FULL COST

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

Program Guidance:

This service includes over the counter, non-prescription pharmaceuticals/medications, including vitamins and supplements. Use of non-prescription medications must be recommended by the client's medical professional.

If insurance can be billed, please refer to guidance under Health Insurance Premium and Cost Sharing Assistance, Medical Access – Copay.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
EMERGENCY FINANCIAL ASSISTANCE	EFA-OTC FULL COST	MEDICATION

EFA OTHER

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

Program Guidance:
With the exception of payment of fees to access form of identification (such as an ID or birth certificate), no other services are allowed under this category without prior authorization from the HIV Care and Treatment Program.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
EMERGENCY FINANCIAL ASSISTANCE	EFA-OTHER	PAYMENT

EFA Rx FULL COST

Description:
The provision of temporary financial assistance to maintain access to necessary medical treatments for HIV infection. Such care must ensure access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections. This service is only intended for short-term access to full cost prescription medications for persons who are uninsured.

Program Guidance:
Full cost prescription medications may not be purchased with EFA unless documentation can be provided that the client is not eligible for CAREAssist/Bridge Program/UPP, or extenuating circumstances apply. Any service authorized under this category must coincide with an application/referral to CAREAssist. Documentation that the client is not eligible for CAREAssist must include, at a minimum: (1) a denial or restricted letter from CAREAssist or (2) notation of the reason(s) the client is not eligible for CAREAssist in the progress notes in the client's file.

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

If insurance can be applied, please refer to guidance under Health Insurance Premium and Cost Sharing Assistance, Medical Access – Rx Copay.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
EMERGENCY FINANCIAL ASSISTANCE	EFA-RX FULL COST	MEDICATION

EFA UTILITIES

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

Program Guidance:
Ryan White Program, Part B funds may only be used to provide assistance for the portion of the client's utility not covered through a utility subsidy and one time within a Fiscal Year (July 1 – June 30). Utility assistance is NOT allowed for any client who has received full utility assistance through any other program.

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

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

The OHOP program may be able to help your clients access LIHEAP. Consult with the assigned regional OHOP Housing Coordinator to determine that Ryan White Program funds are the only resources available to meet a client's utility assistance needs before using Ryan White Program funds for utility assistance.

If a client's utility needs persist beyond a one-time basis, please refer to guidance under Housing Services, Utility Assistance.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
EMERGENCY FINANCIAL ASSISTANCE	EFA-UTILITIES	PAYMENT

EYE CARE – FULL COST

Recommended Service Cap (per Fiscal Year, July-June): $1000 per client per year total for all sub-services in this category.

Description:
Services rendered by an Optometrist, Ophthalmologist or Optician not otherwise covered by insurance.

Program Guidance:
This service category includes corrective prescription eyewear once every two (2) years. Contacts are not covered in this service category unless prescribed as medically necessary by a licensed professional.

If insurance can be applied, please refer to guidance under Health Insurance Premium and Cost Sharing Assistance, Eye Care.

FOOD BANKS/HOME DELIVERED MEALS (FBHDM)

Recommended Service Cap (per Fiscal Year, July-June): $2200 per client per year total for all sub-services in this category.

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

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

Documentation that clients have exhausted other food services, prior to providing this service (i.e. food banks, food stamps), must be in the client's chart. The voucher should clearly state

that purchase of household appliances, pet foods and other non-essential products such as alcohol and tobacco products are not allowed. Where direct provision of the service is not possible or effective, stored value cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

Program Guidance:
Providers are advised to administer voucher and stored value card programs in a manner which assures that vouchers and stored value cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and stored value cards. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable, such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not stored value cards, and therefore are unallowable.

Sub-services:

FBHDM FOOD VOUCHER

Description:
A voucher that cannot be converted to cash, allowing a client to purchase food products and groceries (including hygiene products) necessary to maintain health. A voucher can also be defined as a payment to a store on behalf of a client.

Program Guidance:
Client's care plan must indicate a goal for obtaining ongoing financial and/or food resources and the case note must describe need for food voucher service beyond a short-term emergency need. Documentation that clients have exhausted other food services prior to authorization (i.e. food banks, food stamps) must be in the client's chart, as well as a referral to a food bank service. The voucher should clearly state that purchase of alcohol and tobacco products are not allowed.

If it is an emergent client need, please refer to guidance under EFA, Food Voucher.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
FOOD BANKS/HOME DELIVERED MEALS	FOOD VOUCHER	CARD OR VOUCHER

FBHDM NUTRITIONAL SUPPORT – RN AUTHORIZED, AND NUTRITIONAL SUPPLEMENT-MEDICAL PROVIDER RECOMMENDED

Description:
A card/voucher that cannot be converted to cash, allowing a client to purchase nutritional supplements (i.e. Vitamins, Ensure), or is purchased on behalf of the client, necessary to maintain health. A voucher can also be defined as a payment to a store on behalf of a client.

Program Guidance:
These funds are intended to be used to cover costs not eligible for insurance. Food cards and vouchers under this category can be approved in two ways:

(1) Nutritional Support-RN Authorized service: Approved by the RN Case Manager to address the client's stated nutritional needs/barriers as part of the current Nurse Assessment, or in case notes, and be included as a nutritional goal addressing these needs/barriers within the client's care plan. If approval is from the medical Case Manager/RN Case Manager, documentation of the client's stated nutritional needs/barriers addressing the need for this service in a current Nurse Assessment or in case notes and the client's Nurse care plan has a nutritional goal addressing these needs/barriers are required. Food supplements provided under this category should be provided to a client with specific instructions for maintaining nutrition based on the RN assessment of need (i.e. client needs high protein food, low sodium, high fat meals, vitamins, Ensure, etc.); **or**

(2) Nutritional Supplement-Medical Provider Recommended service: Approved by a care coordinator based on a medical provider's written recommendation or prescription. Documentation of the medical provider's prescription/written recommendation must be in the client chart prior to providing service. The client's Case Manager Care Plan must also have a nutritional goal addressing the client's stated nutritional needs/barriers.

Reporting:

SERVICE CATEGORY	SUB-SERVICE	UNIT
FOOD BANKS/HOME DELIVERED MEALS	NUTRITIONAL SUPPORT-RN AUTHORIZED	CARD OR VOUCHER
FOOD BANKS/HOME DELIVERED MEALS	NUTRITIONAL SUPPLEMENT-MEDICAL PROVIDER RECOMMENDED	CARD OR VOUCHER

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE (HIPCSA)

Recommended Service Cap (per Fiscal Year, July-June): $2200 per client per year total for all sub-services in this category.

Description:

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

Program Guidance:
All medical mental health, substance abuse treatment, and oral health services, covered by insurance can be documented under this service category, including copays, deductibles and coinsurances. The service provision consists of the following:

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

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

- Documented emergency only
- One-time payment only
- One payment per client per fiscal year (July-June)
- The insurance plan covers at least one drug in each therapeutic class of core antiretrovirals from the Department of Health & Human Services treatment guidelines, which can be found through HIV/AIDS Treatment Guidelines.
- Dental and Vision insurance premiums are NOT allowable
- Must contact CAREAssist to find out about Health Insurance coverage options.

Sub-Services:
HIPCSA EYE CARE – COPAY

Description:
The provision of financial assistance to maintain access to necessary services rendered by an Optometrist, Ophthalmologist or Optician.

Program Guidance:
Insurance must be billed and documented in the client file. This service category includes corrective prescription eyewear once every two (2) years. Contacts are not covered in this service category unless prescribed as medically necessary by a licensed professional.

If no insurance is available to assist with costs, refer to Eye Care – Full Cost.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE	EYE CARE-COPAY	PAYMENT

HIPCSA HEALTH AID – COPAY

Description:
Funds to assist client in obtaining an assisting device, which is beneficial to client's physical health. This may include adherence aids (including planners, pill reminders, pill splitters, alarms, and electronic reminders delivered by SMS, phone or email), medical devices (such as crutches, slings, certified guide dog expenses, etc.) and hearing aids. Medical equipment (and supplies) may include diabetic supplies, respiratory equipment (CPAP, BiPAP), oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies.

Notes: Denture replacement or realignment is covered under Oral Health Care.

Program Guidance:
Insurance must be billed and documented in the client file.

If insurance is not available to assist with costs, refer to guidance under Home and Community Based Health Services, Health Aid – Full Cost.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE	HEATLH AID-COPAY	PAYMENT

HIPCSA HEALTH INSURANCE PREMIUM

Description:
Financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

Program Guidance:
Contact CAREAssist for assistance in determining eligibility for payment. Health Insurance Premium funds may not be used for dental and/or vision insurance. Health Insurance premium payments are allowed only under the following circumstances:

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

- The insurance plan covers at least one drug in each therapeutic class of core antiretrovirals from the Department of Health & Human Services treatment guidelines, which can be found through HIV/AIDS Treatment Guidelines
- Must contact CAREAssist to find out about Health Insurance coverage options

Reporting Requirements:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE	HEATLH INSURANCE PREMIUM	PAYMENT

HIPCSA MEDICAL ACCESS - COPAY

Description:
The provision of financial assistance to maintain access to necessary medical care for the treatment of HIV infection. Such care must ensure access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections. This service is intended for short-term assistance in copays or deductibles to maintain access to medical services, including lab work, imaging (x-ray, MRI, CT), Mental Health, Substance Abuse and other medical services covered by insurance.

Program Guidance:
Insurance must be billed and documented in the client file. Any service authorized under the category must coincide with an application/referral to CAREAssist. Documentation that the client is not eligible for CAREAssist must include, at a minimum: (1) a denial or restricted letter from CAREAssist or (2) notation of the reason(s) the client is not eligible for CAREAssist in the progress notes in the client's file.

If no insurance is available to assist with costs, refer to Medical Access - Full Cost.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE	MEDICAL ACCESS - COPAY	PAYMENT

HIPCSA MEDICAL ACCESS – OVER THE COUNTER (OTC) COPAY

Description:
The provision of temporary financial assistance to maintain access to necessary medical care for the treatment of HIV infection. Primary medical provider approved over-the-counter, non-

prescription pharmaceuticals/medications, including vitamins and supplements. This service is only intended for access to over the counter medications covered by insurance.

Program Guidance:
Insurance must be billed and documented in the client file. Any service authorized under the category must coincide with an application/referral to CAREAssist. Medications may not be purchased with support service funds unless documentation can be provided that the client is not eligible for CAREAssist/Bridge Program/UPP, or extenuating circumstances apply. Use of OTC medications must be recommended by the client's primary care provider or pharmacist.

If no insurance is available to assist with costs, refer to Emergency Financial Assistance, Nonprescription Medication.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE	MEDICAL ACCESS – OTC COPAY	MEDICATION

HIPCSA MEDICAL ACCESS – RX COPAY

Description:
The provision of temporary financial assistance to maintain access to necessary prescription medications for the treatment of HIV infection, until such time as the client can apply for CAREAssist. This service is only intended for short-term access to prescription medications covered by insurance.

Program Guidance:
Insurance must be billed and documented in the client file. Any service authorized under the category must coincide with an application/referral to CAREAssist. Prescription medications may not be purchased with support service funds unless documentation can be provided that the client is not eligible for CAREAssist/Bridge Program/UPP, or extenuating circumstances apply. It is recommended that the case manager pursue pharmaceutical company patient assistance programs as an alternative to paying for HIV specific prescription medications with local Ryan White funds.

Documentation that the client is not eligible for CAREAssist must include, at a minimum:

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

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE	MEDICAL ACCESS–RX COPAY	MEDICATION

HIPCSA ORAL HEALTH– COPAY

Description:
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants. This service also includes medications dispensed or administered during the course of the service. Denture replacement or realignment is covered in this category.

Program Guidance:
These funds are intended to be used to cover costs not billable to insurance or another payer. When eligible, clients must apply to CAREAssist dental insurance, and the insurance should be used. Ryan White Part F funded dental clinics could also be used prior to these funds. LCC Dental Clinic (in Eugene) and Russell Street Dental Clinic (in Portland) provide HIV specific comprehensive dental services Dental care provided by LCC or Russell Street is very cost effective. Clients should be referred to LCC or Russell Street Dental Clinics unless extenuating circumstances apply. Extenuating circumstances may include, but are not limited to, illness, pain, disability, family/work responsibilities, travel distance/weather and must be documented in CAREWare Case Notes.

Cosmetic procedure and restorations are not allowable unless they are necessary to alter, restore or maintain occlusion (close mouth) or nutrition. Exceptions may be made with program authorization for infants, children and youth. No show appointment charges and contractual adjustment fees charged by the provider after primary insurance are not allowed. This service is not available to “affected” family members.

If client is not eligible for insurance-covered oral health services, please refer to guidance under Oral Health Care – Full Cost.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE	ORAL HEALTH-COPAY	PAYMENT

HOME AND COMMUNITY-BASED HEALTH SERVICES (HCBHS)

Recommended Service Cap (per Fiscal Year, July-June): $500 per client per year total for all sub-services in this category.

Description:
Home and Community-Based Health Services are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider.

Services include:
- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aid services and personal care services in the home

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Sub-service:

HCBHS HEALTH AID – FULL COST

Description:
Funding to assist client to obtain needed assisting device(s), which is beneficial to client physical health. This may include adherence aids (including planners, pill reminders, pill splitters, alarms, and electronic reminders delivered by SMS, phone or email), medical devices (such as crutches, slings, certified guide dog expenses, etc.) and hearing aids. Medical equipment (and supplies) may include diabetic supplies, respiratory equipment (CPAP, BiPAP), oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies.

Note: Denture replacement or realignment is covered under Oral Health Care.

Program Guidance:
If insurance is applied, refer to guidance under Health Insurance Premium and Cost Sharing Assistance, Health Aid – Copay.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HOME AND COMMUNITY-BASED HEALTH SERVICES	HEATLH AID-FULL COST	PAYMENT

HOME HEALTH CARE (HHC)

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

Description:
Home Health Care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:
This service is not available to "affected" family members. The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities. When available, medical insurance should be billed prior to local services.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HOME HEALTH CARE	HOME HEALTH CARE	PAYMENT

HOUSING SERVICES (HS)

Recommended Service Cap (per Fiscal Year, July-June): $3000 per client per year total for all sub-services in this category.

Description:
Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment that requires more than one-time access within a Fiscal Year (July 1 – June 30). Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated every 6 months, to guide the client's linkage to permanent housing. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services including application fees.

Eligible housing can include either housing that:

- Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or
- Does not provide direct core medical or support services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.

Program Guidance:
Providers must have mechanisms in place to allow new HIV-identified clients access to housing services. Providers must assess every client's housing needs at least annually to determine the need for new or additional services. In addition, providers must develop an individualized housing plan for each client receiving housing services and update it at least annually. Providers must provide a copy of the individualized written housing plan upon request.

Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

Housing Services Sub-services:

HS RENT ASSISTANCE

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

Program Guidance:
In a shared living situation, Ryan White Program funds may only be used to support that portion assigned to a client and their family, based on the pro-rated portion of the private space used by the client in the rental unit (e.g. If a client shares a three-bedroom unit with two roommates, and has exclusive use of one of the three bedrooms, housing assistance funds may be used to support one-third of the total rental cost of the unit). In situations where a client is residing with people that (per HRSA's definition) are not considered family, Ryan White Program funds may only be used for the client and their family's portion.

Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation. For long-term permanent housing services, see Section 6: Oregon Housing Opportunities in Partnership (OHOP).

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

The client's care plan must document the necessity for this service and must be linked to the client's ability to stay in medical care.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HOUSING SERVICES	RENT ASSISTANCE	PAYMENT

HS UTILITY ASSISTANCE

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

Program Guidance:
Client's care plan must include goals regarding housing and utility needs describing how utilities remove barrier(s) to HIV care and treatment. Ryan White Program, Part B funds may only be used to provide assistance for the portion of the client's utility not covered through a utility subsidy. Utility assistance is NOT allowed for any client who has received full utility assistance through any other program.

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

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

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

Clients should provide evidence of application for reduced rate phone or internet services (such as Stand Up Wireless or SafeLink Wireless) and the state energy assistance programs. Ryan White Program, Part B Case Managers must pre-authorize any payment for client services.

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

meet a client's utility assistance needs before using Ryan White Program funds for utility assistance.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HOUSING SERVICES	UTILITIES ASSISTANCE	PAYMENT

HS RESIDENTIAL FACILITY

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

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

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HOUSING SERVICES	RESIDENTIAL FACILITY	DAY

HS TRANSITIONAL HOUSING

Description:
Transitional short-term emergency housing such as motels or hotels for purposes of moving or assisting an individual or family into a long-term stable living situation.

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

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HOUSING SERVICES	TRANSITIONAL HOUSING	DAY

HS MEDICAL LODGING

Description:
Provides lodging necessary when traveling to receive medical care.

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

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HOUSING SERVICES	MEDICAL LODGING	DAY

HS SECURITY DEPOSIT

Recommended Service Cap (per Fiscal Year, July-June): $3000 per client per year total for this category.

Description:
Security Deposits provide funds to cover housing security deposits for eligible clients to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment.

Program Guidance:
RWHAP funding may be used to pay for a client's security deposit if there are policies and procedures in place to ensure that the security deposit is returned to the provider and not to the client. A cash security deposit that is returned to a client violates the RWHAP statutory prohibition on providing cash payments to clients.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
HOUSING SERVICES	SECURITY DEPOSIT	PAYMENT

LINGUISTIC SERVICES (LS)

Recommended Service Cap (per Fiscal Year, July-June): $250 per client per year.

Description:
Linguistic Services provide interpretation (verbal) and translation (written) services, to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.

Program Guidance:
Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). Includes provision of ASL (American Sign Language) interpretation. The provision of Braille falls under translation services.

Sub-services:

TRANSLATION SERVICES

Description:
The subservice category, "Translation Services" is used when paying for the client specific written documents that are translated into the language the client speaks.

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

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
LINGUISTIC SERVICES	TRANSLATION SERVICES	PAYMENT

INTERPRETATION SERVICES

Description:
The subservice, "Interpretation Service" is used for verbal language interpretation.

Program Guidance:
State interpretation services through Language Link should be used whenever possible. Consult with your supervisor with questions about accessing the Language Link account.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
LINGUISTIC SERVICES	INTERPRETATION SERVICES	PAYMENT
LINGUISTIC SERVICES	TRANSLATION SERVICES	15 MINUTES

MEDICAL ACCESS – FULL COST

Recommended Service Cap (per Fiscal Year, July-June): $1000 per client per year total for all sub-services in this category.

Description:
The provision of temporary financial assistance to maintain access to necessary medical care for the treatment of HIV infection. Such care must ensure access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections. This service is only intended for medical services, and lab tests, *not otherwise covered by insurance*.

Program Guidance:
Any service authorized under the category must coincide with an application/referral to CAREAssist. If the client is in the process of submitting a CAREAssist application, documentation must include at a minimum: the plan and timeline for submitting a CAREAssist application. Documentation in a CAREWare case note template that the client is not eligible for CAREAssist must include, at a minimum: (1) a denial or restricted letter from CAREAssist or (2) notation of the reason(s) the client is not eligible for CAREAssist in the progress notes in the client's file.

If insurance can be billed, refer to guidance under Health Insurance Premium and Cost Sharing Assistance, Medical Access – Copay.

MEDICAL NUTRITION THERAPY (MNT)

Recommended Service Cap (per Fiscal Year, July-June): $2500 per client per year total for all sub-services in this category.

Description:
Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation

- Nutrition education and/or counseling

Program Guidance:
All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. When available, medical insurance should be billed prior to local services.

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

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

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

Reporting Requirement:

SERVICE CATEGORY	UNIT
MEDICAL NUTRITION THERAPY	PAYMENT

MEDICAL TRANSPORTATION SERVICES (MTS)

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

Description:
Medical transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services, including access to appointments that support health outcomes (such as social security, SNAP, insurance, psychosocial and/or medical services), self-management trainings, education groups, or during a housing search period for permanent stable housing.

Program Guidance:
Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, appointments that support health outcomes (such as social security, SNAP, insurance, psychosocial and/or medical services), self-management trainings, education groups, or during a housing search period for permanent stable housing, but should not in any case exceed the established rates for federal programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Unallowable costs include:

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

Sub-services:

MTS PUBLIC TRANSPORTATION-SINGLE TRIP

Description: See Above

Program Guidance: None

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
MEDICAL TRANSPORTATION	PUBLIC TRANSPORT-SINGLE TRIP	TRIP

MTS PUBLIC TRANSPORTATION-MONTHLY PASS

Description: See Above

Program Guidance:

Bus passes should be purchased under the local transit system's disability rate wherever possible. Monthly public transportation pass may be issued if the amount of appointments the client has, within a month, exceeds cost effectiveness of purchasing multiple single trip tickets, or for documented special circumstances.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
MEDICAL TRANSPORTATION	PUBLIC TRANSPORT-MONTHLY PASS	MONTH

MTS GAS CARD

Description: See Above

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

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
MEDICAL TRANSPORTATION	GAS CARD	CARD OR VOUCHER

MTS TAXI FARE

Description: See Above

Program Guidance: None

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
MEDICAL TRANSPORTATION	TAXI FARE	ONE WAY TRIP

MTS OTHER SPECIAL TRANSPORT SERVICES

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

Program Guidance: If service is providing a rental vehicle, vehicle must be insured.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
MEDICAL TRANSPORTATION	OTHER SPEICAL TRANSPORTATION SVCS.	PAYMENT

MENTAL HEALTH SERVICES (MHS)

Recommended Service Cap (per Fiscal Year, July-June): $6500 per client per year.

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

Mental Health Services are allowable only for HIV-infected clients. When available, medical insurance should be billed prior to local services.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
MENTAL HEALTH SERVICES	MENTAL HEALTH-FULL COST	PAYMENT

ORAL HEALTH CARE (OHC)

Recommended Service Cap (per Fiscal Year, July-June): $1000 per client per year total for all sub-services in this category.

Description:

Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants,. This service also includes medications dispensed or administered during the course of the service. Denture replacement or realignment is covered in this category.

Program Guidance:
These funds are intended to be used to cover costs not eligible for insurance. When eligible, clients must apply to CAREAssist dental insurance, and the insurance should be used. Ryan White Part F funded dental clinics could also be used prior to these funds. LCC Dental Clinic (in Eugene) and Russell Street Dental Clinic (in Portland) provide HIV specific comprehensive dental services Dental care provided by LCC or Russell Street is very cost effective. Clients should be referred to LCC or Russell Street Dental Clinics unless extenuating circumstances apply. Extenuating circumstances may include, but are not limited to, illness, pain, disability, family/work responsibilities, travel distance/weather and must be documented in CAREWare Case Notes.

Cosmetic procedure and restorations are not allowable unless they are necessary to alter, restore or maintain occlusion (close mouth) or nutrition. Exceptions may be made with program authorization for infants, children and youth. No show appointment charges are not allowed. This service is not available to “affected” family members.

If insurance can be billed, please refer to guidance under Health Insurance Premium and Cost Sharing Assistance, Oral Health Care – Copay.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
ORAL HEALTH CARE	ORAL HEALTH-FULL COST	VISIT

OVER THE COUNTER (OTC) FULL COST

Recommended Service Cap (per Fiscal Year, July-June): TBD – number will be based on analysis of historical spending data per client per year.

Description:
Primary medical provider approved over-the-counter, non-prescription pharmaceuticals/medications.

Program Guidance:
This service includes over the counter, non-prescription pharmaceuticals/ medications. Use of non- prescription medications must be recommended by the client's primary care provider.

If insurance can be billed, please refer to guidance under Health Insurance Premium and Cost Sharing Assistance, Medical Access – Copay.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
NON CARE ACT SERVICE CATEGORY	OTC-FULL COST	MEDICATION

SUBSTANCE ABUSE OUTPATIENT CARE (SAOC)

Recommended Service Cap (per Fiscal Year, July-June): $5000 per client per year for Substance Abuse Outpatient Services

Description:
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include screening and assessment, diagnosis, and/or treatment of substance use disorder, including pretreatment/recovery readiness programs, harm reduction, behavioral health counseling associated with substance use disorder, outpatient drug-free treatment and counseling, medication assisted therapy, neuro-psychiatric pharmaceuticals, and relapse prevention.

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program, it is included in a documented plan. When available, medical insurance should be billed prior to local services.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
SUBSTANCE ABUSE OUTPATIENT CARE	SA-OUTPATIENT FULL COST	PAYMENT

SUBSTANCE ABUSE SERVICES (RESIDENTIAL) (SASR)

Recommended Service Cap (per Fiscal Year, July-June): $5000 per client per year for Substance Abuse Services (Residential)

Description:
Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder.

This service includes:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) are permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program. Acupuncture therapy may be allowable under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the RWHAP. RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license. This service is not available to "affected" family members. When available, medical insurance should be billed prior to local services.

Reporting Requirement:

SERVICE CATEGORY	SUB-SERVICE	UNIT
SUBSTANCE ABUSE SERVICES (RESIDENTIAL)	SA-RESIDENTIAL FULL COST	PAYMENT

EXCEEDING SERVICE CAPS

Service caps are provided as a means of equitably managing the amount of service an individual client receives in a year and is not intended to create a barrier for clients with a documented need for service. CAREWare Custom Reports are available to help RWHAP Part B providers determine when a client might be exceeding the cap.

Exceptions to the "Recommended Service Cap" service caps can be made for clients who meet the following eligibility requirements:

- Client's Care Plan includes activities specific to the service that will help the client meet the service need, without utilizing Ryan White funds, on an ongoing basis.
- The client has been assessed Acuity level 3 or 4 in the acuity life area that corresponds to the intended need.
- Oral Health Care service need for clients with all acuity levels.

Required Documentation
To document delivery of a service that exceeds the maximum service cap, complete the CAREWare "Service Cap" case note template using the same date as the recorded CAREWare service.

Exceptions to the "Recommended Service Cap" service caps for Emergency Financial Assistance (EFA) can be made for clients who meet the following eligibility requirements:

- All other sources of funding in the community for emergency financial assistance have been used and documented in the CAREWare Referral tab.
- The client has a documented emergent need and has not been assessed as having an ongoing, continuous EFA need.
- Allocation of EFA funds will be as the payer of last resort, and for limited amounts, uses, and periods of time, therefore, EFA service caps should not be exceeded for more than 3 months or 3 payments in a Fiscal Year (July 1 – June 30) or one time within a Fiscal Year (July 1 – June 30) for Housing or Utility assistance.

SECTION 5: CAREASSIST: OREGON'S AIDS DRUG ASSISTANCE PROGRAM (ADAP)

PROGRAM OVERVIEW

The mission of the CAREAssist program is to improve the health of HIV+ Oregon residents by paying for insurance premiums and co-payments on prescriptions and medical services. To that end, CAREAssist provides the following services:

1. Insurance premium payment on most insurance types, including "employer sponsored" insurance plans, Medicare, Oregon Health Plan, health plans purchased in or outside of the Exchange, and in limited instances, COBRA policies.
2. Copayments, coinsurance and deductibles on out-patient medical services, including those not specific to HIV treatment. Maximum amount to be identified by CAREAssist each calendar year. For more information, review here.
3. Copayments, coinsurance and deductibles on prescriptions, including those not specific to HIV treatment. There is no annual limit to prescription assistance. Use of an In-Network pharmacy is required except for 1) clients who are mandated to use a specific pharmacy per their insurance coverage or 2) medications for acute conditions can be accessed at an out of network pharmacy. For medications not covered by someone's insurance or uninsured clients, CAREAssist will pay for the medication as long as it isn't on the CAREAssist drug exclusion list, it is on the CAREAssist applicable formulary, and the client is using an in-network pharmacy.
4. Tobacco Cessation Supports. CAREAssist clients who are ready to quit tobacco can receive free Nicotine Replacement Therapy (NRT, such as patches, gum or lozenges), prescription-based therapy, or referral to other supports such as the Oregon Quitline. To qualify, clients must obtain a prescription for NRT products, and attempt to bill primary insurance at a CAREAssist network pharmacy.
5. Medication Therapy Management can be provided to eligible clients who are having difficulty adhering to medication regimens. MTM provides phone-based support to patients through direct adherence counseling with an HIV pharmacist who will work with the patient to fit their medication regimen into their life. MTM Referral form.
6. The Bridge program provides urgently needed HIV specific medical care and limited medications for persons who are in the process of applying for health insurance for individuals without health insurance.
7. The Uninsured Persons Program (UPP) provides access to HIV specific medical care and medications to persons who are ineligible for health insurance until the next open enrollment period or they experience a qualifying life event, allowing them a Special

Enrollment Period. See Appendix B for more information on the roles and responsibilities of case managers in insurance assistance.

8. Dental Insurance: CAREAssist provides dental insurance through Delta Dental. Any CAREAssist client may enroll as long as their primary insurance is not the Oregon Health Plan at the time of application. Dual-eligible clients with Medicare and Medicaid are eligible for this benefit. Only preventative care and examinations are covered within the first six months of enrollment. Restorative fillings are covered after six months and more comprehensive care like root canals, crowns, bridges etc. are allowed after 12 months. These waiting periods can be waived if a client had 12-months of other dental insurance. Other coverage must have been active within the last 90-days of application to Delta Dental to qualify. This includes OHP dental benefits.

CLIENT ELIGIBILITY

To be eligible, a person must:

- Have a confirmed HIV status
- Reside in Oregon
- Have income at or below 550% of the Federal Poverty Level (FPL). CAREAssist includes almost all forms of income, including work income/wages/salaries, disability, self-employment income, pension/retirement income, child support and unemployment.

COORDINATION WITH CAREASSIST

Part B Case Managers are expected to work in partnership with the CAREAssist program to ensure client's maintenance of health insurance and CAREAssist. Part B Case Managers are able to view current client eligibility review data online, including type of insurance and FPL through the Client Eligibility Verification Report on the website.

PROGRAM REQUIREMENTS

1. All CAREAssist clients are required to recertify their eligibility for the program every 6 or 12 months depending on insurance through a process called the Client Eligibility Review (CER.) CERs are mailed to clients every 6 or 12 months and they have a month to return.
2. Clients must immediately notify the program of changes to their monthly premium or eligibility for insurance. This includes notifying the program when a client becomes eligible for new insurance, like employer-sponsored coverage, even if the person is already insured.

ADDITIONAL RESOURCES & INFORMATION

Please see the CAREAssist website for more information, including forms, applications, contact information, and additional ADAP related resources.

SECTION 6: OREGON HOUSING OPPORTUNITIES IN PARTNERSHIP PROGRAM

PROGRAM OVERVIEW

PROGRAM OVERVIEW

The Oregon Housing Opportunities in Partnership (OHOP) program is an important component of the HIV Care and Treatment Program. The goal of the program is to assist clients in achieving and maintaining housing stability, which will improve access to, and engagement and retention in HIV care and treatment, leading to viral suppression and overall well-being. The program provides tenant based rental assistance to low-income persons living with HIV/AIDS through rental subsidy payments and is intended to act as a bridge to long-term assistance programs, such as Housing Choice Voucher (formerly Section 8), and/or self-sufficiency. Additionally, the program assists clients in locating and/or securing suitable rental housing, identifying other related housing and community-based resources that may be available to clients, and providing housing information and referral to those housing resources.

CLIENT ELIGIBILITY

Clients accessing OHOP must be actively enrolled in Part B funded, HIV Case Management services, be homeless or at risk of homelessness, and have a total household income that is at or below than 80 percent of the area median family income. OHOP maintains a wait list based on priority of need, so clients who have higher housing acuity are served first.

COORDINATION WITH OHOP

OHOP regional Housing Coordinators are an important resource to clients with housing needs. Housing Coordinators facilitate in-depth client housing needs assessments and access to housing services provided directly through the OHOP program or through referral(s) to other community-based housing providers. The intent of the OHOP program is that Part B Case Managers, OHOP Housing Coordinators, and eligible clients work together to develop and implement a Client Housing Stability Plan.

REFERRAL PROCESS

In order to assure that Ryan White housing assistance funds are used as the funds of last resort, Case Managers must submit an OHOP Client Referral Packet (scroll down) for the OHOP program whenever chronic client housing needs are identified. Referral packets must be complete, or they will be sent back to Case Manager. Referral to the OHOP program does not preclude the use of Ryan White housing assistance. When clients have emergency housing needs, HIV Case Managers may assist clients with those housing needs immediately, while initiating contact with the local OHOP Housing Coordinator for longer term assistance.

ADDITIONAL RESOURCES

More information about the OHOP program, including full policies, procedures and referral forms, can be found at: www.healthoregon.org/ohop.

SECTION 7: PHARMACIST-LED TREATMENT ADHERENCE SERVICES

PROGRAM OVERVIEW

Pharmacist-led Treatment Adherence is the provision of mediation adherence counseling to ensure readiness for, and adherence to, complex HIV treatments. The goals for this service are to:

- Increase knowledge about the importance of adherence
- Identify strategies to overcome barriers to adherence and manage medications effectively
- Decrease negative drug interactions and side effects
- Improve medication adherence
- Maintain or improve health outcomes.

Although this service is provided by licensed pharmacists who are located at HIV Alliance in Eugene, consultation services are available to all Part B Case Managers and clients.

CLIENT ELIGIBILITY

All Part B case management clients and case management providers are eligible for time-limited consultation services.

REFERRAL PROCESS

Staff employed by HIV Alliance should follow internal referral processes. All other case management providers are welcome to contact the clinical pharmacists at HIV Alliance directly. Consultation without an ROI is allowed, as long as patient identifying information is not shared. If it is determined that direct consultation with the client would be beneficial, the client must sign a release of information prior to the service.

SERVICES PROVIDED

Consultations may occur face to face, over the phone, via email or secure videoconference. For all consultations, the clinical pharmacist will require at least the following information: patient's age, gender, history of present illness, past medical history, social history, family history (if possible), medication list (including supplements), and allergy list. Consultation may include counseling on new medications or changes in medications, medication adherence, drug-interaction analysis, HIV and comorbid disease state education, diet and lifestyle modification, and HIV/comorbid medication selection and recommendations.

ADDITIONAL RESOURCES

For more information, contact the Pharmacy Program at HIV Alliance, 541.342.5088.

SECTION 8: DENTAL CASE MANAGEMENT SERVICES

PROGRAM OVERVIEW

Dental Case Management is available for all Part B clients to assist clients in accessing and retaining dental care through the Part F funded, LLC Dental Clinic (formally Clock Tower) located in Eugene, or other dental services. In addition to dental case management, support services such as medical transportation and lodging are available for eligible clients who face additional barriers to accessing dental care.

CLIENT ELIGIBILITY

All Part B Case Management clients in the 31-county Part B service area are eligible for dental case management offered by HIV Alliance. Clients eligible for locally-funded support services may also be eligible for dental transportation, lodging and food.

REFERRAL PROCESS

The Dental Case Manager is located at HIV Alliance. Staff located at HIV Alliance should follow internal referral and coordination processes. All other case management providers are welcome to refer a client directly to the Dental Case Manager at any time, by calling 541.342.5088. Dental-specific ROI and LCC no show policy, if applicable, are also needed to complete the referral process.

COORDINATION WITH DENTAL CASE MANAGEMENT

While a client is being served by the Dental Case Manager, case conferences should occur regularly between the Dental Case Management program and the referring case manager to ensure coordination of services and support of the client as they complete their treatment.

ADDITIONAL RESOURCES

Please contact the Dental Case Manager at HIV Alliance for more information,.

SECTION 9: EMPLOYMENT SERVICES

PROGRAM OVERVIEW

The HIV Community Services Program is committed to helping clients who are ready to improve their vocation and financial related circumstances, either through employment or other vocational services. To help case managers achieve this goal, employment services may be provided in limited, specific instances as part of non-medical case management services.

ADDITIONAL RESOURCES

Additional employment resources can also be found on the Oregon Health Authority's Getting to Work Initiative website: here.

APPENDIX A: Ryan White Funded Food Services Quick Guide:

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

HRSA Service Category	**Food Bank/Home Delivered Meals**		**Medical Nutritional Therapy**
CAREWare Sub-Service	**Food Voucher**	**Nutritional Support-RN authorized Nutritional Supplement-Medical Provider recommended**	**Medical Nutrition Therapy**
Definition Summary	A voucher that allows a client to purchase food products and groceries (including hygiene products) necessary to maintain health.	Full Cost (no insurance coverage): A card/voucher that allows a client to purchase nutritional supplements (i.e. Vitamins, Ensure), or is purchased on behalf of the client necessary to maintain health.	Includes nutrition assessment and screening, dietary/nutrition evaluation, food and/or nutrition supplements, nutrition education and counseling.
Service Cap	The recommended service cap for this service category is $1,000/per year, per client.		$2500/per year, per client
Approved By	Case Manager/CC or MCM	MCM or Medical Provider prescription and/or written recommendation	Medical Provider referral and written recommendation for food and/or nutritional supplements
Provided By	Case Manager/CC or MCM	MCM or Case Manager/CC	Licensed Dietician
Required Documentation	Documentation the client has exhausted other food services prior to authorization (i.e. food banks, food stamps) must be in the client's chart	MCM approval requires: Documentation of the client's stated nutritional needs/barriers addressing the need for this service are on a current Nurse Assessment form that has been uploaded, or in case notes and the client's Nurse care plan has a nutritional goal addressing these needs/barriers. Medical Provider approval requires: Documentation of the Medical Provider written recommendation or prescription must be in the client chart prior to providing service. The Client's Case Manager Care Plan has a Nutritional goal addressing the client's stated nutritional needs/barriers.	Documentation Required from HIV Medical Provider must be in client chart prior to referral to Dietician. A copy of the Dietician's Medical Nutrition Plan must be included in the client's chart. There must be case conferencing service/case note between the MCM & the Dietician at a minimum of every 3 months during the time the client is receiving this service.

APPENDIX B: ROLES AND RESPONSIBILITES FOR INSURANCE ASSISTANCE

This guide is intended to clarify the roles and responsibilities of each person supporting a client to ensure appropriate support and care coordination regarding insurance assistance. It is each the responsibility of the Case Manager and CAREAssist Caseworker to coordinate with other to ensure each task is completed, documented and not duplicated, even when responsibilities appear to overlap between roles, indicated by highlighted portions of the guide.

Each open enrollment period, Case Managers will receive emails from CAREAssist detailing activities that need to be completed for clients.

Client	Case Manager	CAREAssist (CA) Caseworker
Insurance Eligibility: Open and ongoing enrollment is the same process throughout the year.	CAREAssist client – Support insurance enrollment including Low Income Subsidy (LIS) for Medicare eligible clients Non-CAREAssist client – Provide all insurance enrollment assistance	CAREAssist client – Support insurance enrollment including Low Income Subsidy for Medicare eligible clients
Enroll in Insurance Coverage.	Assist client with insurance enrollment and access to the CAREAssist pharmacy network.	Determine eligibility for CAREAssist services and support Case Manager with insurance enrollment and access to the CAREAssist pharmacy network.
		Provide enrollment education and updates to Case Managers.
	Explain insurance requirements and assist the client with plan selection.	Report enrollment accurately in CAREAssist database.
	Help client submit verification documents to OHP and premium statements, auto-enrollment letters, insurance cards to include Medicare Part A and B card to CAREAssist.	Update premiums in CAREAssist database for payment.
	Provide health literacy support to client.	
	Assist client in insurance enrollment.	Support Case Management in insurance enrollment.

	In a timely manner, inform CAREAssist of new enrollments via the enrollment report	
Provide required paperwork.	Help client submit health insurance enrollment verification (Eligibility results, screenshot, premium, application) to CAREAssist.	Once received from CM, accurately and quickly enter client health insurance information for clients and request a payment.
Keep password and log-in credentials.	Educate clients about how to maintain secure login credentials.	
	Assist clients with unlocking Federally Facilitated Marketplace account and resetting password. CAREAssist does not use Federally Facilitated Marketplace	
	Assist clients with email account creation for purpose of creating FFM account.	
Report life changes to CA and Case Manager.	Monitor client eligibility and enrollment status throughout the year.	Monitor client eligibility and enrollment status throughout the year.
	Assist client to report income and eligibility changes to CA, the FFM, group insurance, Medicare, LIS, group insurance and/or OHP according to the coverage client has.	Inform CM if client does not complete Client Eligibility Review.
	Educate client about Special Enrollment Periods, and follow-up to make sure client submits verification documents, premiums statement, insurance enrollment application confirmation, premiums, and auto enrollment letters.	Support Case Management in educating client about Special Enrollment Periods, and follow-up to make sure client submits verification documents, premiums statement, insurance enrollment application confirmation, premiums, and auto enrollment letters.

RESOURCES:
2025 SHIBA Guide for Medicare Insurance Plans: this booklet is used to verify premiums and availability of Medicare insurance plans for 2025

ACRONYMS:
ACA – Affordable Care Act
QHP – Qualified Health Plan
SEP – Special Enrollment Period
FFM – Federally Facilitated Marketplace
APTC – Advance Premium Tax Credits
IRS – Internal Revenue Service
OHP – Oregon Health Plan
OHOP – Oregon Housing Opportunities in Partnership
CA – CAREAssist