

Program and Application Guidance
For the
2017
Grant Year

The Ryan White HIV/AIDS
Treatment Extension Act of 2009.

(Formerly)
Title XXVI of the Public Health Service Act as Amended by the
Ryan White HIV/AIDS Treatment Modernization Act of 2006

(Formerly)
Ryan White Comprehensive
AIDS Resources Emergency Act of 1990

Part B
Regional HIV CARE Consortia



Tennessee Department of Health
Ryan White Part B Program
15 March 2016

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Amendments

This document is based on proposed Health Resources and Services Administration (HRSA) Program and Application Guidance for 2016. The 2017 HRSA Guidance Document will not be released to States until October/November of 2017. This document may require amendment upon the State's receipt of the final HRSA Program and Application Guidance. In the interest of regional time lines, Ryan White Services offers this as a working document to begin the application process for 2017.

SECTION I: INTRODUCTION

A. PROGRAM AUTHORITY AND ELIGIBILITY

This document is intended to provide guidance to Tennessee's Lead Agency responsible for the four regional Consortia that are eligible for funds under Part B, of the "HIV Grant Program" now referred to as The Ryan White HIV/AIDS Treatment Extension Act of 2009. This was previously titled, Title XXVI of the Public Health Service Act as Amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006, or The Ryan White Program. And before that it was titled The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, (reauthorized in 1996 and 2000, Part B of the Ryan White Program is federally administered by the Division of HIV Services (DHS), Bureau of Health Resources Development (BHRD), Health Resources and Services Administration (HRSA), Public Health Services (PHS), Department of Health and Human Services (DHHS). In Tennessee, the provision of Part B funds is made available through Ryan White Services within the HIV/AIDS/STD Section of the Department of Health.

In 2009 Congress reauthorized the Ryan White Program (HIV/AIDS Treatment Extension Act of 2009), and made several significant changes in the way all funds are to be distributed. Changes in the legislation that impact the structure and operation of Consortia have been incorporated into this guidance.

The HIV/AIDS Treatment Extension Act of 2009 legislation enables-but no longer requires states to use Part B funds to support HIV care consortia within areas most affected by HIV disease to provide a comprehensive continuum of care to individuals and families with HIV disease. Prior to 1996 amendments in the Ryan White CARE Act, states with more than one percent of total national AIDS cases were required to use at least 50 percent of their award to fund consortia. Under the amended program, the grantee (State of Tennessee) may do the following:

- Fund Support Services within each designated consortia region or
- Use Part B funds to directly plan, develop, and deliver such services.

Tennessee Department of Health Ryan White Part B Program remains committed to the Consortia process, but reserves the **right to withdraw funding with 30 days notice** from any Consortia region that consistently does not meet the requirements for funding as outlined in this guidance document. The federal Ryan White grant year is April 1 through March 31 of each year. The State of Tennessee observes the same grant period. However the 2017 grant year will run from 1 January 2017 through 31 March 2018.

B. PURPOSE OF FUNDS

The 2017 Ryan White Program, Part B continues to provide formula-based financial assistance to States and Territories to improve the quality, availability, and organization of health care and support services for eligible individuals and families (Attachment N) with HIV disease or AIDS. In general, eligibility is determined by the individual's lack of third party coverage for the specific service being sought.

In those instances where services are being provided and a client becomes eligible for third party coverage (e.g. TennCare), it is expected that coverage will be obtained and that Ryan White funded services will be utilized only as **PAYER OF LAST RESORT**. (Services in which additional eligibility criteria have been developed are identified in Section I-C.) The Ryan White Program emphasizes that such care and support are to be part of a continuum of care in which the needs of individuals with HIV disease and their families are coordinated. States may spend Part B funds in accordance with the five categories specified in the legislation and listed below.

HIV/AIDS CARE CONSORTIA: Includes comprehensive outpatient health and support services for individuals living with HIV, including early intervention services; essential health services such as case management, primary health care, nursing, substance abuse, mental health, dental care, diagnostics, treatment monitoring, prophylaxis, treatment for opportunistic infections; treatment education within the context of health care delivery, medical follow-up, developmental, rehabilitation, home health care, hospice care; transportation; attendant, homemaker, day, or respite care; benefits advocacy; advocacy provided through public and nonprofit private entities; nutrition services; child welfare and family services (including foster care and adoption services). [See: CARE Act 2613(a)(A-B)]

HOME AND COMMUNITY- BASED CARE: Includes therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professionals.

HEALTH-INSURANCE PROGRAM: Includes health insurance or medical benefits provided under a health insurance program.

PROVISION OF TREATMENTS: Includes therapeutics to treat HIV disease or to prevent the serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections.

STATE DIRECT SERVICES: Include services administered through other State delivery mechanisms—that are deemed to be more effective than providing services through consortia—such as early intervention services, outpatient and ambulatory health and support services, case management services, substance abuse treatment, mental health treatment, comprehensive treatment services, treatment education and prophylactic treatment for opportunistic infections, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge—when medically appropriate—from inpatient facilities.

C. GUIDING PRINCIPLES

HRSA/HAB has identified four guiding principles that have significant implications for HIV/AIDS care services and treatment.

- a) Revise care systems to meet emerging needs;
- b) Ensure access to quality HIV/AIDS care;
- c) Coordinate Ryan White Part B services with other health-care delivery system; and
- d) Evaluate the impact of Ryan White Part B funds and make needed improvements.

Planning bodies should refer to these four principles as they develop their HIV/AIDS care implementation plans for FY2016 and future years. In addition to HAB's guiding principles, the Ryan White HIV/AIDS Treatment Extension Act of 2009 Amendments of 2000 emphasize the use of funds to address the service needs of racial and ethnic minorities who know they have HIV disease but are not receiving HIV/AIDS primary medical care.

D. TENNESSEE'S USE OF RYAN WHITE PART B FUNDS

1) HIV Care Consortia

The Department (Part B) will fund one Lead Agency to provide fiscal and administrative support, oversight and guidance for the four (4) Consortia Regions. The State of Tennessee has 95 counties, of which, 79 are included in the consortia regions. The remaining 16 counties are included in the two "Transitional Grant Areas" (TGAs) that are funded by Ryan White Part A. Part A will provide all Ryan White Services to these counties. The only exceptions are HDAP and IAP, which Part B will continue to provide to all 95 counties in the state.

The Consortia Regions and their associated counties are included below:

- A) ***West Tennessee Consortium:*** Hardeman, McNairy, Hardin, Chester, Haywood, Madison, Henderson, Decatur, Crockett, Lauderdale, Dyer, Gibson, Carroll, Benton, Lake, Obion, Weakley and Henry.
- B) ***Ryan White Community AIDS Partnership of Middle Tennessee:*** Wayne, Lawrence, Giles, Lincoln, Moore, Coffee, Bedford, Maury, Marshall, Lewis, Perry, Humphreys, Houston, Stewart, Montgomery, , Clay, Pickett, Jackson, Overton, Fentress, Putnam, DeKalb, White, Cumberland, Warren and Van Buren.
- C) ***Southeast Regional Consortium:*** Franklin, Marion, Polk, Rhea, Hamilton, Bradley, McMinn, Meigs, Bledsoe, Sequatchie and Grundy.

- D) **East/Upper East Regional Consortium:** Monroe, Loudon, Roane, Morgan, Scott, Campbell, Anderson, Knox, Blount, Sevier, Union, Claiborne, Grainger, Hamblen, Jefferson, Cocke, Hancock, Hawkins, Greene, Washington, Unicoi, Carter, Sullivan and Johnson.

Consortia will be funded on a formula basis during the 2017 grant year. Regional allocations will be determined based on:

- Tennessee's total federal grant award
- Consortium's adherence to the requirements contained within this application guidance.
- Results of the Quality Assurance Monitoring Review
- Number of clients served
- Coverage area (rural vs. Metro)

The State will determine regional allocations based on the Tennessee funding allocation from HRSA. The tentative date for providing this information to the Lead Agency Representative and Consortium Chairs is December 10, 2016.

NOTE: The two Transitional Grant Areas (TGAs) and their associated "Tennessee" counties are listed below:

A) Memphis TGA: Fayette, Tipton, Shelby

B) Nashville TGA: Hickman, Williamson, Rutherford, Wilson, Davidson, Cheatham, Dickson, Robertson, Sumner, Trousdale, Macon, Smith, Cannon

2) HIV Drug Assistance Program (HDAP)

During the 2017 grant year, the State will continue to administer the HIV Drug Assistance Program (HDAP). The HDAP income eligibility limit coincides with the most current Federal Poverty Guidelines for 400% of the federal poverty level. The stipulation that eligible clients have less than \$8,000 in available resources is continued during the 2017 grant year.

(See Verification of Eligibility Policy **Attachment K**)

The HDAP approval process will remain unchanged, but Ryan White Medical Care Managers will be responsible for ensuring that all clients receiving drug assistance through the HIV Drug Assistance Program are recertified every six months.

3) Insurance Assistance Program (IAP)

The Insurance Assistance Program will continue as a statewide program. For the 2017 Grant Year, the IAP will continue to be administered through one state direct contract that was awarded through the Request-For-Proposal (RFP) Process. The contractor will conduct all activities related to the operation of the IAP in accordance with the policies and responsibilities outlined in the Insurance Assistance Program Guidance and subsequent updates to the manual. All clients receiving insurance assistance through the Insurance Assistance Plan must have their eligibility recertified every six months.

4) Other Service Delivery Mechanisms

The state plans to maintain the Home and Community-based Care component through the Medical Services Fee schedule administered in the Ryan White Services Office. This component is a medical/professional services billing system designed to allow HIV infected individuals without insurance access to a network of providers (health department and private) for a number of specific services. These providers invoice the Department of Health for the approved reimbursement, allowing clients to receive quality medical and professional care they would otherwise be unable to access.

The state will maintain the AIDS Centers of Excellence model, consisting of a coordinated network of clinics and private practitioners across the state, which will provide a comprehensive approach to AIDS and HIV therapy. Funds will be used: 1) to establish or maintain Center of Excellence “clinic sites” in areas of the state where there is limited access to HIV services resulting in patients traveling long distances for medical care; and 2) to maintain a statewide system of medical care coordination.

MINORITY AIDS INITIATIVES (MAI): Beginning in 2010, MAI funds are included in the Part B Grant. The MAI Grant Year is the same as the Part B Grant Year (1 April to 31 March). MAI funds will be administered with a separate contract. HRSA strongly encourages that administrative oversight for the MAI Grant be placed within the agency / department that administers Part B. The purpose of Minority Initiative funding is to address the increasing health disparity of the rates of infection among communities of color. MAI funding is specifically for outreach and Linkage activities targeting racial and ethnic minority populations impacted by HIV/AIDS, with specific emphasis on locating minorities who have dropped out of care and returning them into care.

Entities eligible for funding may include: not-for-profit community based organizations, national organizations, faith based organizations; colleges and universities; clinics and hospitals; research institutions; State and local government agencies; and tribal governments and tribal/urban American Indian entities and organizations. We strongly encourage grantees to recognize in their funding decisions the unique capabilities of minority providers in reaching communities targeted by the MAI funds. The funds will be distributed through Consortia.

E. State Coordination

All components under the Ryan White Part B Program are coordinated through the Tennessee Department of Health, HIV/STD/Viral Hepatitis Program, Ryan White Program. For additional information, please contact:

John Birkner
Consortia Coordinator, Ryan White Program
Tennessee Department of Health
710 James Robertson Parkway
Andrew Johnson Tower, 4th Floor
Nashville, TN 37243-4911
Phone: (615) 253-4777 FAX: (615) 741- 3857

**SECTION II: INSTRUCTIONS FOR COMPLETING AND FILING
2017 GRANT YEAR HIV CARE CONSORTIA APPLICATION
TENNESSEE**

A. APPLICATION DEADLINES AND FILING INSTRUCTIONS

1) DEADLINES

NOTE: Packet 1 and Packet 2 are not required for the 2017 funding/grant year because the RFGP process in 2016 was/is for the 2017 funding/grant year.

Signed subcontracts are due to the Ryan White Program by Friday, 9 December 2016.

Descriptions of the four regional Consortia, membership, committees, bylaws and other Consortia requirements will be due to the Ryan White Program at a time to-be-determined, but no later than 1 April 2017.

The due date for submitting the 2017 Ryan White Part B Regional Consortia Application Packet 1 to Ryan White Services is **Friday, October 9, 2016**. The Part B Consortia Application Packet 2, **including copies of proposals from all agencies requesting regional funding**, and applications for recommended community based organizations are due to the Ryan White Program by **Friday, January 8, 2017**. FAXED copies will not be accepted. **All hardcopy materials must be sent in one mailing, unless approved by the Consortia Coordinator.** *The state Contract Office has been instructed to hold all Lead Agency funds until Ryan White Services provides notification that all necessary paperwork has been received.*

Send both Application Packets, including subcontractor proposals and subcontractor documents to:

John Birkner
Consortia Coordinator, Ryan White Program
Tennessee Department of Health
710 James Robertson Parkway
Andrew Johnson Tower, 4th Floor
Nashville, TN 37243-4911
Phone: (615) 253-4777 FAX: (615) 741- 3857

Contents: Ryan White Part B Consortia Application
Phone: (615) 253-4777

2) ELIGIBLE APPLICANTS

The current designated Statewide Lead Agency is eligible to receive funding through this application.

3) AVAILABILITY OF FUNDS

The State of Tennessee will provide funds for the 2017 Part B Consortia process as it is made available to the State through the Health Resources and Services Administration (HRSA) in Washington, D.C. **Funding of Tennessee Ryan White Programs, are contingent upon federal funding availability.**

Regional allocation amounts for the purpose of planning for the Application process are based upon 2016 levels, including the Dental Services allocation, Consortia Coordination & Support allocation and Consortia Administrative Oversight & Fiscal Management allocation. The Consortia Administrative Oversight & Fiscal Management allocation is still funded as a Lead Agency direct cost. Consortia Coordination and Support is also listed under the Lead Agency allocation.

4) INSTRUCTIONS FOR APPLICATION PACKETS

Applications will be submitted in both hardcopy and electronically. Each consortium must provide one copy of both required Application Packets. **All formats contained in this guidance are intended to be reprinted / copied for use in both Application Packets.** The logistical guidelines for submission of this application MUST be followed as listed below:

- All narrative material must be DOUBLE-SPACED.
- All pages (including appendices, if any) must be consecutively numbered.
- All narrative material must be typewritten in standard size type on 8 ½ inch x 11 inch unruled paper.
- Must include all checklists / formats as included in this packet.
- Must include any charts, graphs, letters, etc. as part of the appendices
- Must be submitted bound securely with a metal binder clip (if submitting hardcopies). **DO NOT** punch holes or otherwise attach the packets. **DO NOT SUBMIT MATERIAL UNBOUND.**
- Subcontracts must include language as designated in Section D of original contract.
- Subcontracts must be in the format as the sample template provided in Attachment O.
- **Prior to the Lead Agency awarding and funding any contract or subcontract, one copy of all budget, contract and subcontract documents will be submitted electronically (e-mailed) to John Birkner (John.Birkner@tn.gov) Consortia Coordinator for review.**
- **After awarding contracts / subcontracts, one signed hardcopy of all budget, contract and subcontract documents will be submitted by Friday, March 1, 2017 to John Birkner, Consortia Coordinator, Ryan White Program, HIV/STD Section, 710 James Robertson Parkway, 4th Floor, Andrew Johnson Bldg., Nashville, TN 37243**

5) DISBURSEMENT OF FUNDS

All financial granting and Regional Consortia allocations will be done by grant year. The grant year begins on April 1, 2017 and ends on March 31, 2018. One set of forms is needed. They should reflect a 12 month period of funding. **No funds remaining from this grant period will be carried over by the Consortium into the next grant year.** Recipients of Part B Consortia allocations will be asked to reapply in subsequent years based upon the availability of federal funds.

NOTE: All subcontracts must be approved, signed, and in place BEFORE the effective date of January 1, 2017. If a subcontract is delayed past January 1, 2017 for any reason, the State has determined that no funds from the grant will be used to pay for services or salaries retro-active. The State also reserves the right to withhold any portion of Consortium funds if any subcontractor fails to provide ALL of the required materials by the established deadline date when submitting their subcontract budget/scope of services. Do not submit previous year contract revisions with your application Packets. All contract revisions MUST be submitted under a separate cover to John Birkner, Consortia Coordinator, Ryan White Program.

6) PUBLICITY

Each Consortium must submit to the Ryan White Program Office, prior to release, copies of any proposed promotion of, or publicity pertaining to these funds. Care should be taken to indicate the source of Ryan White Part B funding (i.e. federal funds through the Health Resources and Services Administration as provided in Tennessee through the Department of Health). The State reserves the right to modify or withdraw said publicity. This does NOT include public announcements regarding regular or special meetings. **If any material is in question regarding its submission to the State, please contact The Ryan White Program for clarification.**

B. SPECIFIC REQUIREMENTS

1) PROPOSER REQUIREMENTS AND ASSURANCES (LETTER OF TRANSMITTAL)

The Lead Agency MUST submit a letter of transmittal, signed by an individual legally authorized to bind the Lead Agency, to comply with the following assurances and submission requirements. **If a Lead Agency fails to comply with any of the following requirements, the State shall consider the application to be non-responsive and has the authority to reject the application.**

a) The Lead Agency shall assure that it is a private nonprofit entity under state and local laws, and as demonstrated through the attainment of a tax exempt 501©(3) classification from the IRS. In addition, two specific criteria must be met:

- 1) The agency must have no part of its net earnings inuring to (benefiting) any member, founder, contributor, or individual.**
- 2) The agency must have acceptable financial accountability.**

b) The Lead Agency in coordination with the regional Consortia shall assure:

- 1) they have identified populations and subpopulations that are experiencing disparities in access to services and / or residing in historically underserved communities.**

- 2) that the regional service plan is consistent with the comprehensive plan and addresses the care and service needs of the afore mentioned populations and subpopulations
- 3) they will integrate the delivery of services among the populations and subpopulations.
- 4) that no Part B funds will be used to support programs or materials designed to promote or directly encourage intravenous drug use or sexual activity, whether homosexual or heterosexual and budgets and expenditures will not include any unallowable activities.

c) The Lead Agency shall assure that its application meets all requirements of both Application Packets.

d) The Lead Agency shall assure its obligation to provide sufficient staff/personnel, equipment, etc., at the cost proposed to successfully meet/complete all requirements of this application and any subsequent amendments to this application.

e) The Lead Agency will require each subcontract to include:

- 1) The scope of service(s) expected to be performed by the subcontractor; to include section D of the original contract and language and statements as listed in Section IV, paragraph (F), subparagraphs 1, 2, 3 and 4 of this document. And the “Table” of required deliverables (Attachment O)
- 2) The subcontractor’s capability and willingness to perform the work indicated.
- 3) An assurance that the subcontractor does not discriminate in their employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, sexual orientation, political affiliation, national origin, or handicap.

4) RESPONSIBILITIES OF THE HIV CARE CONSORTIUM

The specific responsibilities of each Consortium include:

- a) Providing for an on-going assessment of HIV/AIDS needs/gaps in service,
- b) Establishing a service delivery plan and priorities for the allocation of Part B funds based upon the findings of the needs assessment,
- c) Coordinating and integrating the delivery of HIV-related services, contracting with other providers when necessary, and
- d) Evaluating the specific outcomes of the consortium’s response to identified needs.
- e) Ensuring that funded providers have the capability to deliver culturally competent, health literate services to non-English speaking clients.

5) RESPONSIBILITIES OF THE LEAD AGENCY

The State will designate a Lead Agency to act as the fiscal agent for the all (4) four consortia. The fiscal agent or Lead Agency is required to be a government agency or an incorporated community organization. The Lead Agency is responsible for receiving and disbursing Ryan White Part B Consortia funds from the State, maintaining records and invoices, using standard accounting practices, coordinating federal and state data reporting requirements, and as necessary, arranging for fiscal audits. Once each Consortia completes a needs assessment and prioritizes the services to be funded, the Lead Agency shall establish a subcontract with service providers approved by the Consortium and implement a subcontractor invoice and monitoring system.

The State has developed a formal outline of the requirements and responsibilities of the Lead Agency; which is included in this Guidance as Attachment A.

6) CONFLICT OF INTEREST

Conflict of interest is an area of primary concern with regard to the operation of Consortia under the Ryan White Extension Act. HRSA has addressed Conflict of Interest in the update Ryan White PART B Manual. Each Consortium MUST provide to the Ryan White Program, policies addressing all areas prone to **conflicts of interest** including:

- Services provider staff serving as Consortium officers
- The process through which services are prioritized by Consortium members
- The development of the regional strategy/comprehensive plan
- Service providers participating in the process of choosing agencies to receive grant funds
- Disclosure of agency affiliation by Consortium members and if they are former employees of an agency requesting grant funds
- Insuring that membership is an open and inclusive process
- Insuring that a formal grievance procedure that allows for fair and appropriate resolution is implemented

7) NEEDS ASSESSMENTS

The Consortia process must begin with a region wide needs assessment to determine gaps in service areas necessary for the comprehensive care of individuals with HIV disease and their families. Once these needs are identified, Consortia members must develop a plan under which the needs are prioritized in such a manner that funds provided by the State are utilized to initiate and/or continue programs that address those needs. **The State has established minimum guidelines requiring five needs assessment tools, including a revised standardized printed client survey that must be adopted by all regional Consortia. These guidelines, PART B CONSORTIA NEEDS ASSESSMENT, are included in this Guidance as Attachment B.**

The Statewide Coordinated Statement of Need (SCSN) must be utilized by the Ryan White Program to determine funding needs for 2017. The SCSN is an on-going process that was last updated in June of 2012.. All current needs assessment activities for this application process were utilized to update the SCSN.

6) REGIONAL STRATEGY/COMPREHENSIVE PLAN

The REGIONAL STRATEGY/COMPREHENSIVE PLAN was updated in the 2012 grant year.

Each Consortium is responsible for developing and submitting to the State a regional strategy/comprehensive plan that includes the following:

- A detailed analysis of the five required needs assessment components, describing the process in which each occurred, the target populations and number of respondents, copies of questions or examples of the information solicited, and the response rate of participants.
- An analysis of the data, to include a description of the needs of the various target populations as identified through the assessments.
- A statement explaining how unmet needs were determined and addressed.
- The overall application of the data to the regional Consortium and the resulting prioritization of needs to be funded through the current allocation.
- An explanation of how the region will demonstrate that the new initiatives (CDC's prevention initiatives) have been taken into consideration as evidenced by increased funding for essential services, such as primary care, access to life-prolonging medications and the provision of essential support services, which seek to identify, enroll and maintain HIV infected persons in systems of care.

7) VERIFICATION OF CLIENT HIV STATUS

HRSA requires that all providers receiving Ryan White funds for direct client services have a procedure in place to verify that these clients are eligible beneficiaries, i.e. individuals living with HIV/AIDS and their families. All medical services must be approved by the Centers of Excellence Medical Case Managers. Each sub-contracted agency must clearly state mechanism for collaboration with the Medical Case Managers.

Procedures for providers supported with Part B funds must address the following:

- A requirement that primary documentation of positive HIV serostatus is to be kept in the client's file on-site in at least one location among the CARE-funded network. Each regional Consortium must communicate this policy and procedure to each agency under subcontract for Ryan White funding.
- Client files at every location should include primary documentation or reference to the primary documentation in the form of a certified referral form or a notation that eligibility has been confirmed (including the name or person/organization verifying eligibility, date and nature and location of primary documentation).

- Program monitoring activities should include a review of documentation of client eligibility by programs/providers.

8) RYAN WHITE ELIGIBILITY SYSTEM

All Ryan White Part B funded agencies are required to utilize the Ryan White Eligibility System (RWES) for determining client eligibility and enrollment into the program. They must ensure that only clients enrolled in the program through the RWES are receiving services.

9) AGENCIES BILLING CLIENTS ON A SLIDING FEE SCALE

All Part B funded agencies that provide direct services to Ryan White Part B clients are required to request payment from their clients at the time of service delivery. The amount of payment will be based on the client's income / poverty level and a Sliding Fee Scale. Payment for services will be in accordance with the State of Tennessee, Ryan White Part B Program Policy (Attachment P). Inability to pay the fee will not affect current or future services. Ryan White clients will NOT be denied services based on their inability to pay.

10) ALLOCATION OF FUNDS FOR WOMEN, INFANTS, CHILDREN AND YOUTH WITH HIV DISEASE

The reauthorized Ryan White HIV/AIDS Treatment Extension Act of 2009 requires funding for women, infants, children and youth be based upon their relationship to the state's entire population with AIDS (i.e. if infants, children, women and youth make up 15-31% of the state's population with AIDS, then 15-31% of the state's Ryan White grant must be dedicated to this population.) The percentage in Tennessee has been determined using HIV infection as well, since HIV reporting is required in the state. In addition, the State is requiring that the percentage be assigned based on Consortia regions and category (i.e. women, infants, children or youth), so that each area will dedicate an appropriate percent of funds to address this population. For clarification, the ages for each category are provided. "Youth" is ages 13 to 24, "adult" is ages 25 and above, "infants" is anyone less than the age of 2 and "children" is considered ages 2-12.

2015 reporting of HIV/AIDS clients who are women, infants, children or youth will be documented using the standardized form (Attachment D).

11) RESTRICTIONS ON USE OF PART B FUNDS (STATE AND FEDERALLY IMPOSED)

The Lead Agency may use NO MORE THAN 10% (Including Indirect Costs) of their Allocation on Consortia Administration; NO MORE THAN 10% of their Allocation on planning and evaluation activities and, WHEN COMBINED, NO MORE THAN 15% of their entire allocation on planning, evaluation and administration.

No funds may be used to purchase or improve any building or other facility, except minor remodeling. **(You MUST obtain prior approval from Ryan White Services before performing minor remodeling.)**

No funds may be used to make cash payments to intended recipients of services (i.e., clients).

All proposals involving the use of funds to pay for automobiles, parts, repairs or maintenance MUST be approved by the state, prior to Consortium approval and/or funding.

No funds may be used to provide grants to for-profit service providers unless these providers are the only available providers of quality HIV care in the area. *All for-profit provider contracts must be preapproved by the Ryan White Program prior to disbursement of funds.*

Part B funds will not be used to support programs or materials designed to promote or directly encourage intravenous drug use (syringe exchange) or sexual activity, whether homosexual or heterosexual and budgets and expenditures will not include any unallowable activities.

The following services cannot be paid with Ryan White funds: Burials and /or prayer services, rent, mortgage, cash payments to clients, buying/building/remodeling a facility, any service which will be or is likely to be paid by a third party payer (i.e. insurance), general HIV education (AIDS 101), methadone treatment, purchasing or improving land/property or direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle (i.e. lease, loan, payments, insurance, or license and registration fees).

Part B funds will not be used to pay salaries over \$179,000.

12) CLIENT SERVICE CATEGORIES ELIGIBLE FOR CONSORTIA FUNDING

Consortiums are to use the HRSA-defined client service categories as a guide when evaluating the data collected from the state-required needs assessment tools and for determining which services can be funded based upon the prioritization of those needs. In general, funds should be allocated to agencies that submit proposals, (based upon a Request For Proposals [RFP] issued through the Lead Agency), that details programs best addressing concerns identified in the analysis of the needs assessment data. **It is acceptable for the Lead Agency to offer “continuation contracts” to agencies already funded under the Ryan White Consortia component if: a) the agency is evaluated and has implemented a successful program, b) the funded service is identified as a need in subsequent assessments, c) the agency submits an updated plan (to include a budget and scope of services and a proposed work plan as required by the State) outlining the continuation of the program and d) the service is an authorized Part B funded service listed in Attachment M.**

NOTE: Ryan White is a medical care priority grant. Medically-related care has been identified as a need; therefore, the Consortium is required to address this need above others that are not medically related. Contact the Ryan White Services office for any service category identified in the needs assessment that is NOT included on this list.

13) STANDARDS OF CARE FOR SELECTED SERVICE CATEGORIES

Each consortium is REQUIRED to develop formal Standards of Care for EVERY service category funded with Ryan White Part B dollars. These Standards should detail exactly what is expected of an agency when applying for funds. These Standards will also be incorporated into the Consortium Evaluation Process to insure that the consortium is receiving the types of services for which it is paying. (Standards of Care should be considered like a job description). Attachment -Q

Example—

Under Food Bank/Home Delivered Meals: One standard would be that all Food Bank client packages incorporate items that have been pre-planned by a Registered Dietitian, so that all bags of food contain items that are used for nutritious meals.

Under Transportation: One standard would define exactly what types of trips are permitted (Core Medical and Support Services) and what trips are not permitted (social outings, shopping malls, recreational).

14) PERSONNEL

The Lead Agency must develop minimum standards for **ANY** position that is to be funded. When positions involve certifications or licensure (nurse, dentist) these must be referenced.

All new hires within currently funded subcontracts or for personnel employed by new subcontracted agencies for case management positions must meet the educational requirements outlined in the Case Management Standards (**Refer to Attachment G**).

The Lead Agency is responsible for regional financial management and oversight of consortium funded services, data collection/reporting, and consortium coordination/support. To provide these services, the Lead Agency is allocated funding for a Lead Agency Representative position and a Consortia Coordinator position. Job descriptions outlining the distribution of duties between these two positions must be developed and submitted with Application Packet 1. (**Suggested distribution of job responsibilities can be found in Attachment E**). Funding for Lead Agency services and Consortia Coordination may be shared with other agency or contracted personnel in order to provide these services. For example, a Lead Agency may fund a portion of their accountant to provide financial management or a portion of a clerical position for support duties. However the Lead Agent must ensure the salaries are listed and charged to the proper budget. Administrative or Direct Services.

15) PROGRAM EVALUATION

HRSA has indicated that it is extremely important that HIV/AIDS Treatment Extension Act of 2009 funds be used both efficiently and effectively, resulting in the delivery of the highest possible quality of care to all clients. In general, this is accomplished through evaluating both the Consortium as a whole and the subsequent delivery of services funded with Consortium funds. These are primary responsibilities that **MUST** be on-going within each Consortium in operation in Tennessee. An

Outcomes Monitoring System, which encompasses outcome measures for each of the service categories funded through the Consortia Request for Proposal process, is an essential tool in meeting this responsibility. Each regional Consortium was required to develop a plan for outcomes measurement for the 2017 grant year and the 2018 grant year must provide information on the impact of funding allocations through the use of this tool. A sample Outcomes Evaluation Plan and Monitoring Tool may be found in **Attachment H**.

16) DENTAL CARE

Dental programs shall be operated in accordance with the State Dental Policy. All invoices for eligible clients provided dental care will be paid by the Designated Administrative Agent and / or Lead Agent, utilizing regional dental funds as per Ryan White Services Dental Policy dated June 3, 2009.

17) EMERGENCY FINANCIAL ASSISTANCE

Beginning in 2010, Food, Rent and Transportation will not be funded under the service category of Emergency Financial Assistance (EFA). Food and Transportation will be funded under the categories of Food and Transportation. Rent assistance will be accessed through HOPWA. The only services Part B will fund under the EFA category are Emergency Medications and Utility Assistance. In order to fund these services the following requirements must be met:

- Ryan White is payer of last resort.
- Standards must be established to define an emergency and provided to the Part B Program Staff.
- Annual expenditure caps (per client, per service) will be established and approved by the state.
- Coordination will be established between agencies to ensure the expenditure caps are not exceeded.
- Each service / instance requires a memorandum explaining why it is an emergency. Memorandum must be placed in the patients file.
- Utility assistance can be accessed only after HOPWA and other (community / etc) resources have been exhausted.
- Emergency medication can be purchased, but any medication purchased, must be listed on the current HDAP Formulary.

C) REPORTS / PLANS

All funded agencies are required to submit certain reports / data files to the State Department of Health and HRSA. All reports will be submitted electronically. HRSA has developed a software program named CAREWare. CAREWare was developed to manage and track Ryan White clients, their services and medical history. Usage of this program is free, and is required for all funded agencies in the State of Tennessee. The following listed reports / data files and Plans are due on a monthly, quarterly and annual basis. Some are due by Calendar Year and some are due by Grant Year

1. Quarterly / Recurring Reports

a. CAREWare Provider Data Export File / Report

Provider Data Export Files / Reports are to be submitted electronically each quarter through the state secure website using the Filezilla application. These export reports yield client level data. These reports / files will be submitted electronically each quarter to John Birkner at John.Birkner@tn.gov. These reports / files are due on the 15th day of the month, following the end of the calendar quarter. These reports / files are cumulative, for example; the first quarter report will include data collected from 1 January 17– 31 March 17. The second quarter report will include data collected from 1 January 17 – 30 June 17. The third quarter report will include data collected from 1 January 17 – 30 September 17 and the fourth quarter report will include all data collected for the year, 1 January 17 – 31 December 17.

b Quarterly Consortia Reports / Implementation Plans

No later than the 15th day of the month following the ending of each quarter, each Consortium will submit an updated Implementation Plan and a Narrative Program Review (**Attachment J**) that summarizes the activities of each funded subcontractor. This Review will incorporate the State-issued scope of service, so that client demographics and actual objectives/activities are evaluated and reported. These reports are cumulative, the **first quarter report will include data collected from 1 April 17 – 30 June 17. The second quarter report will include data collected from 1 April 17 – 30 September 17. The third quarter report will include data collected from 1 April 17 – 31 December 17 and the fourth quarter report will include all data collected for the year, 1 April 17 – 31 March 18.**

d. Revenue and Expenditure Report

No later than the 15th day of the month following the ending of each quarter, the Lead Agency will submit an itemized Revenue and Expenditure report on each funded subcontractor. Any additional questions regarding these reports should be directed to the HIV/STD Fiscal Section at 532-8502.

NOTE: Some agencies funded by the Consortium also have direct contracts with the Tennessee Department of Health. Agencies under direct contract with the Tennessee Department of Health are required to submit quarterly expenditure and revenue reports to the State. Because of this, it is not necessary for the Consortium to submit the quarterly expenditure and revenue report forms on subcontracts with local health departments, regional health offices and agencies under direct contract with the Ryan White Services Program.

2. ANNUAL REPORTS / PLANS

a. Minority AIDS Initiative Plan (MAI)

MAI funds are once again included in the Part B Grant. MAI funds will be administered with a separate contract. All Consortia outside the TGA's are required to include an "MAI" Plan in Application Packet 1, if they receive MAI Funds. This plan describes how FY 2016 MAI funds will be

used for education and outreach services to increase minority participation in the Part B AIDS Drug Assistance Program (ADAP), HIV/AIDS primary care, and/or HIV-related support services. Detailed requirements are listed in Section III, Paragraph K-1.

b. Minority AIDS Initiative (MAI) Accomplishments / Progress Report

All Consortia outside the TGA's are required to submit an annual report listing the accomplishments / progress achieved during the previous grant year. This report is due no-later-than 1 Sep 16. Detailed requirements are listed in Section III, Paragraph K-2.

c. Initial Implementation Plan

The Lead Agency is required to submit (for all Consortia Regions) an "Initial" Implementation Plan, in Application Packet 2. This form (see Attachment J) is designed to detail the specifics of each Service Category. Basically, it is used as a planning tool to project what services will be provided, how many units of each service will be provided and how much money will be allocated to provide the projected services. The initial plan establishes the goals of the consortia and should be updated quarterly and included as part of the Quarterly Consortia Report / Implementation Plan.

d. Ryan White Program Services Report (RSR)

Beginning in 2009, Ryan White Program grantees and service providers will use a new data collection and reporting system to report information on their programs and the clients they serve to the HIV/AIDS Bureau. The annual report will include the full calendar year. The Ryan White HIV/AIDS Program Services Report, or The Ryan White Services Report (RSR) for short, is comprised of three different reports: The Grantee Report, The Service Provider Report and The Client Report.

a. The State of Tennessee, Department of Health is the Part B Grantee of Record and is responsible for completing the Part B Grantee Report.

b. The Service Provider Report will be completed by all providers of services. This report will be filled in online. In addition to providing some basic information about their organization, providers will view a pre-filled list of their active service provider contracts for the most recent reporting period. For each of the service contracts, providers will view a list of Ryan White Program services and check the boxes next to all services that their organization delivered to RW Program clients during the reporting period.

c. The Client Report (AKA Client Level Data) will be submitted by each funded provider. This report is produced in CAREWare and provides client level data on all active clients receiving any Ryan White Funded services. The report is produced in a standard XML format and will be uploaded online as an electronic file. Each upload file will contain one record per client. Each client record will include information on demographic status, HIV clinical information, HIV-care medical and support services received, and the client's 'UCI', an encrypted, unique client identifier.

Note: Due dates are to be determined.

e. Women, Infants, Children and Youth (WICY) Report

All funded agencies are required to submit an annual report listing the amount of dollars expended on all Women (25 years old and older), Infants (Less than 2 years old), Children 2 - 12 years old and Youth (13 – 24 Years old). A separate report will be completed for each of the following WICY categories, WICYs served with MIA funds, WICYs served with IAP funds, and WICYs served with other Part B funds. The WICY Reports are due no-later-than the 15th of June 17. The report formats are included in Attachment D.

SECTION III: REQUIREMENTS FOR APPLICATION PACKET #1 FORMS AND NARRATION

NOTE: Packet 1 and Packet 2 are not required for the 2017 funding/grant year because the RFGP process in 2016 was/is for the 2017 funding/grant year.

Signed subcontracts are due to the Ryan White Program by Friday, 9 December 2016

Descriptions of the four regional Consortia, membership, committees, bylaws and other Consortia requirements will be due to the Ryan White Program at a time to-be-determined, but no later than 1 April 2017.

Included with this Application Packet #1 are forms and checklists which are required to be submitted for the 2015 grant year. Please be aware that many of the formats ask for identical information, but for different grant periods (2016-2017 vs. 2017-2018). In addition, some questions ask for percentages while others ask for specific numbers. Several of the forms and checklists require formal written narration to accompany them.

PLEASE READ THE INSTRUCTIONS CAREFULLY TO INSURE ALL REQUIREMENTS HAVE BEEN MET.

CHECKLIST/FORMS

A. 2017 APPLICATION PACKET #1 CHECKLIST

The Checklist is used to insure that each item required is in the packet due to the State on **October 9, 2016**. Please note on the Checklist as each item is included. Place the Checklist on top of the required application material.

B. 2017 CONSORTIUM AND LEAD AGENCY CONTACTS

This one (1) page form serves as a cover sheet to identify the primary contacts for each regional Consortium. Each question should be self-explanatory. In addition, at the bottom of the form is an area in which the Consortium should identify the “service categories” that are intended to be funded based upon needs identified in the Consortium needs assessment. Definitions of each “service

category” are included as **Attachment M**. You must include copies of Standards of Care for each service category as developed by the Consortium. **(NOTE: At the top of the form on page 27, there is a line for “Regional Allocation”. For the purpose of this Application Process, please enter the total allocation (Consortia and Minority Initiative) for each region. Remember to submit changes to any information supplied to the State within two weeks of the change. These changes should be submitted to the Consortia Coordinator or Ryan White Director.**

C. DESCRIPTION OF HIV CARE CONSORTIA

This 4 page form, beginning on page 28, is designed to provide a complete overview of the make-up of each Consortium, including the area to be covered and the demographics of both the Consortium region and the individual members. This checklist also requires a detailed listing of the various activities undertaken by the Consortium, especially as they pertain to community planning groups. The final section is intended to be a fiscal analysis of all client service categories funded by the Consortium during the 2014 grant year. **(NOTE: For definitions of client service categories, please refer to Attachment M).**

PLEASE DO NOT GUESS AT YOUR ANSWERS. THIS FORM WILL SERVE YOU MORE COMPLETELY IF YOU LEAVE BLANK ANY AREAS IN WHICH NO ACTIVITY HAS BEEN CONDUCTED. DURING THE 2016 GRANT YEAR, IT IS RECOMMENDED THAT THIS CHECKLIST BE USED AS A GUIDE TO COMPLETING THOSE AREAS WHERE A WEAKNESS IS INDICATED.

REQUIRED NARRATION:

In no more than five (5) pages, please describe any concerns that have been encountered as the Consortium has solicited membership from throughout the regions. Please list barriers that have been identified, and steps taken to address those barriers. If the number of counties served by the Consortium does not equal the number of counties represented by ACTIVE members of each Consortium, indicate how the Consortium has attempted to resolve the discrepancies in these numbers. Please indicate the demographics of all Active Consortium members representing the HIV Community, and list their representation on each Consortium Committee/Subcommittee. Finally, please indicate the steps the Consortium has taken and plans to take to increase the number of people with AIDS or HIV disease who sit as ACTIVE members on the Consortium.

D. NEEDS ASSESSMENT AND COMPREHENSIVE PLANNING ACTIVITIES

This (2) page form is designed to indicate the various activities the Consortium has engaged in during the past year. The form is divided into sections detailing both the formal Needs Assessment and the subsequent Comprehensive Planning for the region. The answers all require check marks in the appropriate column, and a few require specific information to be written next to the question.

A YES ANSWER INDICATES THAT THE CONSORTIUM HAS COLLECTED AND/OR ANALYZED DATA ON THE TOPIC IN QUESTION, OR COMPLETED THE ACTIVITY IN QUESTION AS PART OF THE FORMAL ASSESSMENT AND PLANNING PROCESS. IT ALSO INDICATES THIS INFORMATION IS AVAILABLE FOR STATE REVIEW AND EVALUATION.

NOTE: You may use data collected during the SCSN process.

REQUIRED NARRATION:

In no more than 15 pages, please describe the Consortium's Needs Assessment and Comprehensive Planning activities to date, including the following:

- List each of the five (5) needs assessment activities required by the State, and provide a detailed analysis of each component. Include in this narrative the number and demographics of participants, the response (number and percent) for each activity and the manner in which each component was conducted. In addition, several of the required Needs Assessment components required the Consortium to develop the questions and/or the manner in which the data was reported to the membership. Please describe how each activity was coordinated, including the questions asked and the data reporting procedure.
- Describe how the data was analyzed, including the final results to be used for planning and the process in which services were prioritized for funding based upon these findings.
- Describe the process through which the regional Comprehensive Plan was developed and **include a copy of the current plan.**
- List any concerns or barriers identified during the process and any action underway to address those concerns/barriers.

E. DEDICATION OF FUNDS FOR WOMEN, INFANTS, CHILDREN AND YOUTH

1) This is due with Application Packet #1:

In three (3) pages or less, indicate that the Consortium recognizes the HIV/AIDS case rates for the region relative to Women, Infants, Children and Youth and detail the steps being taken to insure this information is collected from all regionally funded agencies.

2) The following will be due no later than 75 days after the completion of the grant Year (June 15, 2017).

In five (5) pages or less, provide a narrative with supportive data indicating the Consortium's analysis of funds dedicated to services for **women (ages 25 and above), infants (less than 2 year), children (ages 2-12) and youth (ages 13-24)**. This analysis should include each subcontractor (as appropriate), total funds allocated with an indication of the percent/total that was dedicated to this population, total number of individuals within this population that were served, and a review of the services received. 2017 reporting of women, infants, children and youth HIV/AIDS clients, who received services from a funded sub-contractor, is required. Women, infants, children and youth will be documented using the standardized form (Attachment D).

F. DENTAL PLAN

In three (3) pages or less, provide a narrative with supportive data indicating the consortium's analysis of funds dedicated to the State's Dental Plan. Include a copy of the Regional Dental Plan as an attachment.

G. CONSORTIUM QUALITY IMPROVEMENT AND EVALUATION PROCESS

In no more than five (5) pages, provide a narrative detailing the Consortium's quality improvement and evaluation process, especially as it pertains to Conflict of Interest of members. Discuss the results of the Consortium's Outcome Evaluation plan, any modifications made to the plan, and how the system was used to determine funding for the 2015 grant year. In addition, identify the subcontractor review process undertaken by the Consortium to insure that funded agencies met their proposed objectives from the 2015 grant year. Please provide information on the review process undertaken to determine that the agency met its proposed objectives from the previous grant year.

Each Consortium must provide regional Goals and Outcome Objectives for the 2017 grant year, including a copy of the regional Outcomes Evaluation Plan.

Note: The Lead Agency is required to conduct a minimum of two contract monitoring site visits (per grant year) to all funded agencies. The 1st contract monitoring site visit must be conducted during the 2nd quarter of the grant year. If problems are observed / discovered during a site visit, a corrective action plan and follow-up visits are required. The 2nd contract monitoring site visit must be conducted during the 4th quarter of the grant year. If problems are observed / discovered during a site visit, a corrective action plan and follow-up visits are required.

The Lead Agency must develop a Contract monitoring visit schedule no later than the last day, of the first month (April), of the grant year. The schedules will immediately be sent to the Ryan White Part B Program Office.

H. REGIONAL ALLOCATIONS AND SERVICE CATEGORIES

Use last year's funding as a baseline for 2017.

I. EXTREME RURAL TRANSPORTATION FUNDING

Extreme Rural Transportation is no longer a stand alone service category. All Transportation will be referred to as "Medical Transportation Services" (See Attachment M).

J. INSURANCE ASSISTANCE PROGRAM (IAP)

IAP is considered a Core Medical Service provided it is delivered as a direct service and not delivered through the consortia. Because of the large amount of funds allocated to the IAP, it

is imperative, that those expenditures count toward Core Medical Services. Therefore, IAP is provided through a state direct contract awarded through the RFP Process.

K. MINORITY INITIATIVE (MAI)

1. PLAN

Describe how FY 2017 MAI funds will be used to link Minorities to the Part B AIDS Drug Assistance Program (ADAP), HIV/AIDS primary care, and/or HIV-related support services, with emphasis on reconnecting people who have fallen out of care or have not received a Ryan White service within the past twelve (12) months and assist them in returning to care.

- Identify the specific outreach services/activities to be provided, the amount of funds budgeted for each service/activity, and the target population(s).
- Indicate whether each activity/service is a new, continuing or expanded effort.
 - **New:** An activity or service not previously directed to a target population(s) using MAI or other Part B funds (in whole or in part).
 - **Continuing:** An activity or service provided to a target population(s) last year using MAI or other Part B funds that will be maintained at the same level during FY 2017 using MAI funds (in whole or in part).
 - **Expanded:** An activity or service provided to a target population(s) last year using MAI or other Part B funds that is being expanded in 2017 with MAI funds in order to serve additional clients or to provide additional units of service.
- Describe the expected result(s) for each MAI-funded outreach service/activity.
- Provide a breakout by race/ethnicity of the number of clients expected to be served or to benefit from each MAI-funded outreach service/activity, A service unit definition for each planned service / activity; and the planned number of service units expected to be provided.

2. ACCOMPLISHMENTS / PROGRESS REPORT. (Report Due No-Later-Than 1 May 2017)

- Identify the outreach / linkage activities provided by each contractor.
- Provide the total amount of MAI funds spent in FY 2016. If the total includes any MAI carryover funds from a prior fiscal year, indicate the fiscal year and carryover amount(s).
- Provide a breakout of actual expenditures for each MAI-funded outreach activity/service.
- What were the results of the grantee's MAI-funded outreach efforts?

- Compare the number and demographics of clients pre- and post- the MAI-funded activity / intervention; for example, with respect to efforts to increase minority participation in the ADAP.
- What was the total number of minority clients that was linked to care through MAI funded outreach / linkage activities?
- What was the total number and ethnicity of the clients returned to care?
- What was the racial/ethnic breakout of clients that received or benefited from each service or activity, using the ethnic and racial categories listed below.
- What other results were achieved, if any?

2017 reporting of minority Women, Infants, Children and Youth (WICY) HIV/AIDS clients, who received services from an MAI funded sub-contractor, is required. Minority Women, Infants, Children and Youth will be documented using the standardized form (Attachment D).

L. WORK PLAN

Each Consortium must complete a Regional Work Plan outlining HIV/AIDS Treatment Extension Act of 2009 funded activities to occur within the consortium region. An example is included as **Attachment I. The work plan must contain a schedule of consortium/RAC meetings for the requested grant cycle.**

M. LEAD AGENCY CONTRACT BUDGET SUMMARY

This two-page form is designed to reflect the entire Lead Agency contract budget and will be used to renew Lead Agency contracts. Expenses are listed by object category under each allocation as they would appear in the final Lead Agency contract budget when it is received for agency signature from the Bureau Contract Office.

PLEASE NOTE: SECTION IV CONTAINS SUBCONTRACTOR BUDGETS AND "SCOPE OF SERVICE" FORMS THAT MUST BE PART OF THE RFP AND SUBSEQUENT PROPOSAL SUBMITTED TO THE CONSORTIUM FOR CONSIDERATION FOR FUNDING. FAILURE OF A POTENTIAL SUBCONTRACTOR TO INCLUDE THESE FORMS WITH EACH PROPOSAL MAY RESULT IN LACK OF FUNDING FOR THOSE SUBCONTRACTORS.

**TENNESSEE DEPARTMENT OF HEALTH
HIV CARE CONSORTIA
2017 APPLICATION PACKET #1 CHECKLIST
DUE **OCTOBER 9, 2016****

Consortium _____ Lead Agency _____

*** NOTE* Narratives are required for agencies that are continuing funding**

FORMATS/REQUIRED REPORTS:

- | | | |
|----|---|-----|
| * | Table of Contents | [] |
| * | Letter of Transmittal | [] |
| A. | Preapplication Checklist | [] |
| B. | 2017 Consortium/Lead Agency Contacts | [] |
| C. | Description of HIV CARE Consortia
(To include required narration) | [] |
| D. | Needs Assessment/Comprehensive Planning Activities
(To include required narration) | [] |
| E. | Report: Dedicated Funds for Women, Infants, Children and Youth
(To include required narration) | [] |
| F. | Dental Plan | [] |
| G. | Quality Assurance and Evaluation Narratives | [] |
| H. | Regional Allocations and Service Categories | [] |
| I. | Extreme Rural Transportation Funding Narrative | [] |
| J. | Nutrition Plan | [] |
| K. | Minority AIDS Initiative Narrative / Plan | [] |
| L. | Initial Implementation Plan | [] |
| M. | Work Plan | [] |
| N. | Lead Agency Budget Summary | [] |

ALSO INCLUDE:

- | | | |
|----|--|-----|
| a. | Membership list indicating Active/Inactive Members | [] |
| b. | Current Needs Assessment Analysis | [] |
| c. | Comprehensive Plan based upon the Needs Assessment | [] |
| d. | Standards of Care for Service Categories | [] |
| e. | Outcomes Monitoring Plan | [] |
| f. | Consortia Committees, including members of the committee | [] |

**IDENTIFY BELOW AND INCLUDE A COPY OF ALL FORMAL
CONSORTIUM POLICIES, GUIDELINES AND OTHER DOCUMENTS
DEVELOPED AS PART OF THE CONSORTIUM'S BUSINESS. *One copy of each
Required Consortia policy must be included in application packet.***

**TENNESSEE DEPARTMENT OF HEALTH
Ryan White Services
2017 CONSORTIUM and LEAD AGENCY CONTRACTS**

CONSORTIUM:
REGIONAL ALLOCATION:

CONSORTIUM CHAIR

CONSORTIUM CO-CHAIR

Name:			
Title:			
Organization:			
Address:			
Phone:	Fax:	Phone:	Fax:
E-mail:	E-mail:		

LEAD AGENCY REPRESENTATIVE

CONSORTIA COORDINATOR

Name:			
Title:			
Organization:			
Address:			
Phone:	Fax:	Phone:	Fax:
E-mail:	E-mail:		

LEAD AGENCY OFFICIAL WITH BOARD AUTHORITY TO COMMIT AGENCY TO CONTRACT

Name:			
Title:			
Organization:			
Address:			
Phone:	Fax:		
E-mail:			

Service Categories Expected to be funded in the Grant Year 2016

Please notify Ryan White Services of any changes in Consortium and/or Lead Agency contracts that occur during the year, in writing, within two weeks of the change.

DESCRIPTION OF 2016 HIV CARE CONSORTIA

State: _____

Region: _____

I. ADMINISTRATIVE INFORMATION	
1. Consortium Name:	
2. Consortium Contact Person:	
3. Consortium Address:	
4. Consortium Phone:	5. Consortium Fax:
6. E-Mail Address:	
7. Lead Agency Name:	
8. Lead Agency Contact Person:	
9. Lead Agency Address:	
10. Lead Agency Phone:	11. Lead Agency Fax:
12. Lead Agency E-Mail Address:	
13. TYPE OF CONSORTIUM (Check the most appropriate response)	CHECK
a. Local (city/county)	
b. Regional	
c. Statewide	
d. Special Populations (specify):	
14. TYPE OF LEAD AGENCY (Fiscal Agency):	CHECK
a. Hospital or Hospital Based Clinic	
b. Public Funded Community Health Center	
c. Other Community Based Service Organization	
d. Health Department	
e. Other Public Agency	
f. Other (specify):	
II. DEMOGRAPHICS OF CONSORTIUM REGION	NUMBER
1. Number of Persons Living with AIDS (as of 3/31/14)	
2. Number of Persons Living with AIDS by Race/Ethnicity (total should equal 1, above)	
a. White (non-Hispanic)	
b. African-American/Black (non-Hispanic)	
c. Hispanic	
d. Asian/Pacific Islander	
e. Native American/Aleutian/Eskimo	
f. Other or unknown (specify):	
3. Estimated Total Number of Persons to be served in 2016 Grant Period	
4. Estimated Total Number to be Served in the 2016 Grant Period by Race/Ethnicity (Total should equal II-3 above)	
a. White (non-Hispanic)	
b. African-American/Black (non-Hispanic)	
c. Hispanic	
d. Asian/Pacific Islander	
e. Native American/Aleutian/Eskimo	
f. Other or Unknown (specify):	

III. CONSORTIUM MEMBERSHIP (An individual can represent more than one group)		NUMBER
1. How many individual members (active only) belong to the Consortium (based on the most recent information available)?		
2. Total Agencies Represented		
3. Total Counties Represented by Consortium		
4. Number of Individual Members Representing Each of the Following Categories (An individual can represent more than one category):		
a. Primary Health Care Providers		
b. Non-AIDS CBO's		
c. Mental Health Providers		
d. Health Planning Agencies		
e. State Government		
f. AIDS-Specific Agencies		
g. Social Service Agencies		
h. Local Public Health Agencies		
i. Non-Elected Community Leaders		
j. Substance Abuse Agencies		
k. People Living with HIV/AIDS		
l. Caregivers		
m. Local Government		
n. Ryan White Program Part A		
o. Ryan White Program Part C		
p. Ryan White Program Part D (or, if none are operating in area, organizations with a history of serving women, infants, children or youth)		
q. Ryan White Program Part E (Special Projects of National Significance, AIDS Education and Training Centers, and Dental Reimbursement Programs, indicate which)		
r. CDC-funded HIV Prevention Community Planning Groups		
s. Other (specify):		
Racial /Ethnic and Gender Diversity of Consortium Members:		
Race/Ethnicity	Numbers of Voting Members of Consortium	Ratio
a. White (non Hispanic)		
b. African American/Black (non Hispanic)		
c. Hispanic		
d. Asian/ Pacific Islander		
e. Native American/ Alaskan Native		
f. Other or Unknown (specify)		
Gender	Number of Voting Members of Consortium	Ratio
Female		
Male		
5. What is the Average Number (or numerical range) of People with HIV (who are not Consortium members) who attend Consortium Meetings?		

III. CONSORTIUM MEMBERSHIP CONTINUED		
5. Does the Consortium Have Bylaws/Operating Procedures that Address the Following: List date last revised after each category	YES	NO
a. Membership		
b. Attendance Policy		
c. Conflict of Interest		
d. Leadership Selection		
e. Orientation for New Members		
f. Grievances		
IV. CONSORTIUM ACTIVITIES	YES	NO
1. Has the consortium conducted a Needs Assessment?		
1a. If yes, What was the most recent year a Needs Assessment was conducted? _____		
2. How often is the Needs Assessment updated? _____		
3. Has the Consortium developed a written, comprehensive plan for service delivery?		
3a. If yes, What is the most recent year for which a plan was developed? _____		
4. In the plan, did the Consortium demonstrate to the state that adequate planning occurred to meet the special needs of families with HIV disease, including family-centered and youth-centered care?		
5. Has the Consortium worked together with the HIV Prevention Community Planning Group to bring HIV-identified people into the CARE System?		
6. Has the Consortium taken steps to coordinate its CARE planning activities with the prevention planning activities of the HIV Prevention Community Planning? (Check all that apply)		
a. Are there Consortium members who are also HIV Prevention Community Planning Group members?		
b. Is there a combined planning body for both care and prevention		
c. Do the consortium and HIV Prevention Community Planning Group share any or all components of the Needs Assessment process?		
d. Does the Consortium review the HIV Community Planning Group's Prevention Plan?		
e. Does the HIV Prevention Community Planning Group review the Consortium's CARE Plan?		
7. Are there other HIV/AIDS Treatment Extension Act of 2009 groups with which the Consortium coordinates? What are they?		
8. Has the Consortium evaluated its effectiveness in meeting needs of persons living with HIV/AIDS?		
8a. If yes, What was the most recent year the evaluation was conducted? _____		
9. During the 2016 Grant year, did the Consortium have:	YES	NO
a. Written procedures for monitoring the performance of Part B funded service providers? List date last revised after each category		
b. A peer review committee or task force?		
c. A contract for an independent review?		
d. A service provider assessment tool?		
e. New member orientation and information packet?		
10. During FY 2015, did the Consortium use any Self-Assessment Modules (provided by HRSA) to evaluate its performance in any area?		

11. How frequently does the full Consortium have regular meetings, either on site or via teleconferencing?	Check
a. Twice monthly	
b. Once monthly	
c. Every other month	
d. Quarterly	
e. Semi-annually	
f. Other (specify)	
V. 2016 GRANT YEAR FUNDING AND ALLOCATIONS (For the Consortium)	
1. Revenues received from:	AMOUNT
a. State funds (non Part B)	
b. Local Consortium funds	
c. Private contributions and grants (In Kind)	
d. Federal Consortium funds (non Part B). Indicate the source and amount of each grant.	
e. In Kind	
2. 2016 Grant Year Part B allocation (Part B funds only)***	
3. Part B Consortium allocation breakdown by service and non-service categories (Part B funds only)	
CATEGORY	AMOUNT
a. State Drug Reimbursement Program	
b. Ambulatory, Out-Patient Medical/Dental Treatment/Supplies	
c. Dental Care	
d. Mental Health Therapy/Counseling	
e. Substance Abuse Treatment/Counseling	
f. Rehabilitation Care	
g. Case Management	
h. Home Health Care	
i. Residential/In-home Hospice Services	
j. Nursing Home Care	
k. Other Services.	
ADMINISTRATION	AMOUNT
4. Consortium Administration	
5. Consortium Planning and Evaluation	
6. Other Non-Service Consortium Part B Grant Allocations (specify)	
6. Unallocated/Unobligated Consortium Part B Funds	
7. TOTAL Consortium Part B Allocations***	

***The total Consortium allocations should equal Questionnaire V, Section #2

NEEDS ASSESSMENT AND COMPREHENSIVE PLANNING ACTIVITIES

CONSORTIUM _____
LEAD AGENCY _____
EFFECTIVE DATE _____

Each activity should be marked. Further clarification or explanation of any activity should be included in the narratives.

A. NEEDS ASSESSMENT	YES	NO	N/A
1. Does the Consortium estimate the number of people living with HIV in primary care?			
2. Does the Consortium estimate the number of people living with HIV NOT in primary care?			
3. Does the Consortium estimate in quantifiable terms the unmet service needs of the people living with HIV?			
4. Is the Consortium able to identify gaps in service/barriers to care?			
5. Is the Consortium able to identify gaps in service/barriers to care for different populations affected by the HIV/AIDS epidemic?			
6. In assessing HIV service needs does the Consortium receive input from:	YES	NO	N/A
a. Part C (b) Grantees			
b. Part D Grantees			
c. HIV service providers/CBOs			
d. Consumer Groups (e.g., PLWA Coalitions)			
e. Individual PLWA/HIV and/or care givers			
f. Other HIV-related programs/services (specify):			
7. In assessing HIV service needs does the Consortium collect, review or analyze:	YES	NO	N/A
a. Consumer surveys			
b. Focus group data			
c. HIV/AIDS case manager assessments			
d. New born heelstick studies			
e. Military and job corps seroprevalance studies			
f. CDC surveys of other people at risk (e.g. blinded seroprevalance hospital studies, STD clinics, drug treatment clinics)			
g. HIV and TB related data			
h. HIV Counseling and Testing data			

i. Other, specify:			
B. COMPREHENSIVE PLANNING			
1. Does an entity with overall responsibility for HIV service planning exist in the Consortium?			
2. Does the Consortium analyze the distribution of AIDS cases across their region?			
3. Does the Consortium analyze cases of AIDS by:	YES	NO	N/A
a. Demographics (e.g. age, sex, ethnicity)			
b. Transmission category (e.g. men having sex with men, injection drug users, etc.)			
4. Does the Consortium analyze trends in the HIV/AIDS epidemic by:	YES	NO	N/A
a. Demographics (e.g. age, sex, ethnicity)			
b. Transmission category (e.g. men having sex with men, injection drug users, etc.)			
5. Does the Consortium analyze trends in the HIV/AIDS epidemic by:	YES	NO	N/A
a. Demographics (e.g. age, sex, ethnicity)			
b. Transmission category (e.g. men having sex with men, injection drug users, etc.)			
6. Does the Consortium conduct an inventory of available local, State and federally funded public and private sector resources?			
7. Does the Consortium assess the continuum of care available to individuals and families with HIV disease within geographic areas across their region?			
8. Does the Consortium take into account the ability of a subcontractor to sustain itself if Ryan White funds are discontinued?			
9. Does the Consortium take into account the ability of a subcontractor to continue to sustain itself if Ryan White funds are discontinued?			
10. Does the Consortium take into account the ability of a subcontractor to continue a specific service if Ryan White funds are discontinued?	YES	NO	N/A
a. Ryan White Program Part A			
b. Ryan White Program Part C			
c. Ryan White Program Part D			
d. AIDS Education and Training Center Programs			
e. Special Projects of National Significance			
f. Substance Abuse and Mental Health Programs			
g. City/County AIDS Programs			
h. State and CDC counseling and testing programs			
i. HOPWA program			
j. AIDS Clinical Trials Groups (ACTG)			
k. Community Programs for Clinical Research on AIDS			
l. Federally funded migrant, homeless and community health centers			
m. Maternal and Child Health programs (e.g. Healthy Start, family planning programs, youth/adolescent programs)			
n. TB programs			
o. Public assistance programs			
p. STD programs			
q. State TENNCARE program			
r. Does the Consortium conduct an overview of the tuberculosis epidemic and analyze its relationship to HIV service delivery?			
11. Does the Consortium assess the impact of the following issues on HIV/AIDS service delivery:	YES	NO	N/A
a. Needs/issues of affected populations			
b. Capacity issues (staff, facilities)			
c. Public health infrastructure constraints			
d. Geographic constraints			
e. Jurisdictional/political factors			
f. Care financing issues			
g. State/Federal Regulatory issues			

12. Has the Consortium identified any primary principles which guide planners, service providers, consumers and community leaders in the development of HIV/AIDS services within the area served by the Consortium (e.g. priority given to individuals with more advanced disease, improved access to under served populations, etc.)?			
13. Does the Consortium have goals and objectives established for:	YES	NO	N/A
a. Three (3) to Five (5) years			
b. One (1) year			
14. Does the Consortium have mechanisms, processes and time frames for assessing:			
a. Progress toward goals and objectives			
b. Changes in the local HIV/AIDS epidemic, service needs and available resources			
c. Update/revisions to the comprehensive plan			
15. Does the Consortium hold public hearings regarding the Part B grant application?			
16. Does the Consortium receive public comment on the development or implementation of the use of Part B funds?			
C. REGIONAL CONSORTIUM PLAN	YES	NO	N/A
1. Are all the components under A (Needs Assessments) and B (Comprehensive Planning) contained in a formal working document for use in regional Consortium planning?			
2. How often is this document updated? _____			

SECTION IV: REQUIREMENTS FOR APPLICATION PACKET #2

NOTE: Packet 1 and Packet 2 are not required for the 2017 funding/grant year because the RFGP process in 2016 was/is for the 2017 funding/grant year.

Signed subcontracts are due to the Ryan White Program by Friday, 9 December 2016

Descriptions of the four regional Consortia, membership, committees, bylaws and other Consortia requirements will be due to the Ryan White Program at a time to-be-determined, but no later than 1 April 2017.

A) FORMATS AND BUDGETS

This section is the final piece of the application process for the FY 2017 HIV CARE CONSORTIA grant. It contains specific forms that **MUST** be used by community organizations as they prepare their proposal in response to the Consortium's RFP. These forms will also be used to submit their final budget and their program's "scope of services".

FUNDING SHOULD NOT BE RELEASED FOR ANY SUBCONTRACT THAT DOES NOT HAVE A SIGNED SUBCONTRACT DOCUMENT ON FILE IN THE RYAN WHITE SERVICES PROGRAM OFFICE.

For the purpose of this application, **SUBCONTRACTOR ADMINISTRATIVE COSTS** will include ANY equipment or supplies or any portion thereof that are not **DIRECTLY** Ryan White client related. When requesting indirect costs, when they are not an indirect agency cost, an agency cost allocation plan for lead agency approval or a copy of the agency's approved indirect cost rate agreement must be submitted (Refer to **Attachment L** for budget category definitions). Indirect / administrative cost cannot exceed 10% of the total contract.

NOTE: If a subcontractor claims equipment costs are Ryan White client-related, adequate documentation must be submitted to the Lead Agency AND be available for State review and audit. Cost sharing must be applied when equipment will be used by other than the Ryan White activities under the subcontract.

CLIENT RELATED equipment and supplies: Supplies or equipment purchased specifically for a client may not always fall under the supply or equipment budget category. **Attachment L**, Budget Narrative/Justification Guidance will assist in defining budget categories. **General AIDS awareness and HIV prevention material is not appropriate for Ryan White expenditures.**

If there are any questions regarding client vs. administrative equipment or supplies, please direct them to Ryan White Services at (615) 741-0312.

IN ADDITION, THIS SECTION RELIES HEAVILY UPON THE SELECTION OF “SERVICE CATEGORIES” WHICH ARE USED TO IDENTIFY THE TYPES OF SERVICES TO BE PROVIDED BY EACH SUBCONTRACTOR. A DEFINITION OF ALL HRSA-SPECIFIC SERVICE CATEGORIES CAN BE FOUND IN **ATTACHMENT M**.

B) COVER LETTER

The Lead Agency will submit all required information with a formal cover letter, co-signed by the Consortium Chair and the Lead Agency Representative that identifies the Consortium, and indicates the material is the region’s formal response to the Tennessee Department of Health, Ryan White Services FY 2017 HIV CARE CONSORTIA application packet #2. The letter should also indicate the client-specific “service categories” that the Consortium intends to fund under the grant, as well as an indication of the percent of funds dedicated to each category.

C) 2017 APPLICATION PACKET #2 CHECKLIST

The Checklist is to be used as a guide for all material that is required to be submitted by the Consortium as part of the formal Application due to the State by **January 8, 2016**. Following the cover letter, it is to be placed on the top of all information being submitted.

D) REQUEST FOR PROPOSALS

A copy of the Consortium’s current, dated RFP must be included with the Application Packet. A pre-bidders conference must be advertised to the community and conducted prior to the awarding of any proposal.

E) SUBCONTRACTOR CHECKLIST

As is referenced in the document “RESPONSIBILITIES OF THE LEAD AGENCY IN RELATIONSHIP TO CONSORTIA; RESPONSIBILITIES OF THE CONSORTIUM IN REGARD TO RYAN WHITE” (**Refer to Attachment A**), the Consortium will include their “subcontractor checklist” for all funded agencies.

F) PROPOSALS RECOMMENDED FOR FUNDING

A copy of all proposals as recommended for funding by the Consortium must be included WITH Application Packet #2. In addition, each proposal **MUST** include a final copy of the Subcontractor Scope of Service form and Subcontractor Budget Information. In addition, please include copies of all letters sent to funded subcontractors noting any changes/revisions to proposal, award or budget.

NOTE: All “Scope of Service” sections on all sub-contracts, must include the statements listed in numbers 1, 2, 3 and 4 below. This is in addition to any and all other requirements.

1. The subcontractor will complete and submit an implementation plan / report to the Lead Agent every quarter. This report is based on the Grant Year which begins on 1 April 17 and ends on 31 March 18. The report is due to the Lead Agent no-later-than ten calendar days after the end of the quarter. The implementation plans / reports are cumulative. The first quarter report will include data collected from 1 April 17– 30 June 17. The second quarter report will include data collected from 1 April 17 – 30 September 17. The third quarter report will include data collected from 1 April 17 – 31 December 17 and the fourth quarter report will include all data collected for the year, 1 April 17 – 31 March 18.

NOTE: See item G (below) for detailed use of the Implementation Plan.

2. The subcontractor will complete and electronically submit an export data file / report to John.Birkner@tn.gov. Reports / files will be completed and submitted in the format and media directed by the state. Reports / files are due no later than the 15th of the month following the end of the calendar quarter. The reports are cumulative. The first quarter report will include data collected from 1 January 17 – 31 March 17. The second quarter report will include data collected from 1 January 17 – 30 June 17. The third quarter report will include data collected from 1 January 17 – 30 September 17 and the fourth quarter report will include all data collected for the year, 1 January 17 – 31 December 17. The subcontractor will submit the (New) Client Level Data Reports as required.

3. The subcontractor will complete and submit the Annual Ryan White Services, Provider Reports and Client Reports as required. The Provider Report is submitted on-line, to HRSA. The Client Report is produced in CAREWare and is uploaded to the HRSA website in an XML Format. The due dates of the reports are to be determined by the Ryan White Program central office.

Note: Omission of required statements in “Scope of Service” will result in disapproval of subcontract.

G) Implementation Plans

This form (see Attachment J) is designed to detail the specifics of each program in a proposal submitted by a potential subcontractor for funding by the Consortium. The agency name and all service categories addressed within the proposal are listed at the top of the form. The initial plan should be updated quarterly and included in the Consortia Quarterly Reports.

Service Unit Definitions: Define the service being delivered, and it must be measurable. For example, Case Management must be broken down into face-to-face and non face-

to-face encounters, with a measurable unit of time. Encounters with Professional Providers shall have a unit of time specified, such as "15 minute unit of service". Transportation and food baskets must have a dollar value included, not simply the number of vouchers or bags. Transportation and Food will be measured and reported in accordance with the values listed below.

Service Provided is Food	
Meal / Voucher / Bag or Box of Food / etc	1 Unit is equal to \$20.
Service Provided is Transportation	
Gasoline	1 Unit is equal to \$20
Bus Pass / Ticket / Voucher / Fare / Trip / etc	1 Unit is equal to \$20

Note: If a voucher / Trip / Meal etc Costs less than \$20, Such as \$15 it will equal .75 Units. If the cost exceeds \$20, such as \$25 it will equal 1.25 Units. Round up or down to the nearest .25 Unit.

For each Objective: Define the Service Units, enter the (est.) number of people to be served by the subcontractor, enter the time frame, and enter the amount funded.

This document is designed to detail each subcontractor's Goals for each service category selected for funding. Underneath each Goal are three boxes; one each for Objective, Measurement and Time Frame. There should be at least one Goal per page for each service category funded. Examples of one entry include:

Goal: To provide Case Management services
Objective: All clients requesting assistance will have a formal intake interview.
Measurement: All intake interviews will be completed within three (3) working days of client's initial agency contact.
Time Frame: On-going beginning April 1, 2017.

In addition, a formal monthly work plan with dates for expected completion is required (Refer to **ATTACHMENT I**).

SUBCONTRACTOR INFORMATION AND BUDGET

Use state budget forms

For instructions on using the state budget forms see (Attachment L)

PLEASE SUBMIT THE APPLICATION PACKET BY **JANUARY 8, 2017.**

TENNESSEE DEPARTMENT OF HEALTH
HIV CARE CONSORTIA

2017 APPLICATION CHECKLIST

CONSORTIA _____ LEAD AGENCY _____

- A. Cover Letter ()
 - B. A copy of the Consortium's current, dated Request for Proposals (RFP) ()
 - C. A copy of the Consortium's subcontractor checklist for each Funded subcontractor (due upon completion) ()
 - D. Subcontracts: to include letters, Proposed Scope of Services, and Final Budget formats ()
 - E. Copy of the most recent fiscal audit of the subcontracted Agencies. ()
- NOTE: This is the complete audit packet not just financial statements.**

**FY 2017 HIV CARE CONSORTIA
SUBCONTRACTOR SCOPE OF SERVICE
(PAGE 1 OF 2)**

AGENCY _____ SERVICE _____
CATEGORY(S) _____

CONSORTIUM _____ -

1. Subcontract Amount	\$
2. Estimated total number of person to be served	
3. Estimated percentage of persons to be served by Race/Ethnicity:	
a. White (non-Hispanic)	
b. African-American/Black (non-Hispanic)	
c. Hispanic	
d. Asian/Pacific Islander	
e. Native American/Aleutian/Eskimo	
f. Unknown	
4. Estimated percentage of persons to be served by gender:	
a. Male	
b. Female	
5. Estimated number of persons to be served by age group:	
a. Under age 2	
b. 2 – 12 Years of Age	
c. 13 – 24 Years of Age	
d. Over age 25	

**FY 2017 HIV CARE CONSORTIA
SUBCONTRACTOR SCOPE OF SERVICE
(Page 2 of 2)**

SERVICE CATEGORY _____

GOAL:		
OBJECTIVE	MEASUREMENT	TIME LINE (BY WHEN)
OBJECTIVE	MEASUREMENT	TIME LINE (BY WHEN)
OBJECTIVE	MEASUREMENT	TIME LINE (BY WHEN)

There should be at least one Goal per service category. There can be more than one objective per goal.
Use as many pages as needed.
Add all required statements here.

RYAN WHITE PART B
 FY 2017 SUBCONTRACTOR INFORMATION & BUDGET (Page 1 of __)

1. Consortium Name:			
2. Lead Agency:			
3. Contract Period:		Subcontractor Funding Request:	\$
4. Subcontractor Name:		Subcontractor EIN Number:	
5. Address:			
6. City/Zip Code:		Total No. of Sites:	
7. Agency Director:			
8. Ryan White Contact (If Different):			
9. (Area Code) Phone No:			
10. E-Mail Address:			
11. Budget Director/ Fiscal Officer:			
12. (Area Code) Phone No.			
13. Provider Type (Check One)			
<input type="checkbox"/> Health Department Organization		<input type="checkbox"/> Other Community Based Service	
<input type="checkbox"/> Hospital or Clinic		<input type="checkbox"/> Other Public Agency	
<input type="checkbox"/> Public Funded Community Health Center		<input type="checkbox"/> Unknown	
<input type="checkbox"/> Public Funded Community Mental Health Center		<input type="checkbox"/> Solo/Group Private Health Practice	
<input type="checkbox"/> PWA Coalition		<input type="checkbox"/> Other	
14. Ownership Status (Check One)			
<input type="checkbox"/> Public/Local Unknown	<input type="checkbox"/> Public/State	<input type="checkbox"/> Public Federal	<input type="checkbox"/>
<input type="checkbox"/> Public/Nonprofit	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Unincorporated	
15. Minority Provider (Check One):			
<input type="checkbox"/> Yes		<input type="checkbox"/> No	
16. Scope of Work: (Briefly Describe Service(s) to be Provided Including the Number of Clients You Intend to Reach with Each Selected Service: See #16)			
17. Scope of Service must list all requirements, including those listed in SECTION IV, ITEM F.			

RYAN WHITE PART B

FY 2017 SUBCONTRACTOR INFORMATION & BUDGET (Page__ of __)

BUDGET NARRATIVE JUSTIFICATION

19. In the space below provide a categorical narrative justification to support all funds requested (administrative and client related) on page 2, 17.A. through 17.I. (For definitions refer to Attachment L-Budget Narrative Justification Guidance) Attach additional pages if necessary.

NOTE:

All funded agencies will provide one overall budget that includes all administrative costs and direct services costs and a budget detail page.

Separate budgets for Administration and Direct costs are no longer required.

RESPONSIBILITIES OF THE LEAD AGENCY IN RELATIONSHIP TO
CONSORTIA RESPONSIBILITIES OF THE CONSORTIUM IN REGARD TO
RYAN WHITE
(Revised 5/20/15)

Beginning in Grant Year 2010, the State of Tennessee will no longer be divided into five (5) consortia regions. The state will consist of four (4) consortia regions and two (2) Transitional Grant Areas (TGAs). The four consortia regions will include 79 of the 95 counties and will be funded by Part B. The remaining 16 counties are included in the two TGAs (Memphis and Nashville) and will be funded by Ryan White Part A. Part A will fund all Ryan White Services in the TGA Counties with the exceptions of, HDAP and IAP. Part B will continue to fund and provide HDAP and IAP to all 95 counties in the state.

All 79 "Consortia" counties will be represented in the distribution of the Consortia funds, and all citizens with HIV disease will have the opportunity to benefit from The Ryan White Program (RWP) funded services. Since, in most instances, the regional Consortium will be similar to a task force and not a legal, incorporated entity, it will not be able to contract with the State of Tennessee for Ryan White dollars. Therefore, a Lead Agency will be selected that will serve as a conduit through which Ryan White funds will be disbursed into the individual communities represented by the four (4) Consortia. These agencies will be under direct contract with the State of Tennessee, and as such, will have responsibilities and obligations to HRSA.

Since 1994, the Health Resources and Services Administration (HRSA) and the Centers for Disease Control (CDC) have encouraged collaboration between HIV care and prevention community planning groups such as The RWP Consortia and Regional Advisory Councils (RACs) for HIV prevention. Care and prevention coordination is now a requirement of the application for funding by each respective federal agency. In keeping with this requirement, Lead Agencies will coordinate Ryan White Consortia meetings with Regional Advisory Committee meetings within their respective Consortia regions.

Listed below are a number of considerations for the Consortium to take into account when discussing with an organization about serving as a Lead Agency.

- The Lead Agency should have demonstrated experience with generally accepted accounting principles, as evidenced by audit reports, appropriate records and financial management-information systems.
- The Lead Agency should not be a recipient of Ryan White direct service funds through the regional Consortium. The Lead Agencies will assume the role of Administrative Agency for fee for service or multiple vendor client service plans (i.e. Dental Services Plan).

- The Lead Agency will sign a formal contract on behalf of the regional Consortium with the State of Tennessee and as such, will adhere to the regulations and requirements of that contract.
- The Lead Agency will sign formal subcontracts with service providers that are identified by the regional Consortium as being recipients of local Ryan White funds (after approval has been received from the State of Tennessee).
- The Lead Agency will be responsible for receiving invoices from subcontractors that have been awarded funds through the regional Consortium.
- The Lead Agency will be responsible for invoicing the State of Tennessee for services performed by the identified subcontractors.
- The Lead Agency will be responsible for reimbursing the subcontractors with funds received from the State.
- The Lead Agency will be responsible for submitting regular (quarterly/annually) programmatic and financial reports to the State, and as required, to the Consortium; including In Kind or match contribution(s).
- If applicable, the Lead Agency will be responsible for employing, supervising and providing office space for the Consortium staff.
- The Lead Agency will keep the State of Tennessee apprised of all regional Consortium meetings, membership lists, committee membership lists, minutes of meetings and other items of business (relating to Ryan White and care/prevention collaboration) within the regional Consortium. The State needs this information to fulfill its requirements under the law. Membership lists should contain name of member and contact information. Changes to ANY of the above need to be sent to the State within two (2) weeks of the change.
- The Lead Agency will be responsible for ensuring that all subcontractors are familiar with the CAREWare Data Collection, used to collect demographic and service related data on all clients receiving Ryan White funded services. An electronic submission of reports is required quarterly and annually by the State. Each agency is required to follow the schedule that has been provided from the State. Reporting is to be done by every agency funded through **Consortia and Minority AIDS Initiative Project funds**.
- The Lead Agency is responsible for maintaining all Consortium meeting files.
- The Lead Agency is responsible for organizing all Consortium mailings.

- The Lead Agency is responsible for monitoring all regional subcontractors and conducting monitoring visits no less than two times per year.
- The Lead Agency is responsible for negotiating with the State the manner and the amount of costs it will require to operate as a Lead Agency.
- The Lead Agency is responsible for submitting to the State, a formal Consortium budget based upon Ryan White funds allocated to the region. This budget should include funding categories (based upon prioritized needs defined within the analysis of the needs assessment) and amounts intended to be awarded within each category. This budget should also include categories and caps on funding as outlined in the Budget section later in this chapter.
- The Lead Agency will be responsible for ensuring that services to women, infants, children, youth and families provided by Ryan White funds fall within the ratio of women, infants, children and youth to the total HIV/AIDS population within the Consortium region. This will involve the collection of data for the State to use in determining that overall, 30% of the State award is used to provide services for this population.
- The Lead Agency will be responsible for reporting to the State any programmatic or funding irregularities that pertain to the operation of the regional Consortium under the Ryan White Program.

In addition to the responsibilities of the Lead Agency, the membership of the Consortium also have responsibilities that relate specifically to the distribution of funds; monitoring of services provided by the funded subcontractors; creation of standards under which services are provided and evaluations of funded programs. In essence, the Consortia are responsible for setting the standards of care from Ryan White funded services being made available in the communities.

The State recognizes the basic underlying principle within Ryan White is that Consortia will take the lead in directing funds for care within the community. It is also important to accept that, within mandates of both HRSA and Tennessee's contractual process, certain requirements must be held as standard operating procedures to ensure that all obligations are met. Therefore, the State has attempted to identify various responsibilities of Consortia and set parameters under which each Consortium must operate, without actually determining how each Consortium will conduct business. (NOTE: A copy of all formal policies and written plans outlined below must be provided to the State.)

- It is the responsibility of the Consortium to maintain a multi-variant, on-going needs assessment and to ensure that the results of that assessment are reported to the State on at least an annual basis.

- It is the responsibility of the Consortium to develop a formal system of tracking unmet needs within the community and to include these needs within the regional needs assessment.
- It is the responsibility of the Consortium to develop a written policy on how the regional needs assessment will be prioritized, and how the funding process relates to those priorities.
- It is the responsibility of the Consortium to develop a Conflict of Interest policy.
- It is the responsibility of the Consortium to develop a policy relating to confidentiality.
- It is the responsibility of the Consortium to develop standards for case management practice (medical and psychosocial) under which all Consortium-funded case managers will be evaluated. These standards must include the minimum standards developed by the Ryan White Services Program.
- It is the responsibility of the Consortium to communicate to each agency under subcontract for Ryan White funding the policies on verification of client HIV status and the definition of “family” as it relates to Ryan White funded programs.
- It is the responsibility of the Consortium to develop formal standards for all remaining services and/or positions funded through Consortium, under which evaluations will be based.
- It is the responsibility of the Consortium to develop a written plan that will outline and detail the coordination of all funded services within the region.
- It is the responsibility of the Consortium to develop a formal selection process for all potential subcontractors.
- It is the responsibility of the Consortium to develop a formal evaluation process for use with each subcontractor that will include procedures and methods to be used in the evaluation.
- It is the responsibility of the Consortium to develop a formal regional budget based upon the allocation of local Ryan White funds.
- It is the responsibility of the Consortium to develop a formal “subcontractor checklist” for all funded agencies that will include the following:

Proof of Incorporation; recent audit or financial statement; general liability insurance; personnel policies of the agency; a formal job description for all (Consortium) funded positions; a client grievance policy; demonstrated collaboration with other service providers; an internal quality and assurance program (and a copy of the funded program's goals and objectives for Ryan White funds); plans to evaluate the cost effectiveness of the funded program; data to indicate the percentage of women, infants, children, youth and families being served through the Ryan White funded component, and specific standards/units of service through which each funded program will be evaluated.

Upon reviewing the above guidelines, it becomes very evident that the responsibilities of both the Lead Agency and the Consortium are extensive. It is imperative that the Lead Agency and the regional Consortium clearly define their respective responsibilities and create a written agreement that specifically details exactly what is required and expected, and to provide the State a copy of that written agreement. The items listed above, especially as they relate to the State, are items that must be included in the overall roles of both the Lead Agency and the Consortium.

TENNESSEE DEPARTMENT OF HEALTH; RYAN WHITE PROGRAM
HIV CARE CONSORTIA NEEDS ASSESSMENT
(Revised 04/06/13)

The purpose of the Ryan White Part B Consortium is to decide how to use its Part B funding allocation to best meet the needs of people with HIV disease within their region, and to submit recommended agencies for funding to the Ryan White Program in Nashville. Members of the Consortium are obliged to develop a responsible, fair and equitable process for the distribution and monitoring of funds. The major activities of the Consortium provide the basis for making these funding decisions.

The needs assessment is one of a number of activities that Consortia must undertake in order to make the most responsible funding decisions based upon information from clients and providers within the represented region. It is one of approximately five (5) activities that will assist the Consortium in developing an informed, professional, and responsible plan. By design, the needs assessment actually sets the stage for the regional planning process by identifying needs in the community, services available to meet those needs, a gap analysis, and a review of all regional community services agencies that may be able to provide services eligible under the Ryan White CARE Act, Part B. (See TN Consortia Development Training Manual, 2010, updated April 2014).

In all instances, the needs assessment should include a variety of surveys, interviews and data analyses that target the actual needs of clients rather than a laundry list of needs from the various service providers that sit at the Consortium table. While knowing the needs of the service providers is important to the overall regional plan, it is imperative that the analysis of the needs assessment concentrate on the medical and social service needs of those living with HIV disease and their families in the community. In fact, some individuals involved in regional Consortia development even suggest that service providers should not complete a formal written survey. Since a comprehensive needs assessment must include formal written surveys, key informant interviews, focus groups and community forums, service provider information is best accessed through key informant interviews.

Once the information from all involved parties has been collected and analyzed, the Consortium must then prioritize the needs of the community and balance them against the dollars allocated for the region. Clearly, not all of the identified needs can or will be funded. The priorities, however, must center around those essential health and supportive services needed by clients and their families, and the staff and incidental items that enable selected providers to meet those needs. Funds from Ryan White Part B can not be used to advance an agency's operation to a "state of the art" facility, regardless of how much the agency may need these improvements. All funds must be centered on the client's needs and the items necessary to help agencies meet those needs. Additionally, there needs to be an identified plan regarding how the consortium is planning to work at reducing any identified gaps from the gap analysis.

A full Needs Assessment must be conducted (at a minimum) every three years. The Needs Assessment must be updated annually to address changes and special areas in order to support annual priority setting and resource allocation activities.



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
 HIV/STD/Viral Hepatitis Program
 Ryan White Part B Program
 Andrew Johnson Tower, 4th Floor
 710 James Robertson Parkway
 Nashville, Tennessee 37243

2016 Federal Poverty Guidelines

Following are the Federal Poverty Levels for all 48 Contiguous states and the District of Columbia. This excludes Hawaii and Alaska. These should replace any poverty guidelines formerly used.

MONTHLY

Family Size	100%	200%	300%	400%
1	\$990	\$1,980	\$2,970	\$3,960
2	\$1,335	\$2,670	\$4,005	\$5,340
3	\$1,680	\$3,360	\$5,040	\$6,720
4	\$2,025	\$4,050	\$6,075	\$8,100
5	\$2,370	\$4,740	\$7,110	\$9,480
6	\$2,715	\$5,430	\$8,145	\$10,860
7	\$3,061	\$6,122	\$9,183	\$12,243
8	\$3,408	\$6,815	\$10,223	\$13,630

For family units with more than 8 members, add \$347 for each additional family member.

ANNUAL

Family Size	100%	200%	300%	400%
1	\$11,880	\$23,760	\$35,640	\$47,520
2	\$16,020	\$32,040	\$48,060	\$64,080
3	\$20,160	\$40,320	\$60,480	\$80,640
4	\$24,300	\$48,600	\$72,900	\$97,200
5	\$28,440	\$56,880	\$85,320	\$113,760
6	\$32,580	\$65,160	\$97,740	\$130,320
7	\$36,730	\$73,460	\$110,190	\$146,920
8	\$40,890	\$81,780	\$122,670	\$163,560

For family units with more than 8 members, add \$4,160 for each additional family member.

**Lead Agency Report
 Ryan White Part B Allocations for Women, Infants, Children and Youth
 Ryan White Grant Year April 1, 2017 – March 31, 2018**

Consortium Region: _____

Contact Person: _____ Telephone # _____ Fax # _____

Total RW Program Administration, Quality Management and Planning Evaluation Costs _____

Total RW Award For Region _____

Part B Contractors serving WICY CBO's	Expenditures For Women		Expenditures For Infants		Expenditures For Children		Expenditures For Youth	
	Number Served	Amount Spent	Number Served	Amount Spent	Number Served	Amount Spent	Number Served	Amount Spent
a.								
b.								
c.								
d.								
e.								
f.								
Total								
Total Spent on WICY								
Percent of award WICY expenditures represent?								

Please return this form by **June 15, 2018** to: John Birkner Consortia Coordinator, Ryan White Services
Tennessee Department of Health, HIV/STD Program
710 James Robertson Parkway, 4th Floor
Nashville, TN 37243
Phone: (615) 253-4777

Sub-Contractor Report
Ryan White Part B Allocations for Women, Infants, Children and Youth
Ryan White Grant Year April 1, 2017– March 31, 2018

Sub Contractor	Expenditures For Women		Expenditures For Infants		Expenditures For Children		Expenditures For Youth	
	Number Served	Amount Spent	Number Served	Amount Spent	Number Served	Amount Spent	Number Served	Amount Spent
a.								
b.								
Total								
Total Spent on WICY								
Percent of award WICY expenditures represent?								

Please return this form to the Ryan White Lead Agency in your Region.
The deadline for submission to your lead agency is June 1, 2018. Thank you.

**Minority AIDS Initiative, Sub-Contractor Report
 Ryan White Part B Allocations for Women, Infants, Children and Youth
 Ryan White Grant Year April 1, 2017 – March 31, 2018**

Consortium Region: _____

Contact Person: _____ Telephone # _____ Fax # _____

Total MAI Dollars For _____

MAI Contractors serving WICY	Expenditures For Women		Expenditures For Infants		Expenditures For Children		Expenditures For Youth	
	Number Served	Amount Spent	Number Served	Amount Spent	Number Served	Amount Spent	Number Served	Amount Spent
a.								
b.								
Total								
Total Spent on WICY								
Percent of award WICY expenditures represent?								

Please return this form by **June 15, 2018** to:
John Birkner
 Consortia Coordinator, Ryan White Program
 Tennessee Department of Health, HIV/STD Program
 710 James Robertson Parkway, 4th Floor
 Nashville, TN 37243
 Phone: (615) 253-4777

Position Descriptions & job Responsibilities
Lead Agency Representative & Regional Consortia Coordinator

POSITION DESCRIPTION

Lead Agency Representative: Regionally administers the consortium process by providing management and oversight of the fiscal, contractual, and reporting processes and oversees compliance to policy.

Consortia Coordinator: Performs all duties as assigned by the Lead Agency to assure effective and efficient administration of the consortium process

JOB RESPONSIBILITIES

Lead Agency Representative:

- Oversees the preparation of consortium application packets 1 and 2 and submits to the State by the appropriate deadlines
- Prepares on behalf of the consortium, finalized subcontracts and, when applicable, appropriate amendments with providers and consultants
- Prepares and submits to the State all contract assurances and certifications as required by the State and HRSA for contractual services
- Oversees receipt and payment of subcontractual invoices
- Develops program and fiscal report formats for subcontractors
- Performs programmatic and fiscal quality assurance monitoring of funded subcontractors
- Prepares and submits quarterly and annual programmatic and financial reports to the State, and as required, to the consortium
- Ensures that subcontractors collect and submit Annual Administrative Report (AAR) data by the appropriate deadline
- Oversees the payment of regional Dental claims and assists in resolving problems
- Oversees the Outcomes Monitoring process
- Reports to the State, any programmatic or funding irregularities that pertain to the operation of the regional consortium
- Provides direct supervision of the regional Consortia Coordinator
- Serves as liaison between state administrative offices and Lead Agency administration

Consortia Coordinator:

- Administers the consortium process
- Serves on each consortium committee
- Assists in the development and preparation of the RFP instrument and evaluation tools
- Assists with all marketing and public relations needs of the consortium
- Serves as liaison between the State Consortium Coordinator and the Regional Consortium
- Assists with the development of other funding sources
- Assists the Lead Agency Representative with meeting all State required reporting deadlines
- Serves on the Tennessee HIV/AIDS Care and Services Alliance
- Works with local and regional collaborative to assure consortium is an intricate part of the collaboration
- Performs other duties as assigned to meet the objectives of the consortium
- Processes dental claims and maintains patient data base and files

**Ryan White Medical Case Managers
Functional Job Description**

*Based on Scope of Service in Agency grant Contracts
And State Employee Job Descriptions*

Ryan White Medical Case Managers are state employees or contract workers assigned a designated geographic area of the state. Medical Case Managers are responsible for the delivery of Ryan White Part A / B HIV/AIDS medical care services provided within the designated geographic area. The Case Manager is the ENTRY POINT into all Ryan White Programs for every patient in the designated geographical area who depends on Ryan White Services to reimburse the cost of their medical care. The duties include, but are not limited to:

1. Coordinate with community based organization's staff to link eligible HIV patients with individuals and organizations that can assist with social support needs such as, transportation, food services and housing.
 - Assist care managed clients in developing an appropriate Individual Service Plan aimed toward meeting their individual needs.
 - Conduct follow-up activities necessary to assist clients in implementation and modification of their Individual Service Plan
 - Obtain pertinent information from family members and/or significant others as it relates to client care.
 - Participate in case conferencing when indicated.
 - Maintain regular contact with clients to facilitate ongoing care management.
 - Ensure client confidentiality as defined by Ryan White Services, policy and procedures.
 - Maintain and update all client records and progress note all interactions.
 - Respond to all telephone and mail messages within 24 hours (to clients).
 - Attend regularly scheduled in-services, as well as outside conferences, workshops, etc. to become updated on the latest referrals and HIV related information necessary to respond to client needs.
 - Monitor referrals and follow-up on those requiring additional advocacy.
 - Provide written and statistical reports as requested.

ATTACHMENT E

2. Assist eligible patients and Grantee's staff in interfacing with TennCare MCO's and related agencies, to facilitate the delivery of health care services
 - Contact appropriate professionals to assist in the determination of need and/or eligibility for services.
 - Advocate for needed services on behalf of clients/
3. Assist eligible patients in accessing health related services which are not provided by the Grantee (including, but not limited to, nutritional counseling, dental care, and home health services).
 - Maintain assigned caseload and assess client health care and psychological needs and provide referral for housing, financial assistance, social support, etc.
 - Provide proof of client eligibility by utilizing Patient Eligibility Form.
 - Ensure that transportation is arranged for clients, when needed for essential services.
4. Encourage Service Providers to provide services for HIV positive patients and assist these providers in obtaining reimbursement for such services through the Ryan White Fee Schedule.
 - Become familiar with the Service Providers who are approved for and working with the Ryan White Medical Services Program.
 - Complete Ryan White Services Form #PH-3716 for each client referred for reimbursement through the Ryan White Fee Schedule, and submit it via FileZilla.
5. Assist eligible HIV positive patients in applying for the HIV Drug Assistance Program (HDAP).
 - Work with Ryan White Services HDAP Coordinator to begin verifying income and other eligibility criteria for the client.
 - Complete Form PH-3716 and submit it via FileZilla.
 - The Medical Case Manager will be the point of entry for each client to HDAP.
 - Ensure the patients are recertified for the program every six months.
6. Assist uninsured patients in applying for TennCare.
 - Offer advocacy to clients for applying for other federal and state programs by contacting TennCare staff and facilitating the application process.
 - Inform Ryan White Services of client eligibility for TennCare.

HOUSING ASSISTANCE

The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-term or Emergency Housing Needs

Ryan White Funds will not be used for Housing Services in the State of Tennessee.

All Housing / Rental assistance will be provided through the Housing Opportunities for People With AIDS (HOPWA) Program,

Consortia Program Policy

Case Management Standards

Tennessee Department of Health, Ryan White Services

I. Introduction

Tennessee Department of Health, Ryan White Services and AIDS Centers of Excellence have established the following standards for case management. These standards are to be considered minimum requirements and were developed after a careful review of existing standards from other states and other agencies within our state. Each Consortium operating within the Ryan White, Part B funded Consortia regions is expected to develop Consortium specific standards according to the standards listed within this document.

Case management is a process whereby a client receives a coordinated and systematic set of services. This set of standards divides this process into seven phases.

Seven Phases of Case Management

- I. Intake and Screening – Each client must participate in an initial intake and screening procedure.
- II. Assessment of Patient Needs – After each client is determined eligible for the program, needs must be assessed in a systematic manner in order to provide for the written plan of care.
- III. Development and Implementation of the Written Plan of Care – A written plan of care must be developed with the participation and agreement of the client or guardian.
- IV. Monitoring – The needs and status of a client receiving case management services will be monitored on a regular basis.
- V. Reassessment - Each client must be reassessed periodically or as the need arises.
- VI. Termination – Each client may be terminated from services as a result of monitoring, reassessment, or any other form of client ineligibility, including a client's failure to follow the written plan of care.
- VII. Documentation – Client records must be maintained in an orderly manner.

II. Intake and Screening

A. Standard

Each client must participate in an initial intake and screening procedure. The purpose for the intake and screening portions of the case management process is for client identification, eligibility determination, and screening. This stage will assist in obtaining client baseline data to be used in determining potential needs. This component is crucial in setting the foundation for providing a coordinated set of services.

B. Elements

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential clients, and reflects demographic information needed by the program.
3. The intake process indicates appropriate eligibility for the program Process include, but is not limited to:
 - Date of intake
 - Medical diagnosis
 - Appropriate financial information
 - Health status
 - Insurance information
 - Method of payment for services
 - Client or guardian signature of authorization
4. Reason for ineligibility for program must be indicated (if applicable).
5. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with Tennessee Department of Health HIV Confidentiality Policy.
6. Intake process is authorized by the client.
7. If determined eligible, a client file is created.
8. Complete PH Form 3716 and submit to the central office, via FileZilla.

III. Assessment of Patient Needs

A. Standard

After each client is determined eligible for the program, needs must be assessed in a systematic manner in order to provide appropriate information for the written plan of care. The purpose of this stage is to develop an understanding of what services the client may need. This stage builds on the information gathered during the initial intake, however, more detailed information is sought.

B. Elements

1. While the assessment of each client may require the selection from a variety of assessment tools, the assessment(s) should gather information from the many areas in which the client functions. These areas include, but are not limited to:
 - Psychosocial
 - Medical History/Physical Health
 - Mental Health
 - Functional Capabilities
 - Financial Resources
 - Services Needs
 - Religious
 - Educational
 - Social Functioning
2. Previous assessments (i.e. medical and nursing) must be used in the determination of client needs.
3. Results of the assessments are maintained in the client's file.

IV. Development and Implementation of a Written Plan of Care

A. Standard

A written plan of care must be developed with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. The written plan also serves as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

B. Elements

1. The written plan must be free of ambiguity with clearly defined priority areas and time frames.

2. Information included in the plan of care may include:
 - List of client service needs
 - Establishment of short and long term goals
 - Objectives and action steps to meet short term goals
 - Formal and informal resources to accomplish goals
 - Gaps in service
 - Alternatives to meet client goals
 - Criteria for determination of completion of goals
3. Services must not be routinely rendered without a written plan of care.
4. The plan must be implemented, monitored and facilitated by a case manager.
5. The plan must be implemented by a case manager.
6. If applicable, the reason client compliance was not or could not be obtained must be included in the written plan.

V. Monitoring

A. Standard

The needs and status of each client receiving case management services will be monitored on a regular basis. The purpose of this stage is to allow the client and case manager to observe the progress of the plan of care in order to make revisions. The intervals between monitoring may vary among clients, but must reflect necessity and consistency with the written plan. However, monitoring may vary among clients, but must reflect necessity and consistency with the written plan. However, monitoring is an ongoing process.

B. Elements

1. Methods used to obtain information may include:
 - Communication with client
 - Direct observation of the client
 - Contact with service provider
2. The types of information to be gathered may include:
 - Present status of client
 - Client satisfaction
 - Quality and appropriateness of services provided
3. The client must be instructed to notify case manager of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client reassessment.

VI. Reassessment

A. Standard

Each client must be reassessed periodically or as the need arises. The purpose of the reassessment is to address the issues noted during the monitoring phase. Reassessment will include, but is not limited to, the original assessment areas. The client and case manager must work together to reevaluate the course of the plan of care. Reassessment also allows for client readmission to programs, assignment to another level of service, and / or the termination of services.

B. Elements

1. Communication with client regarding services
2. Topics to be addressed in the reassessment may include:
 - Appointments, status and referrals
 - Special intervention activities

- Special Needs
3. Entries in the written plan of care
 4. Client acknowledgment of changes resulting from the reassessment.

VII. Education/Experience Requirements

Ryan White Services and the AIDS Centers of excellence Project have adopted the education and experience guidelines set forth for Social Work classifications by the Tennessee Civil Service System. These are minimum standards and each Consortium has the authority to adopt the minimum standards or develop more stringent standards.

Case Managers hired by AIDS Service Organizations who are funded in whole or in part to provide case management services through Ryan White Services, Ryan White Part B funds and/or provide services at an AIDS Center of Excellence must possess one of the following:

- A Bachelor level degree in Social Work or a Master level degree, and equivalent to one year of full-time professional case management in a public service agency.

OR

- A Bachelor level degree or a Master level degree in a health or human services related discipline with equivalent to two years of full-time professional case management in a public service agency.

All Ryan White Services funded case managers and case managers providing services through an AIDS Center of Excellence must have the supervision and guidance of a Master Level Social Worker (MSW). Supervision must occur at a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting. All requests for **exceptions to this policy must include: written justification for the need to change a policy, documentation of credentials of the individual, resume of the individual, and approval from the Tennessee Department of Health, HIV/AIDS/STD Section.**

- Proof of at least 30 college credit hours toward a bachelor level degree in Social Work, Human Services, Sociology, Behavioral Science, Social Welfare, Psychology or Humanistic/Social Anthropology;
- Proof of no less than two years of full-time employment as a professional case manager at an AIDS Service Organization;

- Proof of intent to pursue a Bachelor level degree (i.e. class schedule, letter from college advisor, etc.) in Social Work, Human Services, Sociology, Behavioral Science, Social Welfare, Psychology or Humanistic/Social Anthropology with a time line of not more than 5 years for completion of degree requirements; and
- A plan of supervision as specified above.

AIDS Service Organization applying for funding must provide documentation of the educational level of case managers to be funded in whole or in part by Ryan White Services prior to allocation of funding.

OUTCOMES MONITORING
GUIDANCE
AND
SAMPLE TOOLS
OUTCOME EVALUATION PLAN
2014

HIV Prevention Program
And
Ryan White (Part B) Program

I. BACKGROUND AND RATIONALE

The Government Performance and Results Act (GPRA) requires all Federal programs to document progress towards specific measurable objectives. Documentation of results is necessary to demonstrate program quality and effectiveness and to support HIV Prevention and Ryan White Program (RWP) funding appropriations and reauthorization under the RWP. In addition, the Center for Disease Control and Prevention (CDC) health department grantees who receive \$1 million or more from CDC for HIV prevention activities must collect and report outcome data for at least one CDC-funded intervention.

In Tennessee, the RWP funded programs developed regional outcome monitoring plans for implementation in the 2000 grant year. The HIV Prevention programs will begin with development of outcomes monitoring plans for the 2006 grant year. In an effort to coordinate HIV Prevention and RWP activities, this document focuses on the development and implementation of outcomes measures and outcomes monitoring tools for both program areas. This document provides sample outcome measures for both RWP and Prevention programming. Each Prevention CBO/Consortia may choose to utilize the tools provided or may develop and implement agency specific outcome measures.

In order to meet the federal requirements for both program areas, we will begin slowly and develop a strong base for futures outcome evaluations. **For the 2015 grant year, each HIV/AIDS funded Community Based Organization is required to collect and report outcome data for at least one CDC funded intervention and one HRSA funded services category.** Both Prevention and the RWP outcome monitoring is required if the Community Based Organization receives funding from the Tennessee Department of Health, HIV/STD Section in both program areas.

Grantees and planning bodies need outcomes monitoring data to support their work at the State and local levels. Both grantees and lead agencies need guidance on what data requirements to include in their Requests for Proposals (RFPs) for HIV/AIDS Prevention and Care Services and in provider contracts in order to document results. The Tennessee Community Planning Group (TCPG) needs outcomes data as input in their planning and priority setting. States and municipalities require documentation that programs are making a difference, whether supported solely through RWP or HIV Prevention resources or by a combination of Federal, State, and local funds, public and private. Providers need to be able to document program outcomes for the purpose of ensuring quality services for the HIV/AIDS population and to utilize data when seeking public and private funds.

II. DEFINITIONS

- 1) **Data elements** - the specific items of information that are collected and aggregated in order to make measurements using the indicators.
- 2) **Individual-level Outcomes** – results or benefits for an individual, including biological measures such as improved CD4 count or viral load or morbidity measures such as reduction in opportunistic conditions.
- 3) **Outcomes** – benefits or other results (positive or negative) for clients that may occur during or after program participation. Outcomes can be classified as ***initial, intermediate, and longer-term*** based on how soon they occur after program participation begins.
- 4) **Outcome Indicators/Measures** – are observable, measurable data sets – such as changes in CD4 counts or non-injury-related emergency room visits over time or documented increased condom use – that are used to track a program’s success in reaching desired outcomes.
- 5) **Outcome Monitoring** – refers to efforts to track the progress of clients or a program based upon outcome measures set forth in program goals.
- 6) **System-level Outcomes** – results for all individuals receiving services, such as reduced morbidity or mortality rates.
- 7) **Output-** measures of the direct products or volume of program operations.
- 8) **Targets** – measurable objectives stating the desired level of outcome achievement for a program.

III. OUTCOMES MONITORING PLAN

A copy of each agency's outcomes monitoring plan will be included with the contract and/or subcontract of the funded agency. In future years, the Outcomes Monitoring Plan will be a required component of the proposals in response to the Prevention or RWP Request for Proposals (RFP). If the agency receives funding for both Prevention and CARE, only one coordinated outcomes monitoring plan is required.

The plan must consist of the following components: 1) Narrative addressing questions listed below, 2) Outcome monitoring tools to be utilized, 3) Plan for follow-up resulting from outcome monitoring.

Narrative

In order to evaluate programming, HIV Prevention and RWP funded agencies must respond to the following questions when submitting their outcomes monitoring plan to the State office.

- 1) Describe how you will evaluate and measure each goal, objective and action step listed in your program plan.
- 2) How will your program affect the problems or needs identified in your Program Plan?
- 3) What short-range outcomes are expected from your program? For example, what immediate changes will the services you offer bring about in their lives of the individuals you serve? How will you measure these changes?
- 4) What long-term outcomes are expected from your program? What long-term benefits will the individuals you service experience as a result of your program? How will you measure these impacts?
- 5) How will you know if your program is successful? What are your plans for client follow-up to determine benefits to the individuals you serve?
- 6) Describe what you will do with the results of your evaluation. For previously funded grants, describe how your prior evaluations contributed to program/services improvement.

Outcome Monitoring Tools

Since RWP funded agencies were required to implement outcome monitoring plans in the 2000 grant year, this section of this document focuses on HIV prevention interventions. Suggested outcome measures for the RWP are available in Example A.

HIV Prevention outcome monitoring information should be collected from each participant in these interventions at least once prior to, and at least once following the intervention. The purpose of the outcome monitoring is to:

- Understand clients' progress toward behavioral goals and objectives,
- Understand differential progress within subgroups of clients,
- Understand if particular aspects of implementation contribute to or hinder clients' progress.

Generally, the types of client outcomes that need to be measured to assess the effects of individual or group health education or risk-reduction interventions are in the domains of knowledge, attitudes, beliefs and behaviors (KABB). Most interventions involve activities that encourage reduction of clients' HIV risk behaviors. The measurements must reflect the outcomes that are believed to result from the intervention. These typically are stated as the outcome objectives.

When an agency has determined the domains that need to be addressed in a measurement tool, they will need to identify how to best collect the pre- and post-test data. Assessment of the selected domains is often conducted through administration of a brief survey before and after the intervention. Surveys can be self-administered or administered to an individual or group by a staff member. *Please note that surveys are sometimes inappropriate for populations who have poor reading skills or who are uncomfortable completing questionnaires.*

A draft set of questions has been developed by CDC staff that can be used or modified for use by an interviewer for the client to self-administer. These questions were derived from the Core Items for HIV/STD Behavioral Surveillance being developed at CDC. Example B contains samples of onset of questions that deal with condom use and sexual risk behaviors and another set dealing with injection drug use and other drug-use risks associated with HIV transmission. In the left-hand column of each set are the questions designed to be used prior to the start of an intervention. The right-hand column contains the related question re-worded for use after the end of the intervention.

Each agency may develop their own method of outcome monitoring. The document is only intended to provide guidance. The survey data gathering is only one method of data collection, but seems the most cost effective as we work to develop a more elaborate system for outcome monitoring and evaluation.

IV. ANALYSIS OF OUTCOME MONITORING DATA

The primary purpose of analyzing outcomes monitoring data is for program staff and evaluators to answer the question: “Do clients make progress toward their goals and outcomes after receiving the intervention/service?” This involves a comparison of the mean (average) pre-intervention/services scores for everyone receiving the intervention/services to the mean post-intervention/service scores for that same group. This comparison allows one to determine if, overall, the intervention/service is reaching its goals.

A simple data analysis for monitoring generally involves the following steps:

- 1) Select clients who receive the intervention/service and complete the measurement instrument before and after the intervention/service.
- 2) Calculate the mean scores for pre-intervention/services and the mean scores for post-intervention/service.
- 3) Conduct a paired (matched t-test to determine if the post-intervention scores are significantly different (improved) after receiving the intervention. The paired t-test is a simple statistical test that uses two scores from the same individual, as when collecting pre- and post-intervention/service data in outcome monitoring.

If the data analysis shows that there are no significant differences between pre- and post-intervention/service scores, this is sufficient information to suggest that the program needs some changes to improve its effectiveness. There is no need to carry out a rigorous outcome evaluation to reconfirm the ineffectiveness.

There may be a concern when the analysis shows that the post-intervention/service mean score is significantly greater than the pre-intervention/services score. This is an encouraging finding especially when the intervention has a strong scientific basis and experience and context supports its continued use. However, one cannot confidently attribute the changes to the intervention without the use of a more rigorous design that controls for other possible sources of improvement.

Because of the complex issues of research design, data collection, and statistical analysis, the Statewide Evaluation Plan must have the contribution of individuals with evaluation expertise. However, the following section outlines how HIV/STD programming can begin to put policy in place to assist the contracted evaluation team.

V. DEVELOPMENT OF STATEWIDE STANDARDIZED OUTCOME MEASURES

The HIV/STD Section of the Tennessee Department of Health will facilitate the development of a Community Based Organization (CBO) Alliance. The membership of the CBO Alliance will consist of the Executive Directors of State funded and non-state funded HIV CBOs. One of the first tasks of the CBO Alliance will be to assess the outcome measures of currently being collected statewide and to utilize that information to develop a draft of statewide standardized outcome measures. The CBO Executive Directors will be able to determine what works in practice rather than theory as they represent the agency's that are responsible for implementation of the state HIV Prevention Plan and provide RWP funded services.

The draft statewide standardized outcomes measures document will be shared with the Tennessee Community Planning Group (TCPG), Tennessee HIV/AIDS Care ;and Services Alliance (THACSA), Regional Consortia, Regional Advisory Councils (RACs), Tennessee AIDS Council (TACT), RWP Lead Agents, Members of the All Titles group and the Tennessee Association of People with AIDS (TAPWA). A comment period will be scheduled. Following the comment period, the CBO Alliance will finalize the Statewide Standardized Outcome Measures.

The completed document will be provided to the contractor conducting statewide evaluation of HIV programming. The tools developed and data gathered by the CBO Alliance will become part of the overall evaluation plan.

VI. THE ROLE OF PREVENTION AND CARE PLANNING BODIES

The Department of Health, HIV/STD Section will ensure the following involvement of the TCPG and THACSA in the review and use of outcomes data:

- Ensure that TCPG and THACSA members understand legislative language and federal expectations regarding their roles in developing and implementing outcomes evaluation.
- Provide training to TCPG and THACSA members to understand and use client outcomes data in planning activities.
- Collaborate with TCPG and THACSA members in planning and implementing outcomes evaluation, consistent with their legislative roles and their ability to bring together service providers, consumers, and other “stakeholders” concerned with HIV/AIDS Services.
- Provide TCPG and THACSA members with core outcome evaluation data in consistent and clear formats each year in time for review and use in priority setting and other decision making.
- Ensure that TCPG and THACSA members use outcome data in planning and priority setting.

Note: This document contains information from “Evaluating CDC-Funded Health Department HIV Prevention Programs”, CDC Draft Document, 1999, “outcomes Evaluation Technical Assistance Guide”, HRSA, HIV/AIDS Bureau, 1999 and “Design of Health Indicator System: a How-To manual for State Medicaid Programs”, Evaluation Studies Work Group, Rhode Island DHS/Center for Health Care Strategies, 2000.

YOUR AGENCY NAME 2017 Work Plan		
Month	Activity	Deadline Dates
APRIL 2017		
MAY 2017		
JUNE 2017		
JULY 2017		
AUGUST 2017		
SEPTEMBER 2017		
OCTOBER 2017		
NOVEMBER 2017		
DECEMBER 2017		
JANUARY 2018		
FEBRUARY 2018		
MARCH 2018		

Implementation Plans / Quarterly Programmatic Reports

1. Implementation Plan & Quarterly Updates. This form enables the state to document planned activities and the progress made in reaching the goals and objectives for each funded program area; it is a Condition of the State's Grant Award. It is used to outline planned activities, then updated quarterly to report cumulative progress toward meeting those Goals & Objectives and reporting dollars spent. An **“Initial Implementation Plan”** is required with Packet II. It should list planned Goals and Objectives, service unit definitions, number of people to be served, number of service units, and dollar expenditures projected for the upcoming Grant Year. The **“Quarterly Implementation Plan / Programmatic Report”** is basically a quarterly update of the progress made toward the goals listed in the Initial Implementation Plan. NOTE: Brackets provide language applicable to the initial plan; all other language applies to both.
 - a. For each program area, include service goals and objectives, service unit definitions, number of people (to be) served, number of service units (to be) provided, time frame, and total funds (to be) expended.
 - b. For providers receiving MAI funding, be sure to specifically include outreach and linkage activities targeting racial and ethnic minority populations impacted by HIV Disease with emphasis on locating minorities that have dropped out of care and returning them into care. NOTE: MAI funds are not intended to be used for primary care or HIV-related support services.
2. Narrative Progress Report for FY 2017-2018 Part B Program. Provide a brief update on each of the areas below. Please identify specific activities by name and provide quantifiable information where possible. If no activity occurred put None.
 - a. *New services added:* Provide a description of specific RW funded services added in the new grant year.
 - b. *New access points created to Part B funded care/services:* Provide specific information on new points of entry into the HIV care system, in particular, the points of entry that allow increased access to Ryan White services.
 - c. *Contract monitoring activities:* Provide information on fiscal and program monitoring activities that took place during reporting period, (i.e. number of contractor site visits for fiscal monitoring purposes; corrective actions; improvements in monitoring process etc).
 - d. *Minority AIDS Initiative-* Describe how MAI funds are being used to increase minority access to HIV/AIDS care / treatment services and return to care, those who have fallen out of care. (If known) include a description of how these activities/services are linked to other Part B funded services, including HDAP and other core primary care and support services.

- e. *Accomplishments:* Provide any additional information on successes your program has achieved that are not covered above. Please enclose copies of reports and other documents that reflect and/or were a component of the accomplishment you have described.
3. Quality Improvement/Quality Management Activities-Provide information on the quality assurance/quality management activities (planned) undertaken during the report period. Describe current activities, outcomes and planned activities.
4. Minority AIDS Initiative (MAI) Funding- Part B MAI funds are intended to increase minority participation in the AIDS Drug Assistance Program (ADAP), primary care, and/or HIV-related support services. In your fourth quarter progress report, document the MAI-funded outreach and linkage activities undertaken during the Grant year to achieve that goal. In preparing your description, please address the following questions:
- a. What specific entities received MAI contracts during the fiscal year?
 - b. What specific service(s) and/or activity(s) were provided under each contract, and who were the target populations in each case?
 - c. If the grantee did not contract out their MAI funds, how were the funds used by the grantee?
 - d. With respect to each specific MAI-funded service/activity, how many clients were served during the year?
 - e. Overall, what was the result of MAI-funded services/activities? (For example, compare the number and demographics of ADAP clients in FY 2015 and FY 2017 who received MAI-funded activities/interventions).

This information is needed by the state to prepare the Final Progress Report to HRSA; it is due in May. Please provide this data in your 4th Quarter report.

Ryan White Part B Implementation Plan

Grantee: ___YOUR AGENCY NAME_____

Grant Year 2017

Page ___of___ Pages

Service Priority Name: Outpatient/Ambulatory Medical Services			Total Priority Allocation:		
Service Priority Number:					
Service Goal: Provide comprehensive, accessible and culturally competent HIV Outpatient/Ambulatory Care to PLWHA's in accordance with PHS guidelines in order to improve health outcomes.					
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit provided.	3. Quantity		4. Time Frame: Indicate the duration of activity relating to the objective listed.	5. Funds: Provide the amount of funds used to provide this service.
		3a) Number of people served.	3b) Total Number of service units provided.		
a: Provide high quality medical care to PLWHA in AIDS Centers of Excellence.	15 minute office visit			04/2017 – 03/2018	
Total number of unduplicated clients:					

Ryan White Part B Implementation Plan

Grantee: ___YOUR AGENCY NAME _____ Grant Year 2017__

Page ___of___ Pages

Service Priority Name: Medical Case Management		Total Priority Allocation:			
Service Priority Number:					
Service Goal: Provide Medical Case Management Services in order to facilitate and support PLWHA's access, maintenance and adherence to HIV medical care and access to other needed services in order to enhance their ability to effectively manage their HIV disease.					
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit provided.	3. Quantity		4. Time Frame: Indicate duration of activity relating to the objective listed.	5. Funds: Provide the amount of funds used to provide this service.
		3a) Number of people served.	3b) Total Number of service units provided.		
a: Provide Medical Case Management assessment, service planning, monitoring, follow-up activities and treatment adherence counseling based on identified need and acuity, provided by a nurse.	15 minutes			04/2017 – 03/2018	
b: Provide Medical Case Management assessment, service planning, monitoring, follow-up activities and treatment adherence counseling based on identified need and acuity, provided by a social worker or other related human services professional.	15 minutes			04/2017 – 03/2018	
c: As part of a medical team, provide assistance with service plan implementation, monitoring, follow-up activities and treatment adherence counseling based on identified need and acuity, provided by peer.	15 minute			04/2017 – 03/2018	
Total number of unduplicated clients:					

Ryan White Part B Implementation Plan

Grantee: ___YOUR AGENCY NAME _____ Grant Year 2017__

Page ___of___ Pages

Service Priority Name: Oral Health Care		Total Priority Allocation:			
Service Priority Number:					
Service Goal: Provide Oral Health Services in order to maintain or improve oral health and the overall health status of PLWHAs.					
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Funds:
List quantifiable time-limited objectives related to the service priorities listed above	Define the service unit provided.	3a) Number of people served.	3b) Total Number of service units provided.	Indicate the duration of activity relating to the objective listed.	Provide the amount of funds used to provide this service.
a: Provide diagnostic, preventive, restorative and prosthetic dental care services.	1 Oral Health Care Visit = 1 Unit			04/2017 – 03/2018	
Total number of unduplicated clients:					

Ryan White Part B Implementation Plan

Grantee: ___YOUR AGENCY NAME _____ Grant Year 2017__

Page ___of___ Pages

Service Priority Name: Mental Health Services		Total Priority Allocation:			
Service Priority Number:					
Service Goal: Provide Outpatient Mental Health Treatment Services based on national best practice models in order to enhance maintenance and adherence to HIV medical care and services.					
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Funds:
List quantifiable time-limited objectives related to the service priorities listed above	Define the service unit provided.	3a) Number of people served.	3b) Total Number of service units provided.	Indicate the duration of activity relating to the objective listed.	Provide the amount of funds used to provide this service.
a: Provide PLWHA comprehensive "Individual" outpatient Mental Health Services.	15 minutes			04/2017 – 03/2018	
b: Provide PLWHA comprehensive "Group" outpatient Mental Health Services.	15 minutes			04/2017 – 03/2018	
c: Provide PLWHA comprehensive diagnostic evaluation and treatment from a "Psychiatrist" or "Psychiatric Nurse"	15 minute			04/2017 – 03/2018	
d. Referrals for psychiatric assessment/treatment or inpatient mental health treatment.	1 Referral				
Total number of unduplicated clients:					

Ryan White Part B Implementation Plan

Grantee: ___YOUR AGENCY NAME___ Grant Year 2017

Page ___ of ___ Pages

Service Priority Name: Case Management (non-medical)			Total Priority Allocation:		
Service Priority Number:					
Service Goal: Provide Case Management Services in order to facilitate and support PLWHA's access, to HIV medical care and access to other needed services in order to enhance their ability to effectively manage their HIV disease.					
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit provided.	3. Quantity		4. Time Frame: Indicate the duration of activity relating to the objective listed.	5. Funds: Provide the amount of funds used to provide this service.
		3a) Number of people served.	3b) Total Number of service units provided.		
a: Provide Case Management assessment, service planning, monitoring and follow-up activities based on identified need.	15 minute increment (office visit, non face to face, etc.)			04/2017 – 03/2018	
Total number of unduplicated clients:					

Ryan White Part B Initial Implementation Plan

Grantee: YOUR AGENCY NAME

Fiscal Year 2017

Page ___ of ___ Pages

Service Priority Name: Medical Nutrition Therapy			Total Priority Allocation:		
Service Priority Number:					
Service Goal: Provide Medical Nutrition Therapy services to improve nutritional status of PLWHA and enhance medication adherence.					
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Funds:
List quantifiable time-limited objectives related to the service priorities listed above	Define the service unit provided.	3a) Number of people served.	3b) Total Number of service units provided.	Indicate the estimated duration of activity relating to the objective listed.	Provide the amount of funds used to provide this service.
a: Provide nutrition counseling and develop dietary care plans.	15 Minutes = 1 Unit.			04/2017 – 03/2018	
b: Provide nutritional supplements.	1 Case of Supplements = 1 Unit.			04/2017 – 03/2018	
Total number of unduplicated clients:					

Ryan White Part B Implementation Plan

Grantee: ___YOUR AGENCY NAME___ Fiscal Year 2017

Page ___ of ___ Pages

Service Priority Name: Food Bank/ Home-delivered Meals			Total Priority Allocation:		
Service Priority Number:					
Service Goal: Provide food in order to improve nutritional status of PLWHA and enhance medication adherence.					
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Funds:
List quantifiable time-limited objectives related to the service priorities listed above	Define the service unit provided.	3a) Number of people served.	3b) Total Number of service units provided.	Indicate the duration of activity relating to the objective listed.	Provide the amount of funds used to provide this service.
a: Provide Food Voucher / Card.	\$20 = 1 Unit.			04/2017 – 03/2018	
b: Provide Food Bag / Box.	\$20 = 1 Unit.			04/2017 – 03/2018	
c: Provide Home Delivered Meals.	\$20 = 1 Unit.			04/2017 – 03/2018	
Total number of unduplicated clients:					

Ryan White Part B Implementation Plan

Grantee: YOUR AGENCY NAME

Fiscal Year 2017

Page of Pages

Service Priority Name: Medical Transportation		Total Priority Allocation:			
Service Priority Number:					
Service Goal: Provide transportation services to PLWHA s in order to access HIV medical care and other services.					
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit provided.	3. Quantity		4. Time Frame: Indicate the duration of activity relating to the objective listed.	5. Funds: Provide the amount of funds used to provide this service.
		3a) Number of people served.	3b) Total Number of service units provided.		
a. Provide bus tokens/passes.	\$20 = 1 Unit			04/2017 – 03/2018	
b. Provide mileage reimbursement (i.e. gas card / voucher)	\$20 = 1 Unit			04/2017 – 03/2018	
c. Provide Taxi ride	\$20 = 1 Unit			04/2017 – 03/2018	
d. Provide agency based transportation. (i.e. van ride)	\$20 = 1 Unit			04/2017 – 03/2018	
Total number of unduplicated clients:					

Ryan White Part B Implementation Plan

Grantee: ___YOUR AGENCY NAME___ Fiscal Year 2017

Page ___ of ___ Pages

Service Priority Name: Psychosocial Support Services			Total Priority Allocation:		
Service Priority Number:					
Service Goal: Improve or maintain the emotional well-being of PLWHAs in order to enhance the activities of daily living and access to HIV medical care and services.					
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Funds:
List quantifiable time-limited objectives related to the service priorities listed above	Define the service unit provided.	3a) Number of people served.	3b) Total Number of service units provided.	Indicate the duration of activity relating to the objective listed.	Provide the amount of funds used to provide this service.
a: Provide Individual "PEER" Support to PLWHA.	15 minute increments			04/2017 – 03/2018	
a: Provide Group "PEER" Support to PLWHA.	15 minute increments			04/2017 – 03/2018	
Total number of unduplicated clients:					

Ryan White Part B Implementation Plan

Grantee: ___YOUR AGENCY NAME___ Fiscal Year 2017

Page ___ of ___ Pages

Service Priority Name: Emergency Financial Assistance		Total Priority Allocation:			
Service Priority Number:					
Service Goal: Meet the emergency financial needs of PLWHAs by providing utility and emergency formulary pharmaceutical assistance.					
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	2. Service Unit Definition: Define the service unit provided.	3. Quantity		4. Time Frame: Indicate the duration of activity relating to the objective listed.	5. Funds: Provide the amount of funds used to provide this service.
		3a) Number of people served.	3b) Total Number of service units provided.		
a: Provide emergency financial assistance for utilities not covered by other by other municipal, state or federal programs. (HOPWA etc.)	1 Utility Bill Paid = 1 Unit			04/2017 – 03/2018	
a: Provide emergency financial assistance for prescription drugs. (Formulary Only)	1 Prescription Paid = 1 Unit			04/2017 – 03/2018	
Total number of unduplicated clients:					

**GY 2017 – 2018 MINORITY AIDS INITIATIVES
Subcontractor Implementation Plan**

STATE: Tennessee

ADMINISTRATIVE AGENCY: Tennessee Department of Health

SUBCONTRACTOR:

PREPARED BY:

DATE:

Part B Program Area: Minority AIDS Initiatives			Service Name: Outreach		
Service Goal Statement: Locate minority individuals who have fallen out of care or have been newly diagnosed with HIV/AIDS and assist them in obtaining care and treatment services.					
Objective/s: Provider/s	Service Unit Definition	Quantity:		Time Frame:	GY 14 - 15 Funds
		# People	# Units		
1. Establish and maintain formal referral relationship with service providers.				04/2017 – 03/2018	
2. Locate/Identify HIV+ individuals who have fallen out of care and refer consenting individuals to care and treatment services.	15 minute increments			04/2017 – 03/2018	
3. Locate/Identify individuals who have been newly diagnosed with HIV/AIDS and refer consenting individuals to care and treatment services.	15 minute increments			04/2017 – 03/2018	
Total number served unduplicated:					
Client Demographics:					
Gender:	Male: 90%	Female: 8%		Transgender: 0%	
Race:	African American: 98%	Asian: 0%		Caucasian: 0%	
	Multiple Races:	Native American:		Pacific Islander:	
	Unknown/Undisclosed:				
Ethnicity:	Hispanic: 2%		Non-Hispanic:		
Age:	<2:	2 – 12:	13 – 24:	25 – 44:	
	45 – 64:	65+:	Undisclosed:		

**GY 2017 - 2018 MINORITY AIDS INITIATIVES
Subcontractor Implementation Plan**

STATE: Tennessee

ADMINISTRATIVE AGENCY: Tennessee Department of Health

SUBCONTRACTOR:

PREPARED BY:

DATE:

Part B Program Area: Minority AIDS Initiatives		Service Name: Health Education/Risk Reduction				
Service Goal Statement: Provide educational material and services to minority populations about the importance of HIV/AIDS treatment and availability of care and treatment services, including but not limited to, Ryan White Services.						
Objective/s: Provider/s	Service Unit Definition	Quantity:			Time Frame:	GY 14 -15 Funds
		# People	# Units – Presentations	# Units – Brochures		
1. Educate minority populations about the importance of knowing HIV status and HIV/AIDS treatment.	Presentations - 15 minute increments Brochures - # of materials distributed				04/2017 – 03/2018	
2. Educate minority populations about the availability of care and treatment services, including by not limited to, Ryan White services.	Presentations - 15 minute increments Brochures - # of materials distributed				04/2017 – 03/2018	
3. Refer individuals with unknown HIV status to testing sites.	# of referrals made				04/2017 – 03/2018	
Total number of unduplicated people						
Client Demographics:						
Gender:	Male:	Female:		Transgender:		
Race:	African American:	Asian:		Caucasian:		
	Multiple Races:	Native American:		Pacific Islander:		
	Unknown/Undisclosed:					
Ethnicity:	Hispanic:		Non-Hispanic:			
Age:	<2:	2 – 12:	13 – 24:		25- 44:	
	45 - 64:	65+:		Undisclosed:		



HIV/STD PROGRAM
RYAN WHITE PART B SERVICES
ANDREW JOHNSON TOWER, 4TH FLOOR
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

Ryan White Part B Services **Eligibility Policy**

Purpose

The purpose of this policy is to establish eligibility guidelines and procedures to be utilized when registering and recertifying clients for Tennessee Ryan White Part B assistance programs.

I. Requirements

A. To be deemed eligible for coverage by Ryan White Part B Services programs a recipient must meet the following criteria:

1. The recipient must have been diagnosed with HIV/AIDS.
2. The recipient must be a resident of Tennessee.
3. The recipient must meet the income guidelines established by the program: maximum gross monthly income for the legal household unit is less than 300% of current Federal Poverty Level*.

B. Eligibility is further based upon the applicant's willingness to work with his/her Medical Case Manager (MCM) to apply for all other possibilities of third party coverage (i.e., TennCare, group coverage through an employer, Veterans Administration (V.A.), etc.). Clients must keep MCM informed of a current address and phone number, if available. Persistent failure to cooperate in applying for alternate programs, keeping contact information current, or failure to take medications as prescribed for two consecutive months, is grounds for termination / suspension from all Ryan White Part B Services Programs.

C. Applicants who have Health Insurance (including TennCare) that provides HIV medications, may not receive pharmacy services from HDAP or medical services through the Medical Services Program, while eligible for those services under their policy. Premiums, co-pays and deductible payments may be made under the Insurance Assistance Program, for private health insurance clients and TennCare clients, for policies that have uninterrupted coverage.

Note: State regulations prohibit payment of premiums with government funds for AccessTN policies.

D. Record Keeping Requirements - A separate case file must be maintained on each client, containing the following:

1. PH- 3716, Ryan White Program Application

2. Documentation of HIV status, viral loads and CD4
3. Proof of current Tennessee residency
4. Proof of current income
5. Photo identification of client
6. Household Addendum Form, if applicable
7. PH-4266 Insurance Assistance Plan Application, if applicable
8. Oral Health/Dental Assistance Program Application, if applicable

Note: Proof of U.S. citizenship is NOT required for assistance through Ryan White Part B programs. In cases where an MCM is certifying an undocumented applicant for assistance with no photo identification, 2 forms of proof of residency is required. Also, the Medical Case Manager must call the AIDS Drug Assistance Program Coordinator and obtain an assigned coded number to serve in the place of a Social Security Number for tracking / billing purposes. Once a coded number has been assigned, it will be used for that client for all Ryan White Part B Services. Residency requirements in attachment 5 should also be met.

II. Application Procedure

- A. All clients must be evaluated for eligibility by a Medical Case Manager when the initial application is submitted to the Ryan White Part B Program.
- B. All clients must be recertified every 6 months (per HRSA policy).
- C. A recertification application must be sent to Tennessee Department of Health, Ryan White Part B Program via the Ryan White Eligibility System.
- D. Recertification should occur on, or close to, the client's original application date, and approximately six (6) months later.
- E. A list of clients due recertification will be appear in the Ryan White Eligibility System under Notifications.
- F. Recertification may occur forty-five (45) days prior to the due date up to forty-five (45) days after due date. The next recertification will be due in six (6) months.
- G. If a recertification form is not received within forty-five (45) days following the due date, the client will be disenrolled, and the pharmacy will be notified that the client is no longer on the program.

III. Appeal Process

If a client believes that the Medical Case Manager has made an error in determining that he/she does not meet eligibility criteria, he/she may appeal the decision. The client must submit a written appeal request to the Medical Case Manager's supervisor, explaining why he/she believes he/she meets the eligibility requirements listed in this policy. The eligibility requirements are not appealable, only the accuracy of the eligibility determination. The final level of appeal will be to the Ryan White Part B Services Director.

**PART B BUDGET NARRATIVE
JUSTIFICATION GUIDANCE**

A categorical budget must be submitted for each subcontract awarded with Ryan White Part B grant funds. The following categories must be defined in terms of dollars and be justified in a budget narrative. A budget narrative tells who, what, where, when and why to justify the amount budgeted. All budget line items as well as the total budget amount should be rounded to the nearest one hundred (100) dollars.

ALL CHARGES TO THE GRANT MUST BE IN ACCORDANCE WITH
APPLICABLE OFFICE OF MANAGEMENT AND BUDGET COST PRINCIPLES
(A-87, A-122, OR A-21).

1. Salaries: List all personnel whose salary is to be paid in whole or in part with Part B funds. For each position, provide the job title, employee last name, first name and a brief description of duties and responsibilities as they relate to the funded work, annual salary, percentage of time to be devoted to and paid for by this grant, and amount to be charged to the grant. If the position is vacant indicate such and estimate when the position is expected to be filled. Detail are required.

2. Benefits and Taxes: Provide the aggregate amount of fringe benefits. It is not necessary to provide the calculations for arriving at the amount of fringe benefits for each position. Please provide percentage (%).

3. Professional Fee/Grant & Award: This category includes funds that are to be used to provide services for clients that are not provided directly by the grantee. Details are required.

4. Supplies: Provide a general description of the types of items classified as supplies. These include all supplies, materials, and minor equipment which are consumed by the procurer or which have a useful life expectancy of less than three years or which are of small value (less than \$5,000) and are subject to loss. Computer software should be included in this category. Also, list how much will be expensed per month, how many FTE's, and how many months the expense will occur. For example: Paper - \$50 per month x 2.00 FTEs x 12 months = \$1,200.00.

5. Telephone: This category includes all communication charges. List all communication costs, such as telephone, telegraph, and internet access. Also, list the item description, how much will be expensed per month, how many FTE's, and how many months the expense will occur. For example: Internet Access - \$50 per month x 2.00 FTE's x 12 months = \$1,200.00

6. Postage and Shipping: This category includes all postage, as well as certain freight and shipping charges. List all freight and shipping costs.
7. Equipment Rental and Maintenance: This category includes the cost of maintenance performed or repairs made by commercial firms, and the cost of equipment rentals such as copiers, fax machines, etc. List the item description, how much will be expensed per month, and how many months the expense will occur. For example: Copier Rental - \$50 per month x 12 months = \$600.00.
8. Printing, Duplication, and Publications: This category includes the cost of all printed materials, and duplication costs. List the item description, how much will be expensed per month, and how many months the expense will occur. For example: Brochures - \$50 per month x 12 months = \$600.00.
9. Travel: All travel must directly benefit the work supported by the grant. List all travel anticipated during the contract period. Be specific about who will travel, where, when and why the travel is necessary. All out-of-state travel must be HRSA sponsored and requires the prior approval of the State. All travel must be in adherence to The State of Tennessee's Comprehensive Travel Regulations Policy 8. Details are required.
10. Insurance: This category includes the cost of all insurance payments. List the item description, how much will be expensed per month, and how many months the expense will occur. For example: Liability Insurance - \$50 per month x 12 months = \$600.00.
11. Specific Assistance to Individuals: This category includes funds for the payment of dental bills, insurance premiums, and emergency financial assistance (medications and utility assistance). **Bus tokens for client transportation and food pantry items; etc. may be included in this category. Be specific in describing each item listed in terms of what it is, who will benefit, and why it is necessary.** Please note that you must have state approved caps for emergency financial assistance expenditures. Details are required.
12. Equipment: List specifically equipment that is being purchased. Explain who will use the equipment and why is it necessary to purchase the equipment. A purchase versus lease analysis should be done for large dollar items. Cost sharing must be applied when equipment will be used by other than Ryan White activities. This includes items with a unit cost of \$5,000 or more, but under \$25,000 with a minimum useful life expectancy of three years, which does not lose its identify when used for the purpose intended. Freight charges and installation costs associated with the purchase of equipment should be included as cost of equipment. Equipment items costing over \$25,000 require prior approval from the State and HRSA. Details are required.

13. Indirect Costs: Indirect costs are allowable only in accordance with applicable Cost Principles and cannot exceed 10% of the contract amount. When requesting indirect costs, an approved cost allocation plan is required to be submitted to the State. Lead Agent's are required to obtain an approved cost allocation plan from all sub-recipients who are requesting indirect costs. Lead Agents are also required to submit these approved plans (as well as their agency's approved plan to the State

***In-Kind Contributions:** In-kind contributions are for reporting the value of contributed non-cash resources applied to the program or project. For example, the value of food, clothing, personal hygiene supplies, diapers, etc., donated for distribution to a client should be listed as an in-kind contribution. This may also include donated professional services by physicians, counselors, nurses, or other voluntary time etc. for the support of the program or project. Buildings and equipment may also be included.

***Cash Contributions (Nongovernmental):** Funds that are from such sources as cash contributions from corporations, foundations, trusts, individuals, fund raisers, other not-for-profit organizations, and from affiliated organizations.

***Matching Funds:** The non-federal cash or in-kind contributions provided to supplement the Ryan White funds received for a project or program. Contributions claimed as match for other federal funds may not be used to meet the match requirement for Ryan White Part B.

Three budgets are NO LONGER required from all agencies. One overall budget that includes all costs with a detail page is all that is required. . Administrative Costs cannot exceed 10% of the total contract amount, inclusive of Indirect Costs.

GLOSSARY OF HIV-RELATED SERVICE CATEGORIES

NOTE: The following list of HIV-related service categories are defined by the HIV/AIDS Bureau. They are also used by Part A, C, and D. These definitions can be found in the annual Ryan White Program Services Report (RSR). This glossary has been updated for the FY 2016~~7~~ Application Guidance.

HEALTH CARE SERVICES

CORE SERVICES

Outpatient/ambulatory medical care includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. **Emergency room services are not outpatient settings.** Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).

Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **Note:** Early Intervention Services provided by Ryan White Part C and Part D programs should be reported under *Outpatient/ambulatory medical care*.

Local AIDS pharmaceutical assistance includes local pharmacy assistance programs implemented by Part A, B, and/or C grantees that provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds, Part B base award funds, and/or Part C grant funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding. (This service is not funded by Part B in Tennessee).

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

Early intervention services (Parts A and B) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures. **Note:** EIS provided by Ryan White Part C and Part D Programs should NOT be reported under this service category. Part C and Part D EIS should be included under *Outpatient/ambulatory medical care*. **(This service is not funded by Part B in Tennessee).**

Health Insurance Premium & Cost Sharing Assistance is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, copayments, and deductibles. **(This service is not funded by Part B in Tennessee).**

Home health care includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies (This service is not funded by Part B in Tennessee).

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

Hospice services include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients. (This service is not funded by Part B in Tennessee).

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

Medical nutrition therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

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

Substance abuse services - outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel. (This service is not funded by Part B in Tennessee).

SUPPORT SERVICES

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

Child care services are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training. **Note:** This does not include child care while a client is at work. **(This service is not funded by Part B in Tennessee).**

Pediatric developmental assessment and early intervention services are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or a child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category. **Note:** Only Part D programs are eligible to provide Pediatric developmental assessment and early intervention services. **(This service is not funded by Part B in Tennessee).**

Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. **Note:** Part A and Part B programs must allocate, track, and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02).

Beginning in 2010, Food, Rent and Transportation will not be funded under the service category of Emergency Financial Assistance (EFA). Food and Transportation will be funded under the categories of Food and Transportation.

Rent assistance will be accessed through HOPWA. The only services Part B will fund under the EFA category are Emergency Medications and Utility Assistance. In order to fund these services the following requirements must be met:

- Ryan White is payer of last resort.
- Standards must be established to define an emergency.
- Annual expenditure caps will be established and approved by the state.
- Coordination will be established between agencies to ensure the expenditure caps are not exceeded.
- Each service / instance requires a memorandum explaining why it is an emergency. Memorandum must be placed in the patients file.
- Utility assistance can be accessed only after HOPWA and other resources have been exhausted.
- Any medication purchased must be on the HDAP formulary.

Food bank/home-delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. This includes vouchers to purchase food.

Health education/risk reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Housing services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services. **This service will not be funded by Part B in Tennessee, Housing is provided through HOPWA.**

Legal services are the provision of services to individuals with respect to powers of attorney, do not- resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver. **(This service is not funded by Part B in Tennessee).**

Linguistics services include the provision of interpretation and translation services.

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

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

Permanency planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them. **(This service is not funded by Part B in Tennessee).**

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

ATTACHMENT M

Referral for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. **Note:** Referrals for health care/supportive services that were not part of ambulatory/outpatient or case management services this item. Referrals for health care/supportive services provided by outpatient/ambulatory medical care providers should be included under Item 33a, Outpatient/ambulatory medical care. Referrals for health care/supportive services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category, Item 33k Medical Case Management or Item 33m Case management (non-medical).

Rehabilitation services are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training. (This service is not funded by Part B in Tennessee).

Respite care is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS (This service is not funded by Part B in Tennessee)..

Substance abuse services - residential is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short term). **Note:** Part C programs are not eligible to provide Substance abuse services - residential. (This service is not funded by Part B in Tennessee).

Treatment adherence counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical settings. (This service is not funded by Part B in Tennessee).



HIV/STD PROGRAM
RYAN WHITE PART B SERVICES
ANDREW JOHNSON TOWER, 4TH FLOOR
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

DEFINITION OF FAMILY

Definition of Family (Ryan White Part B Services Program):

“A family consists of the client, the clients spouse (if legally married) , dependent children under 19 years of age or legally dependent because of disability living at the same address, Court ordered dependent child (ren) living separate, or a full-time student less than 24 years of age.”

The above listed definition of family is to be used in determining the eligibility of individuals to receive services approved for “family members” provided with Ryan White Treatment Modernization Act funds.

Definitions of Family (Per Federal Register):

A family is a group of two or more person related by birth, marriage, or adoption that live together; all such related persons are considered as members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the older couple’s nephew all lived in the same house or apartment, they all be considered members of a single family.

Revised 8/28/2015

**GRANT
BETWEEN THE
LEAD AGENCY
AND
PROVIDER**

This Grant, by and between “**The Lead Agency Name**” the contractor of record for the “**REGION**”, herein referred to as “Lead Agency”, and “**Provider Name**”, hereinafter referred to as “Grantee,” is for provision of “**List Service to be provided**”, as further defined in the Scope of Services.

The Grantee is “**PROVIDER NAME**”. The Grantee’s address is “**PROVIDER’S ADDRESS TO INCLUDE STREET, CITY, STATE and ZIP CODE**”. The Grantee’s place of incorporation or organization is Tennessee.

NOW, THEREFORE, In consideration of the mutual promises herein contained, the parties have agreed and do hereby enter into this grant according to the provisions set out herein:

A. SCOPE OF SERVICES

A.1. The Grantee shall provide all service and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Grant Contract.

A.2. Service Definitions

List the definitions of the services to be provided. Used the service definitions listed in Attachment M.

A.3. Service Goals

Item “a” is an example. Item B must be included verbatim.

a. This contract will provide support services such as Case Management, Food Bank Home Delivered Meals, and Psychosocial Support to clients living with HIV/AIDS. These services are needed to achieve medical outcomes that affect the HIV related clinical status of a person living with HIV/AIDS.

b. The federal authority for this program is The Ryan White HIV/AIDS Treatment Extension Act of 2009. It is funded with federal money and is administered at the federal level by the Health Resources and Services Administration. This program is administered at the state level by the State Department of Health, Communicable and Environmental Disease Services, HIV/STD Section.

A.4. Service Recipients – Enter the following.

People affected by HIV Disease and meet established eligibility requirements.

A.5. Service Description

- Service One - Allocated Amount (Sample \$4,000)
- Service Two - Allocated Amount (Sample \$40,500)
- Service Three – Allocated Amount (Sample \$9,900)
- Service Four – Allocated Amount (Sample \$6,900)

A.6. Service Reporting -The GRANTEE must keep accessible service records throughout the grant cycle in accordance with the administrative reports required by the Lead Agency.**Your Reporting Requirements may vary.**

- a. The GRANTEE is required to complete the following reports:
 - **Monthly Service Reporting Form** – due by the 15th day of the month for services rendered the previous month.
 - **Monthly Invoice** – due by the 10th day of each month for services rendered the previous month. Supporting documentation for all expenditures must accompany the invoice.
 - **Monthly Expenditure Report** – due by the 10th day of each month for services rendered the previous month. This form should reflect total client services reimbursed with Lead Agency, Inc. funds.
 - **Quarterly Implementation Plan and Narrative Report** – due by the 10th day of the month following the end of the quarter. It should summarize the activities of each funded subcontractor, including progress made towards achieving the program’s goals/objectives and outcomes. This review is to incorporate the State-issued Scope of Service, so that client demographics and actual objectives/activities are evaluated and reported. This report will also include an itemized expenditure report based on the monthly reports submitted.
 - **Ryan White Service Report (RSR)** – RSR is due on the 15th of February 2014. This is an annual report, based on the Calendar Year (1 January 2013 – 31 December 2014). This report shall be electronically submitted online to HRSA.
 - **Quarterly Provider Data Export Report** – to be submitted by the 15th day of the month following the end of each quarter. This form shall be electronically submitted directly to the Tennessee Department of Health, HIV/AIDS/STD Branch, Ryan White Services.
 - **Women, Infants, Children, and Youth Report (WICY)** – to be submitted by May 31st following the end of the funding cycle. This is an annual report of expenditure of funds for women, infants, children and youth with HIV disease.
 - **Final Expenditure Report** – to be submitted at the completion of the one-year grant period.
- b. Each GRANTEE will have quarterly monitoring visits by the staff of the Lead Agency and/or member(s) and/or their designee of the during the grant cycle. During this visit, a client chart audit may be conducted. All GRANTEES must make arrangements (including having clients sign information related forms) for all charts to be reviewed. Each GRANTEE is required to participate in a return site visit during the grant cycle, if the results of the first visit determine that a follow-up visit is necessary. All GRANTEES must make adequate arrangements to ensure staff availability to fully participate in this visit.

- c. All GRANTEES must have the following:
1. Proof of Incorporation as a legal entity
 2. Most recent financial audit
 3. Proof of general liability insurance
 4. Personnel policy manual
 5. Formal job description of all positions funded by this grant and copies of appropriate licensure or accreditation
 6. Client grievance policy
 7. Organization chart/list of board of directors
 8. Mission/vision statements
 9. Affirmative action statement
 10. By-laws

Any updated copies of the above information must be submitted to the Lead Agency during the site visit.

- d. Each GRANTEE is responsible for gathering and reporting client needs throughout the grant cycle. As a client contacts each agency with a specific request for assistance, the agency will report the following during the site visit:
1. Identify the request
 2. Was the need met within your agency?
 3. Was the need met through a referral to another agency?
 4. Was the need resolved?
- e. Each GRANTEE is required to collect primary documentation or verify the primary documentation of every client's HIV positive serostatus. Examples of acceptable proof of HIV serostatus include lab test results and clinical statements. Client files at each GRANTEE organization must include primary documentation or reference to the primary documentation that verifies HIV positive status. The verification must include the name of the person/organization verifying eligibility, date and nature and location of primary documentation.
- f. Each GRANTEE is must spend down to 1 – 1.5% of grant award. GRANTEES are responsible for monitoring and ensuring that awarded funds will be spent in a timely manner. Based on monthly financial invoicing, The Contracted Administrator will determine that sufficient progress is made in achieving Legislative expenditure requirements. Should the Contracted Administrator determine that progress towards expenditure indicate failure to comply with this requirement, the Contracted Administrator is authorized to modify contracted budget amounts. GRANREES are also subject to Contracted Administrator desk audits to ensure that funds are properly spent and documented.

A.7 Service Deliverables – Provide/list in detail the deliverables necessary for the vendor to successfully complete the grant/contract.

Example Language:

Deliverable	Contract Section*	Delivery Date	Due to Whom?*	Requested Format
MCM Agreement submitted as required	A.5 d.	On-going after project initiation	ADAP Director	MS Word
Participate in the State Quality Management Studies.	A.5 g.	On-going after project initiation	Quality Management Section	TBD at time of study
Provide one staff person to serve as a member of the State Quality Management Committee.	A.5 h.	On-going after project initiation	Quality Management Section	MS Word
Submit CAREWare Quarterly Export Data Files as required.	A.6 a.	15 th day of the month following the end of the quarter.	Consortia Coordinator	The current CAREWare Format. via Secure website.
Submit Initial Ryan White Implementation Plan.	A.6 b.	Upon signing Contract.	Consortia Coordinator	MS Word
Submit Quarterly Ryan White Implementation Plans.	A.6 b.	15 th day of the month following the end of the quarter.	Consortia Coordinator	MS Word
Submit the annual Ryan White Services Report.	A.6 c.	The 15 th day of February 2015	HRSA	Electronic via secure website
Submit the annual WICY Report	A.6 d.	75 days following the end of the Grant Year.	Consortia Coordinator.	MS Word
Submit Initial MAI Implementation Plan.	A.6 e.	Upon signing Contract.	MAI Coordinator	MS Word
Submit Quarterly MAI Implementation Plans.	A.6 e.	15 th day of the month following the end of the quarter.	MAI Coordinator	MS Word

**The deliverables should relate back to A.5 Service descriptions.*

**Keep the “Due to Whom” generic; if you want it to go to a specific person refer to the individual in the contract by his/her official title.*

B. GRANT CONTRACT TERM

B. 1. Grant Contract Term. This grant shall be effective for a period commencing on April 1, 2017, and ending on March 31, 2018. The Lead Agency shall have no obligation for services rendered by the Grantee, which are not performed within the specified period.

C. PAYMENT TERMS AND CONDITIONS

C. 1. Maximum Liability. In no event shall the maximum liability of the Lead Agency under this Grant exceed (**SAMPLE AMOUNT \$61,300**). The Grant Budget, attached and incorporated herein as a part of this Grant Contract as Attachment 1, shall constitute the maximum amount due the Grantee for services and all the Grantee's obligations hereunder. The Grant Budget line items include, but are not limited to, all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Grantee.

C. 2. Compensation Firm. The maximum liability of the Lead Agency is not subject to escalation for any reason unless amended. The Grant Budget amounts are firm for the duration of the Grant Contract and are not subject to escalation for any reason unless amended, except as provided in Section C. 5.

C. 3. Payment Methodology. The Grantee shall be compensated for actual, reasonable, and necessary costs based upon the Grant Budget, not to exceed the maximum liability established in Section C.1. Upon progress toward the completion of the work, as described in Section A of this Grant Contract, the Grantee shall submit invoices, in form and substance acceptable to the Lead Agency, with all of the necessary supporting documentation, prior to any reimbursement of allowable costs. Such invoices shall be submitted no more that monthly and indicate at a minimum the amount charged by budget line item for the period invoiced, the amount charged by line item to date, the total amount charged for the period invoiced, and the total amount charged under this Grant Contract to date. The LEAD AGENCY will not be responsible for payment of claims later than the 15 days required for the final program budget. **Any unexpended grant funds shall be returned to the LEAD AGENCY no more than 15 days following the end of the grant period.**

C.4. Travel Compensation. Reimbursement to the GRANTEE for travel, meals or lodging shall be subject to amounts and limitations specified in the "State Comprehensive Travel Regulations," as they are amended from time to time and subject to the Grant Budget.

C. 5. Budget Line Items. Expenditures, reimbursements, and payments under this Grant Contract shall adhere to the Grant Budget. The Grantee may request revisions of Grant Budget line items by letter, giving full details supporting such requests, provided that such revisions do not increase the total Grant Contract amount. Grant Budget line item revisions may not be made without prior, written approval of the Lead Agency and the State in which terms of the approved revisions are explicitly set forth. Any increase in the total Grant Contract amount shall require a contract amendment.

C. 6. Disbursement Reconciliation and Close Out. The Grantee shall submit a grant disbursement reconciliation report within thirty days (30) following the end of the Grant Contract. Said report shall be in form and substance acceptable to the Lead Agency and State. The Lead Agency will not be responsible for the payment of invoices that are submitted to the Lead Agency after the final grant disbursement reconciliation report.

The Grantee must close out its accounting records at the end of the grant period in such a way that reimbursable expenditures and revenue collections are NOT carried forward.

C. 7. Indirect Cost. Should the Grantee request reimbursement for indirect cost, the Grantee must submit to the Lead Agent and State a copy of the indirect cost rate approved by the cognizant

federal agency and the State. The Grantee will be reimbursed for indirect cost in accordance with the approved indirect cost rate to amounts and limitations specified in the attached Grant Budget. Once the Grantee makes an election and treats a given cost as direct or indirect, it must apply that treatment consistently and may not change during the grant period. Any changes in the approved indirect cost rate must have prior approval of the cognizant federal agency and the State. If the indirect cost rate is provisional during the term of this agreement, once the rate becomes final, the Grantee agrees to remit any overpayment of funds to the Lead Agency and State, and subject to the availability of funds the Lead Agency and State agrees to remit any underpayment to the Grantee.

C. 8. Payment of Invoice. The payment of the invoice by the Lead Agency shall not prejudice the Lead Agency's right to object to or question any invoice or matter in relation thereto. Such payment by the Lead Agency shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the costs invoiced therein.

- a. The Grantee shall submit invoices within forty-five (45) days after the end of the calendar month in which the subject costs were incurred or services were rendered by the Grantee. Invoices submitted more than forty-five (45) days after such date will NOT be paid. The State will not deem such Grantee costs to be allowable and reimbursable by the State unless, at the sole discretion of the State, the failure to submit a timely invoice is warranted. The Grantee shall submit a special, written request for reimbursement with any such untimely invoices. The request must detail the reason the invoice is untimely as well as the Grantee's plan for submitting future invoices as required, and it must be signed by a Grantee agent that would be authorized to sign this Grant contract.
- b. Complete Itemization of Reimbursement Requested for the Invoice Period, which shall detail, at a minimum, the following: 1. Reimbursement Amount Requested by Grant Budget Line-Item for the invoice period (including any travel expenditure reimbursement requested in accordance required by the above-referenced "State Comprehensive Travel Regulations")

C. 9. Unallowable Costs. The Grantee's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Lead Agency or State, on the basis of audits or monitoring conducted in accordance with the terms of this Grant Contract, not to constitute allowable costs.

C. 10. Deductions. The Lead Agency reserves the right to deduct from amounts which are or shall become due and payable to the Grantee under this or any Contract between the Grantee, the Lead Agency, and the State of Tennessee any amounts which are or shall become due and payable to the Lead Agency and the State of Tennessee by the Grantee.

D. STANDARD TERMS AND CONDITIONS

D. 1. Required Approvals. The Lead Agency is not bound by this Grant Contract until it is approved by the appropriate State of Tennessee officials in accordance with applicable Tennessee State laws and regulations.

D. 2. Modifications and Amendment. This Grant Contract may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations.

D. 3. Termination for Convenience. The Lead Agency may terminate this Grant Contract without cause for any reason. Said termination shall not be deemed a Breach of Contract by the Lead Agency or State. The Lead Agency shall give the Grantee at least thirty (30) days written notice before the effective termination date. The Grantee shall be entitled to compensation for authorized expenditures and satisfactory services completed as of the termination date, but in no event shall the Lead Agency or State be liable to the Grantee for the compensation for any service, which has not been rendered. The final decision as to the amount, for which the Lead Agency or State is liable, shall be determined by the Lead Agency or State. Should the Lead Agency or State exercise this provision, the Grantee shall not have any right to actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D. 4. Termination for Cause. If the Grantee fails to properly perform its obligations under this Grant Contract in a timely or proper manner, or if the Grantee violates any terms of this Grant Contract, the Lead Agency or State shall have the right to immediately terminate the Grant Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Grantee shall not be relieved of liability to the Lead Agency or State for damages sustained by virtue of any breach of this Grant Contract by the Grantee.

D.5. Subcontracting. The Grantee shall not assign this Grant Contract or enter into a subcontract for any of the services performed under this Grant Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, each shall contain, at a minimum, sections of this contract pertaining to "Conflicts of Interest," "Lobbying," "Nondiscrimination," "Public Accountability," "Public Notice," and "Records" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Grantee shall be the prime contractor and shall be responsible for all work performed.

D.6. Conflicts of Interest. The Grantee warrants that no part of the total Grant Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Grantee in connection with any work contemplated or performed relative to this Grant Contract.

The Grantee acknowledges, understands, and agrees that this Grant Contract shall be null and void if the Grantee is, or within the past six months has been, an employee of the State of Tennessee or if the Grantee is an entity in which a controlling interest is held by an individual who is, or within the past six months has been, an employee of the State of Tennessee.

D.7. Lobbying. The Grantee certifies, to the best of its knowledge and belief, that:

- a. No federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- b. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member

of Congress in connection with this contract, grant, loan, or cooperative agreement, the Grantee shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

- c. The Grantee shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into and is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, *U.S. Code*.

D.8. Nondiscrimination The Grantee hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Grant Contract or in the employment practices of the Grantee on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Grantee shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.9. Public Accountability. If the Grantee is subject to *Tennessee Code Annotated*, Title 8, Chapter 4, Part 4, or if this Grant Contract involves the provision of services to citizens by the Grantee on behalf of the State, the Grantee agrees to establish a system through which recipients of services may present grievances about the operation of the service program, and the Grantee shall display in a prominent place, located near the passageway through which the public enters in order to receive Grant supported services, a sign at least twelve inches (12") in height and eighteen inches (18") in width stating:

NOTICE: THIS AGENCY IS A RECIPIENT OF TAXPAYER FUNDING. IF YOU OBSERVE AN AGENCY DIRECTOR OR EMPLOYEE ENGAGING IN ANY ACTIVITY WHICH YOU CONSIDER TO BE ILLEGAL, IMPROPER, OR WASTEFUL, PLEASE CALL THE STATE COMPTROLLER'S TOLL-FREE HOTLINE: 1-800-232-5454

D.10. Public Notice. All notices, informational pamphlets, press releases, research reports, signs, and similar public notices prepared and released by the Grantee shall include the statement, "This project is funded under an agreement with the State of Tennessee." Any such notices by the Grantee shall be approved by the State.

D.11. Records. The Grantee (and any approved subcontractor) shall maintain documentation for all charges under this Contract. The books, records, and documents of the Grantee (and any approved subcontractor), insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the state agency, the Comptroller of the Treasury, or duly appointed representatives. The records of not-for-profit entities shall be maintained in accordance with the *Accounting and Financial Reporting for Not-for-Profit Recipients of Grant Funds in Tennessee*, published by the Tennessee Comptroller of the Treasury and found at <http://www.comptroller1.state.tn.us/ma/finreptmanual.asp>. The records for local governments shall be maintained in accordance with the *Internal Control and Compliance Manual for Tennessee Municipalities*, published by the Tennessee Comptroller of the Treasury and found at

<http://www.comptroller1.state.tn.us/ma/citymanual.asp> and in accordance with GFOA's publication, *Governmental Accounting, Auditing and Financial Reporting*.

D. 12. Licensure. The Grantee and its employees and/or all sub-grantees shall be licensed pursuant to all applicable Federal, State and local laws, ordinances, rules and regulations and shall upon request provide proof of all licenses.

D.13. Monitoring. The Grantee's activities conducted and records maintained pursuant to this Grant Contract shall be subject to monitoring and Evaluation by the State of Tennessee, the Comptroller of the Treasury, or their duly appointed representatives.

D. 14. Annual Report and Audit. The Grantee shall prepare and submit, within nine (9) months after the close of the reporting period, an annual report of its activities funded under this Grant to the Commissioner or head of Granting agency, The Tennessee Comptroller of the Treasury, and the Tennessee Commissioner of Finance and Administration. The annual report for any Grantee that receives five hundred thousand dollars (\$500,000.00) or more in aggregate federal funding for all its programs shall include audited financial statements. All books of account and financial records shall be subject to annual audit by the Tennessee Comptroller of the Treasury or the Comptroller's duly appointed representative. When an audit is required, the Grantee may, with the prior approval of the Comptroller, engage a licensed independent public accountant to perform the audit. The audit contract between the Grantee and the licensed independent public accountant shall be on a contract form prescribed by the Tennessee Comptroller of the Treasury. Any such audit shall be performed in accordance with generally accepted government auditing standards, the provisions of OMB Circular A-133 and the *Audit Manual for Governmental Units and Recipients of Grant Funds* published by the Tennessee Comptroller of the Treasury. The Grantee shall be responsible for reimbursement of the cost of the audit prepared by the Comptroller of the Treasury, and payment of fees for the audit prepared by the licensed independent public accountant. Payment of the audit fees of the licensed independent public accountant by the Grantee shall be subject to the provisions relating to such fees contained in the prescribed contract form noted above. Copies of such audits shall be provided to the State Granting Department, the Tennessee Comptroller of the Treasury, the Department of Finance and Administrators, and shall be made available to the public.

D. 15. Procurement. If other terms of this Grant Contract allow reimbursement for the costs of goods, materials, supplies, equipment and/or services, such procurement shall be made on a competitive basis, including the use of competitive bidding procedures, where practical. Further if such reimbursement is to be made with funds derived wholly or partially from federal sources the determination of cost shall be governed by and reimbursement shall be subject to the Grantee's compliance with applicable federal procurement requirements.

The Grantee shall obtain prior approval from the Lead Agency and State before purchasing any equipment under this Grant Contract.

D. 16. Strict Performance. Failure by any party to this Grant Contract to insist in any or more cases upon the strict performance of any of the terms, covenants conditions or provisions of this agreement shall not be construed as a waiver or relinquishment of any such term, covenant, conditions, or provision. No term or condition of this Grant Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D. 17. Independent Contractor. The parties hereto, in the performance of this Grant Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly

acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Grant Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The Grantee, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Grantee's employees, and to pay all applicable taxes incident to this Grant Contract.

D. 18. State of Tennessee Liability. The State shall have no liability except as specifically provided in this Grant Contract.

D. 19. Force Majeure. The obligations of the parties to this Grant Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including but not limited to, acts of God, riots, wars, strikes, epidemics or any other similar cause.

D. 20. State and Federal Compliance. The Grantee shall comply with all applicable state and federal laws and regulations in the performance of this Grant Contract.

D. 21. Governing Law. This Grant Contract shall be governed by and construed in accordance with the laws of Tennessee. The Grantee agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Grant Contract. The Grantee acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising there from, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Section 9-8-101 through 9-8-407.

D. 22. Completeness. This Grant Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Grant Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D. 23. Severability. If any terms and conditions of this Grant Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Grant Contract are declared severable.

D. 24. Headings. Section headings are for reference purposes only and shall not be construed as part of this Grant Contract.

E. SPECIAL TERMS AND CONDITIONS

E. 1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Grant Contract, these special terms and conditions shall control.

E. 2. Subject to Funds Availability. The Grant Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the Lead Agency and State reserve the right to terminate the Grant Contract upon written notice to the Grantee. Said termination shall not be deemed a breach of Contract by the Lead Agency and State. Upon receipt of the written notice, the Grantee shall cease all work associated with the Grant. Should such an event occur, the Grantee shall be entitled to compensation for all satisfactory and authorized services completed as of termination date. Upon termination, the Grantee shall have no right to recover from the Lead Agency and State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E. 3. Printing Authorization. The Grantee agrees that no publication coming within the jurisdiction of **Tennessee Code Annotated**, Section 12-7-101, *et seq.*, shall be printed unless a printing authorization number has been obtained and affixed as required by **Tennessee Code Annotated**, Section 12-7-103 (d).

E. 4. Equipment Acquisition. This Grant Contract does not involve the acquisition and disposition of equipment acquired with funds provided under this Grant Contract.

E. 5. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Grantee by the Lead Agency and State or acquired by the Grantee on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Grantee to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Grantee's obligations under this section do not apply to information in the public domain; entering the public domain but not from breach by the Grantee of this Grant; previously possessed by the Grantee without written obligations to the Lead Agency and State to protect it; acquired by the Grantee without written restrictions against disclosure from a third party which, to the Grantee's knowledge, is free to disclose the information; independently developed by the Grantee without disclosure. Nothing in this paragraph shall permit Grantee to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Grantee due to intentional or negligent actions or inactions of agents of the State or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant.

E. 6. Environmental Tobacco Smoke. Pursuant to the federal "Pro-Children Act of 1994" and the Tennessee "Children's Act for Clean Indoor Air of 1995," the Grantee shall prohibit smoking of tobacco products within any indoor premises in which services are provided to individuals under the age of eighteen (18) years. The Grantee shall post "no smoking" signs in appropriate, prominent sites within such premises. This prohibition shall be applicable during all hours, not just the hours in which children are present. Violators of the prohibition may be subject to civil

penalties and fines. This prohibition shall apply to and be made part of any subcontract related to this Grant Contract.

E. 7. Debarment and Suspension. The Grantee certifies, to the best of its knowledge and belief, that it and its principles:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal or State department or agency;
- b. have not within a three (3) year period proceeding this Grant been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or Local) transaction or grant under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State or Local) with commission of any of the offenses detailed in section b. of this certification; and
- d. have not within a three (3) year period preceding this Grant had one or more public transactions (Federal, State or Local) terminated for cause or default.

E. 8. HIPAA Compliance. The State and Grantee shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

- a. Grantee warrants that is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Grant Contract.
- b. Grantee warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Grant Contract so that both parties will be in compliance with HIPAA.
- c. The State and Grantee will sign any documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and the Grantee in compliance with HIPAA. This provision shall not apply if information received by the Lead Agency and State under this Grant Contract is NOT

“protected health information” as defined by HIPAA, or if HIPAA permits the Lead Agency and State to receive such information without entering into a business associate agreement or signing another such document.

IN WITNESS WHEREOF, the parties have by their duly authorized representative set their signatures.
LEAD AGENCY NAME

BY: _____

Name and title of individual from Lead Agency who can Sign/ Date
Obligate the agency to a contract.

PROVIDER'S NAME

BY: _____

Name and title of individual from Provider Agency who can Sign/ Date
Obligate the agency to a contract.



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HIV/STD SECTION, RYAN WHITE PART B PROGRAM
ANDREW JOHNSON TOWER, 4th FLOOR
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

RYAN WHITE PART B PROGRAM PAYMENT FOR SERVICES POLICY AND PROCEDURES



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HIV/STD SECTION, RYAN WHITE PART B PROGRAM
ANDREW JOHNSON TOWER, 4th FLOOR
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

RYAN WHITE PART B PROGRAM
PAYMENT FOR SERVICES PROGRAM POLICY

August 1, 2014
(Updated March 2, 2016)

Purpose

The purpose of this document is to establish policy and procedures for implementing and maintaining a payment for services system, based on a Sliding Fee Scale.

Authority

The Ryan White HIV/AIDS Treatment Extension Act of 2009, formerly known as, Title XXVI of the Public Health Service Act as Amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006. Prior to 2006, it was known as The Ryan White Comprehensive AIDS Resources Emergency Act of 1990. This was commonly referred to as the Ryan White CARE Act. All of the aforementioned legislation requires that all clients be asked to pay a fee for services based on a Sliding Fee Scale, which is based on the current established Federal Poverty Levels.

Requirements

All Part B funded agencies that provide direct services to Ryan White Part B clients, are required to immediately begin requesting payment from their clients at the time of service delivery. The amount of payment will be based on the client's income / poverty level and a Sliding Fee Scale (Attachment A). Inability to pay the fee will not affect current or future services. Ryan White Part B clients will NOT be denied services based on their inability to pay.

Procedures

Providers will verify each client's income / poverty level using the Ryan White Eligibility System (RWES) and request a payment at the time of service delivery. Payment will not be requested from clients at 100% of poverty and below. All clients at 101% of poverty and above will be asked to make a payment. The amount of payment will be based on the client's income / poverty level and a Sliding Fee Scale (Attachment A). Payment will only be requested / collected during office / pharmacy visits and will not be requested or collected during home visits or for the services of Food, Transportation and Emergency Financial Assistance.

a) Procedures for clients who can afford to make payment.

The provider will validate the client's income / poverty level using the RWES. The provider will then refer to the Sliding Fee Scale (Attachment A) to determine the amount of payment required and will explain why the payment is being requested (Attachment B). The provider will request and accept payment and complete a memorandum (Attachment C) that lists the date, service delivered, amount of payment, form of payment: cash, check, credit / debit card or other form of payment. The memorandum will serve as the client's receipt / proof of payment and will be signed by both, the client and provider. One copy will be placed in the client's file and one copy will be provided to the client. The payment will be passed to the agency's fiscal section for safekeeping and disposition.

b) Procedures for clients who cannot afford to make payment.

The provider will validate the client's income / poverty level using the RWES. The provider will then refer to the Sliding Fee Scale to determine the amount of payment required. The provider will request payment. If the client states they cannot afford to pay the payment for services, the provider will complete a memorandum that lists: the date, amount of payment requested, the service delivered and a statement by the client attesting to the fact they cannot pay the payment in full or partial, and that in doing so would cause additional hardship to the client. The memorandum will be signed by the client and provider and placed in the client's file. The provider will then proceed with delivering the required services to the client. The client's inability to make the payment will not affect the delivery of any services.

Frequently asked questions

A list of frequently asked questions and answers can be found in Attachment D.

Dispensation of Funds Collected

All funds collected will be the responsibility of the agency fiscal / accounting section for security and disposition. Agencies must develop, if not already established, internal controls and procedures to ensure that all funds collected are credited to the proper account code and are deposited in the agency's account to be used for the Ryan White Program. Funds will be reported on the monthly invoice as program income. Funds will also be reported on the quarterly expenditure report as program income. All program income must be spent first, before spending Ryan White funds.

Effective Date

This policy is effective October 1, 2014. The point of contact for this policy is John Birkner at (615) 741-7500, <John.Birkner@tn.gov>.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
 Ryan White Part B Program
 ANDREW JOHNSON TOWER, 4th FLOOR
 710 JAMES ROBERTSON PARKWAY
 NASHVILLE, TENNESSEE 37243

2016 Federal Poverty Guidelines

Following are the Federal Poverty Levels for all 48 Contiguous states and the District of Columbia. This excludes Hawaii and Alaska. These should replace any poverty guidelines formerly used.

MONTHLY

Family Size	100%	101-200%	201-300%	301-400%
1	\$0 - \$990	\$991-\$1,980	\$1,981-\$2,970	\$2,971-\$3960
2	\$0 - \$1,335	\$1,336-\$2,670	\$2,671-\$4,005	\$4,006-\$5,340
3	\$0 - \$1,680	\$1,681-\$3,360	\$3,361-\$5,040	\$5,041-\$6,720
4	\$0 - \$2,025	\$2,026-\$4050	\$4,051-\$6,075	\$6,076-\$8,100
5	\$0 - \$2,370	\$2,371-\$4,740	\$4,741-\$7,110	\$7,111-\$9,480
6	\$0 - \$2,715	\$2,716-\$5,430	\$5,431-\$8,145	\$8,146-\$10,860
7	\$0 - \$3,061	\$3,062-\$6,122	\$6,123-\$9,183	\$9,184-\$12,243
8	\$0 - \$3,408	\$3,409-\$6,815	\$6,816-\$10,223	\$10,224-\$13,630

For family units with more than 8 members, add \$347 for each additional family member.

2016 Federal Poverty Guidelines

Following are the Federal Poverty Levels for all 48 Contiguous states and the District of Columbia. This excludes Hawaii and Alaska. These should replace any poverty guidelines formerly used.

ANNUAL

Family Size	100%	101-200%	201-300%	301-400%
1	\$0 - \$11,880	\$11,881-\$23,760	\$23,761-\$35,640	\$35,641-\$47,520
2	\$0 - \$16,020	\$16,021-\$32,040	\$32,041-\$48,060	\$48,061-\$64,080
3	\$0 - \$20,160	\$20,161-\$40,320	\$40,321-\$60,480	\$60,481-\$80,640
4	\$0 - \$24,300	\$24,301-\$48,600	\$48,601-\$72,900	\$72,901-\$97,200
5	\$0 - \$28,440	\$28,441-\$56,880	\$56,881-\$85,320	\$85,321-\$113,760
6	\$0 - \$32,580	\$32,581-\$65,160	\$65,161-\$97,740	\$97,741-\$130,320
7	\$0 - \$36,730	\$36,731-\$73,460	\$73,461-\$110,190	\$110,191-\$146,920
8	\$0 - \$40,890	\$40,891-\$81,780	\$81,781-\$122,670	\$122,671-\$163,560

For family units with more than 8 members, add \$4,160 for each additional family member.

TENNESSEE RYAN WHITE PART B
SLIDING FEE SCHEDULE

LEVEL	FEDERAL POVERTY LEVEL (FPL)	Patient Payment	CAP ON CHARGES
1	Less than 100% FPL	\$0	\$0
2	101 to 200% FPL	\$2	5% of Total Annual Income (\$594 - \$4,089)
3	201 to 300% FPL	\$5	7% of Total Annual Income (\$1663.27 - \$8,586.90)
4	301 to 400% FPL	\$7	8% of Total Annual Income (\$2,851.28 - \$13,084.80)

Discussion Points

Purpose

The purpose of this document is to establish some discussion points to assist the provider during the client encounter when requesting a payment for service.

When the client is initially asked for a payment, the request will probably be a surprise and may lead to question the reason. Prior to requesting payment, the provider should explain to the client that there is a new requirement which requires them to make a small payment at the time of service delivery.

The provider should explain the reason behind the payment request, how the fee is determined and the consequences of non-payment.

- The Ryan White HIV/AIDS Treatment Extension Act of 2009 requires that all Ryan White Clients above 100% of the current poverty level pay a fee for services.
- The amount of the payment is based on a sliding fee scale and the current poverty levels.
- Services will not be denied based on ability to pay.

At this point the provider should show the client a copy of the Fee Scale and Poverty Guidelines and explain to the client exactly where his/her income places them on the fee scale and what the client is requested to pay. If the client is above 100% of the current poverty level, the provider should ask the client if he/she can afford to make the payment.

- If the client states that the payment can be made on that day, the provider will then receive the payment, complete the memorandum (Attachment C) and make a copy for the client, a copy for the provider's files and continue with the appointment.
- If the client states that they cannot make the payment, the provider will complete the memorandum (Attachment C) and make a copy for the client, a copy for the provider's files and continue with the appointment. At this point the provider should explain to the client that his/her inability to make the payment will have no effect on care /services. The provider will probably need to reassure the client that they will continue to receive the same level and types of services as long as he/she is an eligible Ryan White client.

Frequently Asked Questions

Q. *Why am I being asked for a payment for services?*

A. The Ryan White HIV/AIDS Treatment Extension Act of 2009 has language requiring payment for services based on a Sliding Fee Scale and the current Poverty Levels.

Q. *Is there a limit or cap on the payments?*

A. There is an annual cap that is based on a percentage of income. (See Attachment A)

Q. *I have no income, how much will I be required to pay?*

A. Payment for services only applies to clients above 100% of the current poverty guidelines.

Q. *Is the amount of the fee different for various services?*

A. No, the fee is based solely on income and the Sliding Fee Scale.

Q. *What happens if I cannot pay the requested fee?*

A. You will be asked to sign a memorandum (Attachment C) that states you cannot afford to make the payment. You will be given a copy and a copy will be placed in your file. You will then proceed with your scheduled appointment.

Q. *Will I be billed later if I cannot pay?*

A. No, you will not receive a bill in the mail for any Ryan White Part B Service.

Q. *If I cannot pay, will I still be able to receive Ryan White Part B Services in the future?*

A. Yes, your ability to pay or not pay will have no effect on future Ryan White Part B Services.



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
Ryan White Part B Program
Quality Management Program
ANDREW JOHNSON TOWER, 4th FLOOR
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NASHVILLE, TENNESSEE 37243

PART B STANDARDS OF CARE

MARCH 1, 2010
Revised July 7, 2011



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UNIVERSAL STANDARDS OF CARE

These standards are to be used as minimum requirements for all subcontractors of the Ryan White Part B. The Ryan White Part B Grantee and/or staff of the Fiscal Agent will review agency documentation to ensure that these standards are being met.

GENERAL

1. Every client is treated with respect, dignity and compassion.
2. Promote autonomy and informed participation in care
3. Subcontractors/providers demonstrate a willingness to provide services to all affected communities.
4. Subcontractors/providers demonstrate cultural sensitivity must have a plan for providing language translation services and assistance for clients who are visually or hearing impaired, when necessary. (☆1)
5. Coordinate services with collateral care providers to ensure efficient service delivery and optimal client services and avoid duplication of services, as appropriate. (☆2)
6. Involve the client's caregivers, as appropriate and with client consent, in supporting client's optimal well being.
7. Within existing resources, ensure that services are available and accessible to all individuals in need of and eligible for services.
8. Provider is licensed and accredited by appropriate local, state and/or federal agencies if applicable.
9. Offer services in a safe, timely, reliable, and cost-efficient manner

CONFIDENTIALITY

1. **Strict standards of confidentiality of records and information shall be maintained in accordance with applicable local, state and federal law.**
2. Subcontractor/provider has in place a policy addressing client confidentiality. Clients are informed of this policy and confirm their understanding of the policy. (☆3A)
3. Subcontractor/provider will have a system of safeguarding client information (written, verbal, electronic). (☆3B)
4. The provider shall have an "Authorization for "the Release of Confidential Information" form, signed by the client prior to the release of any information about the client, as required by state and federal laws including but not limited to the Health Insurance Portability and Accountability Act. (☆3C)

STAFF

1. Staff receives annual training and is knowledgeable regarding HIV/AIDS and the affected community.
2. Staff members will have a clear understanding of their job description and responsibilities.
3. The staff shall be appropriately certified or licensed as required by the state or local government for the provision of services.
4. There are written personnel and agency policies, including a formal complaint procedure for staff. (☆4A)
5. A job performance evaluation is conducted regularly for each Ryan White Part B funded position. (☆4B)

OPERATIONS/FACILITY

1. Subcontractor/provider demonstrates compliance with physical and programmatic accessibility requirements designated by the Americans with Disabilities Act (ADA).
2. Facility meets the applicable Occupational Safety and Health Administration (OSHA) requirements.
3. Service delivery hours will accommodate target populations.
4. The subcontractor/provider shall maintain a safe environment for provision of services. This shall

include adopting a written policy to refuse services to clients who:

- Threaten physical abuse to staff or other clients;
- Are being verbally or physically abusive of to staff or other clients;
- Engage in sexual harassment of staff or other clients; or
- Possess illegal substances or weapons while accessing services.

ELIGIBILITY

• Ryan White Eligibility

1. Providers must document that those clients receiving services are eligible for Ryan White: 1) have HIV/AIDS; 2) have a household income, which does not exceed 300% of the Federal Poverty Level and 3) are a resident of Tennessee (☆5A)
2. There must be documentation that clients have been properly screened for other service resources as appropriate **to verify that Ryan White is payer of last resort.**
3. Documentation of Ryan White eligibility updated every six (6) months. (☆5B)
4. When presenting for services, client will be informed of the eligibility requirements for services, either in writing or verbally, in a manner that he or she is able to understand. (☆5C)
5. Services are made available to any individual who meets program eligibility requirements subject to the availability of funding and if the client abides by the rules of behavior established by each subcontractor/provider.

NOTE: In instances where the person served is a person affected by HIV, such as caregivers, partners, family and friends, verification of HIV status of the infected person is required when available.

• Service Specific Eligibility

1. **Service providers/agencies must have written eligibility policy/standards, consistent with the eligibility requirements of the funding source(s) in the service area, that define who is eligible for the service and must follow those policies/standards.**
2. If applicable, reason for ineligibility for program must be documented in the client's record. If applicable, eligibility for each specific service is included in standards of care for that service.

REFERRAL

1. Demonstrate a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of HIV-related services to facilitate referral.
2. A current list of provider agencies that provide services by referral is maintained and updated. . (☆6A)
3. Subcontractors/providers make appropriate referrals to collateral services when clients have additional service needs beyond the scope of Part B services.
4. Provision of all Ryan White Part B funded services and referrals are documented. (☆6B)

CLIENT EDUCATION

1. **The subcontractor/provider shall have an agency plan for each funded service for conducting client education, including education on HIV/AIDS, HIV transmission and role and importance of HIV medical care (including assessment of whether the person has seen their HIV medical doctor at least two times within the last year), medications (including assessment of medication adherence) and oral health. (☆7)**

CLIENT RIGHTS

1. The subcontractor/provider shall inform all clients of their rights, obligations, and realistic

expectations of service. (★8A)

2. No client shall be discriminated against with regard to race, color, religion, age, gender, gender identity, marital status, political affiliation, national origin, sexual orientation, or disability.
3. The subcontractor/provider shall have a formal complaint procedure. Clients are informed of this policy and confirm their understanding of the policy. (★8B)
4. The subcontractor/provider has written policy and procedures to ensure that any incidents of abuse, neglect, or exploitation of clients by a subcontractor/provider are reported to the proper authorities. (★8C)

CLIENT SURVEY

1. A client survey must be conducted on a **yearly** basis, including a measure of satisfaction. (★9)
2. Subcontractors/providers must encourage input from consumers (and, as appropriate, caregivers) in service design and delivery through a mechanism chosen by the agency.
3. There must be evidence that the results of customer surveys have been incorporated into the subcontractor's/provider's plans and objectives.
4. The subcontractor/agency will have a procedure for internal review and evaluation Continuous Quality Improvement.

QUALITY MANAGEMENT

1. Grantees must develop a quality management/improvement plan in accordance with Part B Grantee requirements, including a procedure for internal review and evaluation. (★10)

Universal

Standard 1	Measure
Subcontractors/providers must have a plan for providing language translation services and assistance for clients who are visually or hearing impaired, when necessary	Client's file includes: <ul style="list-style-type: none"> • Documentation for service need
Standard 2	Measure
Coordinate services with collateral care providers to ensure efficient service delivery and optimal client services and avoid duplication of services, as appropriate.	Discussion with provider on how they coordinate with collateral providers and identification of key partners.
Standard 3	Measure
A. Subcontractor/provider has in place a policy addressing client confidentiality. Clients are informed of this policy and confirm their understanding of the policy.	Agency documentation of policy; and Client's file includes: <ul style="list-style-type: none"> • Documentation of client notification
B. Subcontractor/provider will have a system of safeguarding client information (written, verbal, electronic).	Discussion with provider on how they assure confidentiality & see actual demonstration for: <ul style="list-style-type: none"> • Hard copy records in files • Computer storage of information • Employee working space in relation to public areas
C. The provider shall have an "Authorization for "the Release of Confidential Information" form, signed by the client prior to the release of any information about the client, as required by state and federal laws including but not limited to the Health Insurance Portability and Accountability Act.	Review release of information form to assure compliance with HIPAA
Standard 4	Measure
A. There are written personnel and agency policies, including a formal complaint procedure for staff. (☆4A)	Documentation of agency policy
B. A job performance evaluation is conducted regularly for each Ryan White Part B funded position.	Employee's file includes: <ul style="list-style-type: none"> • Documentation of performance evaluation according to agency policy
Standard 5	Measure
A. Providers must document that those clients receiving services are <u>eligible for Ryan White</u> : 1) have HIV/AIDS; 2) have a household income, which does not exceed 300% of the Federal Poverty Level and 3) are a resident of the Tennessee	Client's file includes: <ul style="list-style-type: none"> • Documentation of client eligibility
B. Documentation of Ryan White eligibility updated every six (6) months.	Client's file includes: <ul style="list-style-type: none"> • Documentation of 6 month eligibility update
C. When presenting for services, client will be informed of the eligibility requirements for services, either in writing or verbally, in a manner that he or she is able to understand.	Client's file includes: <ul style="list-style-type: none"> • Documentation that client informed
Standard 6	Measure
A. A current list of provider agencies that provide services by referral is maintained and updated.	List of agencies
B. Provision of all Ryan White Part B funded services and referrals are documented.	Client's file includes: <ul style="list-style-type: none"> • Documentation of referral

Universal

Standard 7	Measure
The subcontractor/provider shall have an agency plan for each funded service for conducting client education, including education on HIV/AIDS, HIV transmission and role and importance of HIV medical care (including assessment of whether the person has seen their HIV medical doctor at least two times within the last year), medications (including assessment of medication adherence) and oral health.	Documentation of plan & discussion of current status
Standard 8	Measure
A. The subcontractor/provider shall inform all clients of their rights, obligations, and realistic expectations of service.	Client's file includes: <ul style="list-style-type: none"> • Documentation of informing clients of rights
B. The subcontractor/provider shall have a formal complaint procedure. Clients are informed of this policy and confirm their understanding of the policy.	Agency documentation of procedure; and Client's file includes: <ul style="list-style-type: none"> • Documentation of client notification
C. The subcontractor/provider has written policy and procedures to ensure that any incidents of abuse, neglect, or exploitation of clients by a subcontractor/provider are reported to the proper authorities	Documentation of agency policy
Standard 9	Measure
A client survey must be conducted on a yearly basis, including a measure of satisfaction.	Documentation of yearly client survey and results
Standard 10	Measure
Grantees must develop a quality management/improvement plan in accordance with Part B Grantee requirements, including a procedure for internal review and evaluation.	Documentation of QM/QI plan & Grantee approval

HIV DRUG ASSISTANCE PROGRAM (HDAP)

Ryan White Services

Eligibility Policy

February 27, 2007

Supersedes policy dated February 14, 2007

Purpose

The purpose of this policy is to establish eligibility guidelines and procedures to be utilized when registering and recertifying clients for Ryan White Part B e.g., the HIV Drug Assistance Program (HDAP), Medical Services Program and Insurance Assistance Plans.

I. Requirements

To be deemed eligible for coverage by state Ryan White Services Programs a recipient must meet the following criteria:

1. The recipient must have been diagnosed with HIV/AIDS as determined by:
 - A positive HIV sero-status confirmed by a Western Blot assay
 - Laboratory results showing a detectable Viral Load
 - A letter, office note or discharge summary signed by a licensed physician documenting HIV or AIDS as a diagnosis may be used temporarily until one of the first two described lab results can be obtained.
2. The recipient must be a resident of **Tennessee** evidenced by one of the following:
 - Valid Drivers License or State Identification Card
 - Mortgage or Rental Lease in recipient's name
 - Local utility bills in recipients name
 - Letter of identification and verification of residency from a verifiable homeless shelter or community center serving homeless individuals
 - Mail postmarked within the last 30 days and delivered to recipient's street address. (HDAP medications may be sent to a Post Office Box in the **Tennessee**. However, a P.O. Box alone is not acceptable as proof of residency, when applying for Ryan White Part B Services. If a physical location is not available, one of the other methods listed above proving residency must be met. Rural box numbers are acceptable, because they denote a physical location.)
3. The recipient must meet the income guidelines established by the Program: Maximum gross monthly income for the legal household unit is less than or equal to 300% of current Federal Poverty Level* as evidenced by one of the following:
 - Recent paycheck stub
 - Copy of most recent Federal Income Tax Return (1040) using line #22 (Gross Income **), unless self-employed.
 - Self-employed client's income will be determined by taking their total income (line 22 on form 1040) and subtracting, one-half of self-employment tax (line 27), Self-employed SEP, SIMPLE, and qualified plans (line 28), and Self-employed health insurance deduction (line 29) (if applicable). Note: A client may not count IAP payment of premiums, co-pays and deductibles as a deduction on his/her federal income tax return and use it to reduce total income to qualify for the Ryan White Services programs.
 - Letter from and signed by Employer, providing income information, i.e., defining pay period, salary per pay period, rate of hourly pay, number of hours normally worked per pay period, etc.

- For fixed income applicants, a letter or benefits statement from originating source, showing the amount of benefits and frequency received (Social Security, Private Disability, Retirement, Unemployment, etc.).
- Letter from the Department of Human Services (DHS), showing calculated income and/or resources.
- Statement of Direct Deposit as long as the gross income is reflected.

* Dependent children residing outside the client's home may be counted, if the client can produce evidence of court ordered child support.

** Garnishments may also be deducted from Gross Income.

4. Household resource values less than or equal to \$8,000, as reported by the client. (Resources include cash on hand, money in checking and/or savings accounts, or resources that can be quickly converted into cash, such as stocks, bonds, or certificates of deposit.)
5. Eligibility is further based upon the applicant's willingness to work with his/her State / Designee (MCMs) to apply for all other possibilities of third party coverage (i.e. TennCare, group coverage thru an employer, V.A. etc.). Clients must keep MCM informed of a current address and phone number, if available. Persistent failure to cooperate in applying for alternate programs, keeping contact information current, or failure to take medications as prescribed for two consecutive months, is grounds for termination / suspension from all Ryan White Services Programs.
6. Applicants who have Health Insurance (including TennCare) that provides HIV medications, may not receive medical or pharmacy services from ADAP or Medical Services Program. However, co-pay and deductible payments may be made under the Insurance Assistance Plans.

II. Application Procedure

- All clients must be evaluated for eligibility by a State (or designee) when the initial application is submitted.
- All Clients must be recertified semi-annually (per HRSA policy). (★1)
- Recertification should occur on, or close to, the client's original application date, and approximately six (6) months later.
- Recertification forms must be sent to Tennessee Department of Health, HIV/AIDS Drug Assistance Program Coordinator.
- A list of clients due recertification will be sent to all Medical Care Managers each quarter.
- Recertification may occur 45 days prior to the due date, to 45 days after due date. The next recertification will be due in six (6) months.
- If a recertification form is not received within 60 days of the due date, the client will be disenrolled, and the pharmacy will be notified that the client is no longer in the program.

III. Appeal Process

1. If a client believes his /her State has made an error in determining eligibility, they may appeal the decision. The client must submit a written appeal request to his/her State's supervisor explaining why they believe they meet eligibility requirements listed in this policy. The eligibility requirements are not subject to appeal, only the accuracy of the eligibility determination. The final level of appeal will be to the state Ryan White Services Director

Note: Prof of US citizenship is NOT required for assistance through Ryan White Part B program. In cases where a MCM / Designee is certifying an undocumented alien for assistance, he/she should call the Medical Services Program Coordinator and obtain an assigned coded number to serve in the place of a Social Security Number for

tracking / billing purposes. Once a coded number has been assigned, it will be used for that client for all Ryan White Services programs.

MISCELLANEOUS

- 1. HDAP applications must be processed (approved or denied for enrollment) within 2 business days. (☆2)**
- 2. A list of the HDAP formulary must be kept current and provided to the Part A TGAs. The list must include classes of each medication. (☆3)**

UNITS OF SERVICE FOR REPORTING:

Units are reported by line item for client name including zip code, county and for each drug provided National Drug Code, quantity total cost and dispensing fee. (☆4)

HDAP

Standard 1	Measure
All Clients must be recertified semi-annually (per HRSA policy).	Review of TDOH enrollment data base documenting recertification
Standard 2	Measure
ADAP applications must be processed (approved or denied for enrollment) within 2 business days.	Review of TDOH enrollment data base documenting process date
Standard 3	Measure
A list of the ADAP formulary must be kept current and provided to the Part B Grantee. The list must include classes of each medication.	Documentation that formulary sent to Part B Director at beginning of grant year and when formulary changed.
Standard 4	Measure
Units are reported by line item for client name including zip code, county and for each drug provided National Drug Code, quantity total cost and dispensing fee.	Review of billing documentation and match to monthly invoice

EMERGENCY FINANCIAL ASSISTANCE

A. DEFINITION:

This service includes the provision of short-term emergency financial assistance to clients with HIV/AIDS for utilities (gas, electricity, water and sewer). Total amount of assistance for any one client will be based on need, financial status, and eligibility for other public benefits programs, and is paid directly to vendors based on need and actual bill. The client's name must be on the bill and/or account. Under no circumstances shall payment be made directly to recipients of this service. (☆1A-B)

B. PURPOSE:

The provision of short-term emergency financial assistance is defined as necessary for the client to: a) gain or maintain access to medical care, adherence to medical care/treatments and/or health and wellness and B) Address financial need that arises from high and/or unexpected medical costs.

C. ELIGIBILITY:

1. Total amount of assistance for any one client will be based on need, financial status, and eligibility for other public benefit programs and is limited to 21 weeks of support per year, or a dollar amount cap set by the agency/program. (☆3)

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process includes but is not limited to:
 - a. Appropriate eligibility for the service
 - b. Date of intake
 - c. Ryan White Face Sheets demographic and statistical information
 - d. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - e. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
7. A record of the intake process must be kept and if determined eligible, a client file is created.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes re-assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

I. ELEMENTS

1. The assessment(s) must gather information the client's service need(s), function(s) and resources.
2. Previous / ancillary assessments (i.e. medical and nursing) may be used in the determination of client needs.
3. A result of the assessment(s) is maintained in the client's file.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes re-assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

F. REASSESSMENT:

Re-assessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a re-assessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase.

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards
2. Updating assessment per stated standards.
3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Entries in the written plan of care
6. Client acknowledgement of changes resulting from the reassessment

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes re-assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

G. PLAN OF CARE:

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serves as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

I. ELEMENTS

1. Information in the plan of care include:
 - a. List of client service needs
 - b. Establishment of the goal(s) to address stated need
 - c. Objectives and action steps to meet short-term goals
2. Services must not be routinely rendered without a written plan of care.
3. The plan must be implemented, monitored and facilitated by a designated staff member directly

involved in the provision of this service.

4. If applicable, provide the rationale(s) for client non-compliance in the written plan.
5. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
6. The Written Plan of Care must evidence on-going involvement and review by designated service staff.
7. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and if appropriate, client signature.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

I. ELEMENTS

1. Methods used to obtain information may include:
 - a. Communication with client
 - b. Direct observation of the client
 - c. Contact with service provider
2. The types of information to be gathered include:
 - a. Present status of client
 - b. Client satisfaction
 - c. Quality and appropriateness of services provided
3. The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client reassessment.
6. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures must be documented in the client chart (written plan and/or progress notes).
7. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes monitoring with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

I. TERMINATION:

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes termination with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services

J. DOCUMENTATION:

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

I. ELEMENTS

1. Supporting documentation guidelines must be developed and maintained. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)
3. Documentation requirements from each section as outlined above (i.e., intake/screening, assessment, reassessment, plan of care, monitoring and termination).
4. A log documenting service recipients, medications provided and cost must be maintained.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

K. STAFF REQUIREMENTS

Are soundly coordinated and administered by qualified persons with designated specific administrative and program responsibilities.

L. MISC. REQUIREMENTS:

Demonstrate coordination with other emergency financial assistance agencies to avoid duplication of services.
(☆4)

M. UNITS OF SERVICE FOR:

• REPORTING:

Units of service need to be reported by the dollars per client. Programs must report the number of unduplicated clients served each month, and the dollars spent per client on detailed utility payments.

• REMIMBURSEMENT

Units of service for reimbursement need to be reported by the dollars per client. Providers will be reimbursed based on this unit of service plus administrative costs to cover any additional service

delivery costs, including salaries for staff who distribute vouchers, payments, etc. after proper eligibility screening by a Medical Care Manager or case manager.

EFA

Standard 1	Measure
A. This service includes the provision of short-term emergency financial assistance to clients with HIV/AIDS for utilities (gas, electricity, water and sewer).	Client's file includes: <ul style="list-style-type: none"> • Documentation that bill paid was for utilities
B. is paid directly to vendors based on need and actual bill. The client's name must be on the bill and/or account.	Client's file includes: <ul style="list-style-type: none"> • Documentation that payment was made to the vendor
Standard 2	Measure
Service providers/agencies must have written eligibility policy/standards that define who is eligible for the service and must follow those policies/standards.	Agency documentation of policy; and Client's file includes: <ul style="list-style-type: none"> • Documentation of service eligibility
Standard 3	Measure
Total amount of assistance for any one client will be based on need, financial status, and eligibility for other public benefit programs and is limited to 21 weeks of support per year, or a dollar amount cap set by the agency/program.	Agency documentation of agency dollar cap; and Client's file includes: <ul style="list-style-type: none"> • Documentation that service did not exceed 21 weeks in a year • Documentation that service did not exceed dollar cap
Standard 4	Measure
Demonstrate coordination with other agencies offering emergency financial assistance, to avoid duplication of services.	Discussion with provider on how coordination occurs.

FOOD BANK AND HOME DELIVERED MEALS

A. DEFINITION:

Food bank and home delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. This includes vouchers to purchase food.

Food Bank/Home Delivered Meal services fund the provision of:

- **Food Bank.** A food bank is a central distribution center within an agency's catchment area or home delivery providing groceries for indigent clients with HIV/AIDS and their families. The food is distributed in cartons or bags of assorted products to Ryan White clients.
- **Food Vouchers.** This service provides certificates or cards, which may be exchanged for food at cooperating supermarkets, or meals at clinics or social service agencies.
- **Home Delivered Meals.** This service provides nutritionally balanced home delivered meals for clients with HIV/AIDS who are indigent, disabled or homebound, and/or who cannot shop for or prepare (or have others shop for or prepare) their own food. This includes the provision of both frozen and hot meals
- **Non-Food Products.** This service provides reimbursement for the cost of non-food products, such as personal hygiene products, to be provided to eligible individuals through food and commodity distribution programs. Ryan White Part B funds **may not be used** for household appliances, household products, car care products, pet foods or products, or baby care items (e.g., diapers, formula, layette items, etc.). Personal care kits must be provided from the agency's central distribution center. (☆1)

B. PURPOSE:

The purpose of Food Bank and Home Delivered Meals is to provide the nutrition and personal and home hygiene items to enhance a person's health status.

C. ELIGIBILITY:

1. Providers must document that those clients receiving services have been properly screened for other community resources as appropriate by the primary case manager. (☆2B)

Food Vouchers

2. Documentation that clients have applied for food stamps, if eligible.

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process includes but is not limited to:
 - a. Appropriate eligibility for the service
 - b. Date of intake
 - c. Ryan White Face Sheets demographic and statistical information
 - d. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - e. Client or guardian signature of authorization

4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
7. A record of the intake process must be kept and if determined eligible, a client file is created.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes re-assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

I. ELEMENTS

1. The assessment(s) must gather information the client's service need(s), function(s) and resources.
2. Previous / ancillary assessments (i.e. medical and nursing) may be used in the determination of client needs.
3. A result of the assessment(s) is maintained in the client's file.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes re-assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

F. REASSESSMENT:

Re-assessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a re-assessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase.

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards
2. Updating assessment per stated standards.
3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Entries in the written plan of care
6. Client acknowledgement of changes resulting from the reassessment

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes re-assessment with the established Ryan White Standards of Care are not

required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

G. PLAN OF CARE:

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

I. ELEMENTS

1. Information in the plan of care include:
 - a. List of client service needs
 - b. Establishment of the goal(s) to address stated need
 - c. Objectives and action steps to meet short-term goals
2. Services must not be routinely rendered without a written plan of care.
3. The plan must be implemented, monitored and facilitated by a designated staff member directly involved in the provision of this service.
4. If applicable, provide the rationale(s) for client non-compliance in the written plan.
5. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
6. The Written Plan of Care must evidence on-going involvement and review by designated service staff.
7. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and if appropriate, client signature.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

I. ELEMENTS

1. Methods used to obtain information may include:
 - a. Communication with client
 - b. Direct observation of the client
 - c. Contact with service provider
2. The types of information to be gathered include:
 - a. Present status of client
 - b. Client satisfaction
 - c. Quality and appropriateness of services provided
3. The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client reassessment.

6. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures must be documented in the client chart (written plan and/or progress notes).
7. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes monitoring with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

I. TERMINATION:

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes termination with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services

J. DOCUMENTATION:

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

I. ELEMENTS

1. Supporting documentation guidelines must be developed and maintained. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)
3. Documentation requirements from each section as outlined above (i.e., intake/screening, assessment, reassessment, plan of care, monitoring and termination).
4. A log documenting service recipients, medications provided and cost must be maintained.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not

required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

K. STAFF REQUIREMENTS

ALL	Are soundly coordinated and administered by qualified persons designated specific administrative and program responsibilities. Provide services by paid staff and/or unpaid volunteers who receive training and supervision by a designated staff member of the agency
Food Vouchers	Appropriately trained and supervised staff and/or volunteers will be asked to coordinate the provision of emergency food vouchers.
Home Delivered Meals	These services may be administered by or coordinated through appropriately trained and supervised staff and/or volunteers
Non-Food Products	This service may be administered by or coordinated through appropriately trained and supervised staff and/or volunteers

- ▶ SUPERVISION:
- ▶ TRAINING:

L. MISC. REQUIREMENTS:

Food Bank	The provision of this service will be limited to \$30 worth of groceries per week. Households with more than one client with HIV/AIDS will be entitled to \$30 per adult member with HIV/AIDS. Families with minors (under the age of 18) will be entitled to provisions based on family size. (☆3A) Providers must specify criteria processes and procedures utilized to determine allotment provided for dependents, which should take into account factors such as age, special nutritional needs, etc. Providers must demonstrate their capacity to provide foods suited to special client needs. (☆3B)
Food Vouchers	Food vouchers will be issued in denominations no greater than \$25. Provision of food vouchers for any one client is limited to \$30 per week, \$100 per month, and \$500 per year. Clients with HIV/AIDS with dependent children (under 18 years of age) are eligible for an additional \$25 per month in food vouchers for each dependent child, up to \$500 per year for a household/family with dependent children. (☆4A) Providers must ensure vouchers are utilized for appropriate purchases. (☆4B)
Home Delivered Meals	Providers must demonstrate their capacity to provide nutritious food suited to special client needs. (☆5A) Providers will be required to demonstrate that they will adhere to generally accepted nutritional standards for provision of meals to persons with HIV/AIDS. (☆5B) Providers responsible for the preparation of meals will be required to adhere to state and/or local health department regulations for the preparation of food. (☆5C)
Non-Food Products	The provision of this service will be limited to \$20 per kit twice a year per

	client. Clients with HIV/AIDS with dependent children (under 18 years of age) are eligible for an additional \$15 in kit items. (☆6)
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M. UNITS OF SERVICE FOR REPORTING:

Food Bank	Monthly reporting for this service will be on the basis of units (boxes, bags, etc.) of food received with a dollar amount per unit calculated.
Food Vouchers	Monthly activity reporting for this service will be on the dollar amount of the vouchers issued, the number of vouchers, and the number of clients served.
Home Delivered Meals	Monthly reporting for this service will be on the basis of units (boxes, bags, etc.) of food received with a dollar amount per unit calculated. Providers must report monthly activity on the basis of a delivered meal (frozen or hot), i.e., 1 frozen meal box contains breakfast, lunch, and dinner = 3 units of service.
Non-Food Products	Providers must report monthly activity according to the dollar amount of the kit distributed, the number of kits, and the number of clients served.

Food Bank

Standard 1	Measure
This service provides reimbursement for the cost of non-food products..... may not be used for household appliances, household products, car care products, pet foods or products, or baby care items	Client's file includes: <ul style="list-style-type: none"> • Documentation of allowed expenses
Standard 2	Measure
A. Service providers/agencies must have written eligibility policy/standards that define who is eligible for the service and must follow those policies/standards.	Agency documentation of policy; and Client's file includes: <ul style="list-style-type: none"> • Documentation of service eligibility
B. Providers must document that those clients receiving services have been properly screened for other community resources as appropriate by the primary case manager.	Client's file includes: <ul style="list-style-type: none"> • Documentation of screening
Standard 3	Measure
A. The provision of this service will be limited to \$30 worth of groceries per week. Households with more than one client with HIV/AIDS will be entitled to \$30 per adult member with HIV/AIDS. Families with minors (under the age of 18) will be entitled to provisions based on family size	Client's file includes: <ul style="list-style-type: none"> • Documentation that service did not exceed dollar cap
B. Providers must demonstrate their capacity to provide foods suited to special client needs.	Discussion with provider on how they meet special needs.
Standard 4	Measure
A. Food vouchers will be issued in denominations no greater than \$25. Provision of food vouchers for any one client is limited to \$30 per week, \$100 per month, and \$500 per year. Clients with HIV/AIDS with dependent children (under 18 years of age) are eligible for an additional \$25 per month in food vouchers for each dependent child, up to \$500 per year for a household/family with dependent children	Client's file includes: <ul style="list-style-type: none"> • Documentation that service did not exceed dollar cap
B. Providers must ensure vouchers are utilized for appropriate purchases.	Discussion with provider on how they assure this.
Standard 5	Measure
A. Providers must demonstrate their capacity to provide nutritious food suited to special client needs.	Discussion with provider on how they meet special needs.
B. Providers will be required to demonstrate that they will adhere to generally accepted nutritional standards for provision of meals to persons with HIV/AIDS.	Discussion with provider on how they assure this.
C. Providers responsible for the preparation of meals will be required to adhere to state and/or local health department regulations for the preparation of food.	Obtain copy of last health department inspection; must document compliance with this requirement.
Standard 6	Measure
The provision of this service will be limited to \$20 per kit twice a year per client. Clients with HIV/AIDS with dependent children (under 18 years of age) are eligible for an additional \$15 in kit items.	Client's file includes: <ul style="list-style-type: none"> • Documentation that service did not exceed dollar cap

MEDICAL CARE MANAGEMENT

A. DEFINITION:

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

*NOTE: To qualify as Medical Care Management, activities must be tied to providing, facilitating, and keeping a client in primary medical care. This includes **communicating with the clinical care team when necessary in order to help clients navigate medical care.** The Medical Care Manager need not be located in the primary care facility, but must work closely and directly with the primary care provider.*

B. PURPOSE:

The purpose of Medical Case Management is to assist Persons Living with HIV/AIDS (PLWHA) is to identify and address barriers that limit a person's ability to connect to care and then link with needed services and to support the coordination and follow up of a person's medical care so that they successfully participate in and adhere to HIV medical care. (☆2)

C. ELIGIBILITY:

Service providers/agencies must have written eligibility policy/standards that define who is eligible for the service and must follow those policies/standards. (☆3)

NOTE: All eligibility /ineligibility determination for Ryan White services is a function of the Tennessee Department of Health.

D. INTAKE AND SCREENING

Each client must participate in an initial intake and screening procedure (☆4). The purpose of the intake and screening portions of the case management process is for client identification, and screening of potential needs. This stage will assist in obtaining client baseline data to be used in determining potential needs. This component is crucial in setting the foundation for providing a coordinated set of services.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client and reflects demographic information needed by the program.
3. The intake process indicates appropriate eligibility for the program. This process includes but is not limited to:
 - a. Date of intake
 - b. Ryan White Face Sheets demographic and statistical information
 - c. HIV /AIDS diagnosis and if appropriate, other medical diagnosis

- d. Appropriate financial information
 - e. Health status
 - f. Insurance information
 - g. If appropriate, method of payment for services
 - h. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
 5. Intake process is authorized by the client.
 6. The intake process includes the mechanisms to gather at the time of intake and/or secure within an appropriate time, all needed documentation verifying service eligibility. This is minimally: HIV status, income, residency **and service eligibility for Medical Case Management services.**
 7. Reason for ineligibility for program must be indicated (if applicable).
 8. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
 9. A record of the intake process must be kept and if determined eligible, a client file is created.

E. ASSESSMENT

After each client is determined eligible for the program, needs must be assessed **within 30 calendar days** from intake and completed in a systematic manner in order to provide appropriate information for the written plan of care. (☆5) The purpose of this stage is to develop an understanding of what services the client may need. This stage builds on the information gathered in the initial intake; however, more detailed information is sought.

I. ELEMENTS

1. While the assessment of each client may require the selection from a variety of assessment tools, the assessment(s) should gather information from the many areas in which the client functions. These areas include but are not limited to:

PRIMARY FOCUS

- a. Psychosocial (i.e., emotional functioning, alcohol and/or drug use, mental health diagnosis/history/tx, substance abuse diagnosis/history/tx, etc.)
- b. Medical History/Physical Health (i.e., HIV/AIDS, OI's, other medical conditions, medication(s) and adherence, medical providers / settings, hospitalizations, etc.)
- c. Health Resources (i.e., Insurance, Ryan White, TennCare, Medicare)
- d. Safer Sex Practices (i.e., awareness and/or practice of, resources to maintain)
- e. Service Needs (Client list of personal/family resource(s) and service(s) need(s)). **Secondary Focus:** (as each impacts and/or is impacted by the client/patients health and medical needs, services and/or resources)

SECONDARY FOCUS (as each impacts and/or is impacted by the client/patient's health and medical needs, services and/or resources)

- f. Housing (i.e., housing resources, utilities, special needs)
- g. Mental Health
- h. Functional Capabilities (i.e., Activities of daily living)
- i. Financial Resources (i.e., income, entitlements, public assistance, budget)
- j. Service Needs

- k. Religious/Spiritual/Cultural Resources and functioning (i.e., particular affiliations, memberships, rituals, and/or role in personal well-being)
 - l. Educational/Employment
 - m. Social Functioning (i.e., family, peers, social activities)
 - n. Practical resources (i.e., transportation, food, clothing)
2. Previous assessments (i.e. medical and nursing) may be used in the determination of client needs.
 3. Results of the assessments are maintained in the client's file.

F. REASSESSMENT

Each client must be reassessed **every 6 months minimally** or as the need arises. (☆6) The purpose of the reassessment is to address the issues noted during the monitoring phase. Reassessment will include but is not limited to the original assessment areas. The client and Medical Care Manager work together to reevaluate the course of the plan of care plan. Reassessment also allows for client readmission to programs, assignment to another level of service, and the termination of services.

I. ELEMENTS

1. updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards
2. Updating assessment per stated standards.
3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Topics to be addressed in the reassessment may include:
 - a. Appointments, status and referrals
 - b. Special intervention activities
 - c. Special needs
6. Entries in the written plan of care
7. Client acknowledgement of changes resulting from the reassessment

G. PLAN OF CARE:

A Written Plan of Care must be developed **within 30 calendar days** from assessment date and with the participation and agreement of the client or guardian. (☆7)The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. The written plan also serves as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

I. ELEMENTS

1. Information included in the plan of care include:
 - a. List of client service needs
 - b. Establishment of short- and long-term goals
 - c. Objectives and action steps to meet short-term goals
 - d. Formal and informal resources to accomplish goals
 - e. Gaps in services
 - f. Alternatives to meet client goals
 - g. Resources to be used to meet client goals
 - h. Criteria for determination of completion of goals
2. Services must not be routinely rendered without a written plan of care.
3. The plan must be implemented, monitored and facilitated by a Medical Care Manager. This is documented in accordance with the stated Monitoring Standard (#H).
4. If applicable, provide the rationale(s) for client non-compliance in the written plan.

5. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
6. The Written Plan of Care should evidence on-going involvement and review by the case manager with the client. Minimally this should be bi-annually with contact and review within 6 months of intake and/or re-assessment.
7. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and if appropriate, client signature.
8. The subcontractor/provider shall document client's progress with care plan(s).

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to allow the client and Medical Care Manager to observe the progress of the plan of care in order to make revisions. The needs and status of each client receiving medical case management services will be reassessed every 6 months in a face to face encounter monitored on a regular basis. Phone follow up is needed quarterly. The intervals between monitoring may vary among clients but must reflect necessity and consistency with the written plan, However, monitoring is an ongoing process., therefore phone follow up may be more frequent than a quarterly basis.

1. Methods used to obtain information may include:
 - a. Communication with client
 - b. Direct observation of the client
 - c. Contact with service provider
2. The types of information to be gathered include:
 - a. Present status of client
 - b. Client satisfaction
 - c. Quality and appropriateness of services provided
3. The client must be instructed to notify Medical Care Manager of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client reassessment.
6. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures **must** be documented in the client chart (written plan and/or progress notes).
7. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

I. TERMINATION

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or Medical Care Manager.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility (Determined by TDOH Medical Case Management)
 - d. Client desire to terminate services

e. Death

2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy in the Medical Case Management Manual.
3. Client must be afforded information regarding transfer to an outside agency.

J. DOCUMENTATION

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

I. ELEMENTS

1. Supporting documentation guidelines must be developed and maintained. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)
3. Documentation requirements from stages C-I (as outlined in each section.)

K. STAFF REQUIREMENTS

▶ MINIMUM EDUCATIONAL/EXPERIENCE REQUIREMENTS FOR MEDICAL CASE MANAGEMENT POSITIONS (☆8A)

All Medical Care Managers hired by subcontractor/provider agencies that are funded in whole or in part to provide medical case management services through Ryan White Part B funds, must possess one of the following:

- Bachelor level degree in a health or human services related discipline with equivalent to two year of full time professional case management in a public service agency
Or
- Bachelor level degree in Social Work with equivalent to two years of full time professional case management in a public service agency (an appropriately supervised BSW internship may count for one year's experience)
Or
- Master level degree in a health or human services related discipline with equivalent to one year of full time professional case management in a public service agency.

Note 1: Educational and experience requirements for medical case management may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Fiscal Agent who will in turn seek approval of the modification/waiver from the Metropolitan Public Health Department. Documentation of the request for modification/waiver must include relevant reasons and justification for such action and specific information why the person to be hired as Medical Care Manager has sufficient education, certification, licensure and/or experience to merit the modification/waiver. In addition to a written statement of relevant education/experience, the agency seeking modification/waiver must present a written plan to insure that the Medical Care Manager receives appropriate additional education (degree), training and/or supervision to insure quality provision of care.

Note 2: In such cases where a Medical Care Manager was employed prior to the implementation of the Standard and does not meet the given qualifications, there is need to use the aforementioned /modification/waiver provision. In addition to a written statement of relevant education/experience, the agency

seeking modification/waiver must present a written plan to insure that the Specialist receives appropriate additional education (degree), training and/or supervision to insure quality provision of care.

▶ SUPERVISION: (☆8B)

Ryan White Part B Medical Care Managers must have the supervision and guidance of a Master Level Social Worker. Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting. Supervision will address issues of client care (e.g. boundaries and appropriate interactions with clients), case manager job performance, and skill development (e.g. record keeping). Clinical supervision addresses anything directly related to client care (e.g., supervision in order to address specific client issues), and issues related to job related stress. Administrative supervision addresses issues relating to staffing, policy, client documentation, reimbursement, scheduling, trainings, quality enhancement activities, and the overall running of the program and/or agency.

Note: MSW requirements for clinical supervision may be modified and/or waived. The agency seeking modification and/or waiver must request such in writing to the Fiscal Agent who will in turn seek approval of the modification/waiver from the Metropolitan Public Health Department. Documentation of the request for modification/waiver must include relevant reasons and justification for such action and specific information why the person to provide clinical supervision has sufficient education (Masters Degree in a Health or Human Services field), certification, licensure and clinical experience to merit the modification/waiver.

▶ TRAINING:

Agencies providing medical case management services must document efforts to assist Medical Care Managers and clinical supervisory staff in securing on-going education and training to better perform their respective job duties.

1. Individuals who hold certification and/or licensure as a part of their job duties must maintain that in good standing with the respective governance bodies.
2. Medical Care Managers and clinical supervisors must have opportunities to participate in annual training for **at least five (5) hours per year** on one or more of the following topics: (☆9)
 - a. HIV 101 Updating
 - b. HIV/AIDS Medical Management Updating
 - c. Treatment Adherence
 - d. Cultural Issues / Competency
 - e. Community Resources / Services (health, housing, income....)
 - f. CM Skills Building (documentation, interviewing)
 - g. Particular Client Issues/Needs (MH, A&D, poverty....)

L. MISC. REQUIREMENTS:

- 1. Providers must demonstrate strong linkages with HIV/AIDS medical providers. This must be in the form of a written Memorandum of Agreement. (☆10A)**
- 2. Providers must demonstrate strong linkage with Early Intervention Specialists. This must be in the form of a written Memorandum of Agreement. (☆10B)**

M. UNITS OF SERVICE FOR REPORTING:

Units of service need to be reported by the number of individual contacts. A unit of service is defined as 15 minutes of face-to-face or phone contact or communication on behalf of client's medical care.

Medical Case Management

Standard 1	Measure
A. The coordination and follow-up of medical treatments is a component of medical case management.	Client's file includes: <ul style="list-style-type: none"> • Documentation of client's last 2 HIV medical appointments
B. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments	Client's file includes: <ul style="list-style-type: none"> • Of the last 3 encounters, documentation of discussion with client on treatment adherence
Standard 2	Measure
The purpose of Medical Case Management is to assist Persons Living with HIV/AIDS (PLWHA) is to identify and address barriers that limit a person's ability to connect to care and then link with needed services and to support the coordination and follow up of a person's medical care so that they successfully participate in and adhere to HIV medical care	Client's file includes: <ul style="list-style-type: none"> • Documentation of client barriers
Standard 3	Measure
Service providers/agencies must have written eligibility policy/standards that define who is eligible for the service and must follow those policies/standards.	Agency documentation of policy; and Client's file includes: <ul style="list-style-type: none"> • Documentation of service eligibility
Standard 4	Measure
Each client must participate in an initial intake and screening procedure.	Client's file includes: <ul style="list-style-type: none"> • Documentation of intake/screening
Standard 5	Measure
After each client is determined eligible for the program, needs must be assessed within 30 calendar days from intake and completed in a systematic manner in order to provide appropriate information for the written plan of care.	Client's file includes: <ul style="list-style-type: none"> • Documentation of assessment within required timeframe
Standard 6	Measure
Each client must be reassessed every 6 months minimally or as the need arises	Client's file includes: <ul style="list-style-type: none"> • Documentation of reassessment within required timeframe
Standard 7	Measure
A Written Plan of Care must be developed within 30 calendar days from assessment date and with the participation and agreement of the client or guardian.	Client's file includes: <ul style="list-style-type: none"> • Documentation of plan of care within required timeframe, including documentation of client/guardian participation/agreement
Standard 8	Measure
A. Medical Care Managers must meet minimum educational/experience requirements.	MCM staff's personnel file includes: <ul style="list-style-type: none"> • Documentation of education/experience
B. Medical Care Managers must have the supervision and guidance of a Master Level Social Worker. Supervision must occur a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting.	Agency documentation of MCM supervision

Medical Case Management

Standard 9	Measure
Medical Care Managers and clinical supervisors must have opportunities to participate in annual training for at least five (5) hours per year on one or more of the following topics	MCM staff's personnel file includes: <ul style="list-style-type: none">• Documentation of training

MEDICAL TRANSPORTATION SERVICES

A. DEFINITION:

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services. **Medical transportation is used to provide transportation to eligible Ryan White clients to core medical services and support services.**

Medical transportation services fund the provision of:

- Transportation passes (public transportation passes). This service provides reduced fare transportation passes to eligible clients with HIV/AIDS and their caregivers attending core medical service appointments. This includes two-way and one-way passes. (☆1)
- Agency based transportation (van, transporter, etc.). This service provides free transportation to and from core medical services for eligible clients with HIV/AIDS and their caregivers, in vehicles 1) operated directly by the service provider or 2) through a subcontract with a provider of transportation services.
- Mileage reimbursement (private transportation, staff transportation, voucher, etc.). This service provides reimbursement for the cost of mileage for eligible clients with HIV/AIDS and their caregivers, appropriate staff persons and volunteer drivers assisting clients attending core medical service appointments. Gas vouchers to participating gas stations are an acceptable form of mileage reimbursement.
- Taxicab reimbursement (voucher, invoice, etc.). This service provides reimbursement for the cost of each qualifying taxicab ride for eligible clients with HIV/AIDS and their caregiver attending core medical service appointments.

B. PURPOSE:

Offer services in a safe, timely, reliable, and cost-efficient manner that facilitates access to core medical services for clients and their caregivers.

C. ELIGIBILITY:

Clients receiving transportation passes must be documented as having been properly screened for other transportation resources as appropriate. While clients qualify for other funding sources for transportation, they will not be eligible for Ryan White Part B funding for this service (☆2B)

MILEAGE REIBURSEMENT-Additional Requirement:

- To qualify for mileage reimbursement, the client must demonstrate, if needed, that a caregiver provided transportation assistance. (☆2C)
- To qualify for mileage reimbursement, non-clients must: 1) be an eligible staff person and/or unpaid volunteer of the agency and 2) have proof of the appropriate insurance and other liability issues either personally or through agency coverage (☆2D)

TAXICAB REIBURSEMENT-Additional Requirement:

- To qualify for reimbursement for taxicab transportation, the client must: 1) have a medical emergency or severely inclement weather which prohibits the use of other transportation sources and/or 2) no available public transportation or other resource (☆2E)

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process includes but is not limited to:
 - a. Appropriate eligibility for the service
 - b. Date of intake
 - c. Ryan White Face Sheets demographic and statistical information
 - d. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - e. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
7. A record of the intake process must be kept and if determined eligible, a client file is created.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes re-assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

I. ELEMENTS

1. The assessment(s) must gather information the client's service need(s), function(s) and resources.
2. Previous / ancillary assessments (i.e. medical and nursing) may be used in the determination of client needs.
3. A result of the assessment(s) is maintained in the client's file.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes re-assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

F. REASSESSMENT:

Re-assessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a re-assessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase.

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include confidential releases,

- eligibility requirements and contractual agreements per stated standards
- 2. Updating assessment per stated standards.
- 3. Updating/revising written plan of care per stated standards.
- 4. Communication with client regarding services
- 5. Entries in the written plan of care
- 6. Client acknowledgement of changes resulting from the reassessment

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes re-assessment with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

G. PLAN OF CARE

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

I. ELEMENTS

1. Information in the plan of care include:
 - a. List of client service needs
 - b. Establishment of the goal(s) to address stated need
 - c. Objectives and action steps to meet short-term goals
2. Services must not be routinely rendered without a written plan of care.
3. The plan must be implemented, monitored and facilitated by a designated staff member directly involved in the provision of this service.
4. If applicable, provide the rationale(s) for client non-compliance in the written plan.
5. Documentation of the client's participation in the planning process is done with signature by the client and/or legal guardian. If the client is unable to sign written plan, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
6. The Written Plan of Care must evidence on-going involvement and review by designated service staff.
7. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reasons and if appropriate, client signature.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

I. ELEMENTS

1. Methods used to obtain information may include:
 - a. Communication with client
 - b. Direct observation of the client
 - c. Contact with service provider
2. The types of information to be gathered include:

- a. Present status of client
- b. Client satisfaction
- c. Quality and appropriateness of services provided
3. The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client reassessment.
6. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures must be documented in the client chart (written plan and/or progress notes).
7. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes monitoring with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

I. TERMINATION:

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes termination with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services

J. DOCUMENTATION:

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

I. ELEMENTS

1. Supporting documentation guidelines must be developed and maintained. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)

3. Documentation requirements from each section as outlined above (i.e., intake/screening, assessment, reassessment, plan of care, monitoring and termination).
4. A log documenting service recipients, medications provided and cost must be maintained.

NOTE: Agencies that have existing procedures to accomplish this step through case management or another recognized service that completes care planning with the established Ryan White Standards of Care are not required to duplicate this process for involvement in this or other agency/program Ryan White funded services.

K. STAFF REQUIREMENTS

ALL	Are soundly coordinated and administered by qualified persons with designated specific administrative and program responsibilities Provide services by paid staff and/or unpaid volunteers who receive training and supervision by a designated staff member of the agency
Passes	Administered by or coordinated through appropriately trained and supervised staff and/or volunteers.
Agency Based	Coordinated and administered by qualified persons with designated specific administrative and program responsibilities. Provided by paid staff and/or unpaid volunteers who receive training and supervision by a designated staff member of the agency. (★3)
Mileage Reimbusem	NA
Taxi	This service may be administered by or coordinated through appropriately trained and supervised staff and/or volunteers.

▶ SUPERVISION:

▶ TRAINING:

L. MISC. REQUIREMENTS:

ALL	Demonstrate coordination with other transportation agencies and services, TennCare Special Transportation and other existing transportation programs to avoid duplication of services. (★4)
Agency Based	Provided in combination with core services to clients of Ryan White Part B funded programs. They must be in compliance with all state regulations regarding transportation including driver’s license; appropriate insurance and other liability issues; and/or any applicable state regulations. (★5)
Mileage Reimbusem	Mileage will be reimbursed at no more than the current State rate. Provider agencies may state their own rate as long as Ryan White funded reimbursement does not exceed the current state rate. (★6)

M. UNITS OF SERVICE FOR REPORTING:

Passes	Units of service need to be reported by dollar amount of vouchers issued, i.e., \$1=1 unit of service, so \$5 voucher = 5 units of service. Providers must report monthly activity according to the dollar amount of the voucher issued, the number of vouchers, and the number of clients served.
Agency Based	Monthly reporting for this service will be on the basis of one-way trips, i.e., one round trip to medical appointment and home = 2 units of service. Providers must report monthly activity according to the number of one-way trips and the number of clients served
Mileage Reimbusem	Monthly activity reporting for this service will be on the basis of one-way trips i.e., one round trip to medical appointment and home = 2 units of service.

Taxi	Monthly reporting for this service will be on the basis of one-way trips, i.e., one round trip to medical appointment and home = 2 units of service. Providers must report monthly activity according to the number of one-way trips and the number of clients served.
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Medical Transportation

Standard 1	Measure
<p>Transportation passes (public transportation passes). This service provides reduced fare transportation passes to eligible clients with HIV/AIDS and their caregivers attending core medical service appointments. This includes two-way and one-way passes.</p>	<p>Documentation that includes:</p> <ul style="list-style-type: none"> • Proof of purchase of one or two way passes (not month long passes, etc.)
Standard 2	Measure
<p>2A. Service providers/agencies must have written eligibility policy/standards that define who is eligible for the service and must follow those policies/standards.</p>	<p>Agency documentation of policy; and Client's file includes:</p> <ul style="list-style-type: none"> • Documentation of service eligibility
<p>2B. Clients receiving transportation passes must be documented as having been properly screened for other transportation resources as appropriate. While clients qualify for other funding sources for transportation, they will not be eligible for Ryan White Part B funding for this service</p>	<p>Client's file includes:</p> <ul style="list-style-type: none"> • Documentation of screening for other transportation resources
<p>2C. To qualify for mileage reimbursement, the client must demonstrate, if needed, that a caregiver provided transportation assistance</p>	<p>Client's file includes:</p> <ul style="list-style-type: none"> • Documentation of caregiver transportation
<p>2D. To qualify for mileage reimbursement, non-clients must: 2) have proof of the appropriate insurance and other liability issues either personally or through agency coverage</p>	<p>Agency documentation that includes:</p> <ul style="list-style-type: none"> • Proof of appropriate insurance and liability
<p>2E. To qualify for reimbursement for taxicab transportation, the client must: 1) have a medical emergency or severely inclement weather which prohibits the use of other transportation sources and/or 2) no available public transportation or other resource</p>	<p>Client's file includes:</p> <ul style="list-style-type: none"> • Documentation of emergency or inclement weather and no other resource available
Standard 3	Measure
<p>Agency Based Transportation. Coordinated and administered by qualified persons with designated specific administrative and program responsibilities. Provided by paid staff and/or unpaid volunteers who receive training and supervision by a designated staff member of the agency.</p>	<p>Personnel file includes:</p> <ul style="list-style-type: none"> • Documentation of compliance
Standard 4	Measure
<p>Demonstrate coordination with other transportation agencies and services, TennCare Special Transportation and other existing transportation programs to avoid duplication of services.</p>	<p>Discussion with provider on how they coordinate</p>

Medical Transportation

Standard 5	Measure
Agency Based. They must be in compliance with all state regulations regarding transportation including driver's license; appropriate insurance and other liability issues; and/or any applicable state regulations.	Personnel file includes: <ul style="list-style-type: none"><li data-bbox="857 289 1300 321">• Documentation of compliance
Standard 6	Measure
Mileage Reimbursement. Mileage will be reimbursed at no more than the current State rate.	Client's file includes: <ul style="list-style-type: none"><li data-bbox="857 512 1443 573">• Documentation of correct reimbursement amount

MENTAL HEALTH SERVICES

A. DEFINITION:

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

B. PURPOSE:

The purpose of mental health services is to address and stabilize mental health issues so that a person is able to engage in and maintain participation in HIV medical care.

C. ELIGIBILITY:

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process indicates appropriate eligibility for the program. The intake process includes but is not limited to:
 - a. Appropriate eligibility for the service
 - b. Date of intake
 - c. Ryan White Face Sheets demographic and statistical information
 - d. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - e. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. The intake process includes the mechanisms to gather at the time of intake and/or secure within an appropriate time, all needed documentation verifying service eligibility as described in universal standards of care and as described in each service area.
7. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
8. A record of the intake process must be kept and if determined eligible, a client file is created.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

CLIENT ASSESSMENT REQUIREMENTS FOR OUTPATIENT FACILITIES.

- (1) The facility must ensure that the following assessments are completed prior to the development of the Individual Program Plan:
 - a. Assessment of current functioning according to presenting problem including a history of the presenting problem;
 - b. Basic medical history and information;
 - c. A six-month history of prescribed medications, frequently used over-the-counter medications and alcohol and other drugs; and
 - d. A history of prior mental health and alcohol and drug treatment episodes.

F. REASSESSMENT

Re-assessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a re-assessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase. Reassessment must occur at the time the IPP is revised (see 0940-5-14-.05) and include items from 0940-5-14-.03.

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards
2. Updating assessment per stated standards.
3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Entries in the written plan of care
6. Client acknowledgement of changes resulting from the reassessment

G. PLAN OF CARE:

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

INDIVIDUAL PROGRAM PLAN REQUIREMENTS FOR OUTPATIENT FACILITIES.

- (1) An Individual Program Plan must be developed for each client which is based on an initial history and ongoing assessment and which is completed within thirty (30) days of admission. Documentation of the Individual Program Plan (IPP) must include the following:
 - a. The client's name;
 - b. The date of development of the IPP;
 - c. Specified client problems in the IPP which are to be addressed within the particular service/program component;
 - d. Client goals which are related to specified problems identified in the IPP and which are to be addressed by the particular serve/program component;
 - e. Interventions addressing goals in the IPP;
 - f. The signatures of the appropriate staff;
 - g. Documentation of client participation in the treatment planning process;
 - h. Standardized diagnostic formulation(s), (e.g., DSM-III, ICD-9); and
 - i. Planned frequency of contacts.

INDIVIDUAL PROGRAM PLAN REVIEW IN OUTPATIENT FACILITIES. The facility must review and, if indicated, revise the IPP every six (6) months.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

I. ELEMENTS

1. Methods used to obtain information may include:
 - a. Communication with client
 - b. Direct observation of the client
 - c. Contact with service provider
2. The types of information to be gathered include:
 - a. Present status of client
 - b. Client satisfaction
 - c. Quality and appropriateness of services provided
3. The client must be instructed to notify designated service staff of any change in status or if any problems are found with the services provided.
4. Non-scheduled care plan meetings may occur as the need arises.
5. Monitored information must be recorded in order to aid in the client reassessment.
6. Documentation of service/ written care plan implementation/monitoring/review, client participation, success, barriers and/or failures must be documented in the client chart (written plan and/or progress notes).
7. As indicated and appropriate, monitoring may lead to update, revise and or modify the written plan of care. This should be completed in accordance with the stated Written Plan Standards.

I. TERMINATION:

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff. Medical Care Manager.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

J. DOCUMENTATION

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

INDIVIDUAL CLIENT RECORD REQUIREMENTS FOR ALL FACILITIES. The governing body must ensure that an individual client record is maintained for each client being served which minimally include the following information:

- a. The name of the client;
- b. The address of the client;
- c. The telephone number of the client;
- d. The sex of the client;
- e. The date of the client's birth;
- f. The date of the client's admission to the facility;
- g. The source of the client's referral to the facility;
- h. The name, address, and telephone number of an emergency contact person;
- i. If the facility charges fees for its services, a written fee agreement dated and signed by the client (or the client's legal representative) prior to provision of any services other than emergency services. This agreement must include at least the following information;
 1. The fee or fees to be paid by the client;
 2. The services covered by such fees, and
 3. Any additional charges for services not covered by the basic service fee;
- j. Appropriate informed, signed, and dated consent and authorization forms for the release or obtainment of information about the client; and
- k. Documentation that the client or someone acting on behalf of the client has been informed of the client's rights and responsibilities and of the facility's general rules affecting client.

AND

CLIENT RECORD REQUIREMENTS FOR OUTPATIENT FACILITIES.

- (1) An individual client record must be maintained which includes the following:
 - a. Progress notes which must include written documentation of progress or changes which have occurred within the IPP and which must be developed after each service contact;
 - b. Documentation of all drugs prescribed or administered by the facility which indicates date prescribed, type, dosage, frequency, amount and reason;
 - c. Narrative summary review of all medications prescribed at least every six (6) months which includes specific reasons for continuation of each medication; and
 - d. A discharge summary which states, if appropriate, the client's condition at the time of discharge and signature of person preparing the summary.

K. STAFF REQUIREMENTS

PERSONNEL REQUIREMENTS FOR OUTPATIENT FACILITIES.

- (1) Provide direct-treatment and/or rehabilitation services by mental health professionals or by mental health personnel who are under the direct clinical supervision of a mental health professional.
- (2) Maintain a written agreement with or employ a physician to serve as medical consultant to the facility.
- (3) If the physician is not a psychiatrist, the facility must also arrange for the regular, consultative and emergency services of a psychiatrist.
- (4) In case of a medical or other type of emergency, the facility staff must have immediate access to relevant information in the client's record.

AND ADDITIONALLY

Direct service providers must **be Master's degree prepared, licensed or license eligible mental health providers including but not limited to Medical Doctor (M.D.), Licensed Psychologist**

(Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Masters Level Social Worker (L.M.S.W.) seeking L.C.S.W., or Licensed Professional Counselor (L.P.C.). (★2)

▶ SUPERVISION:

▶ TRAINING:

0940-5-6-.04 PERSONNEL REQUIREMENTS FOR ALL FACILITIES.

- (3) Training and development activities which are appropriate in assisting the staff in meeting the needs of the clients being served must be provided for each staff member. The provision of such activities must be evidenced by documentation in the facility records.
- (4) Training and development activities which are appropriate in assisting volunteers (if used by the facility) in implementing their assigned duties must be provided for each volunteer. The provision of such activities must be evidenced by documentation in the facility's records.

AND

Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics and implications, including cognitive impairment and generally accepted treatment modalities and practices. (★3)

L. MISC. REQUIREMENTS:

0940-5-3-.08 APPLICATION OF RULES FOR MENTAL HEALTH OUTPATIENT FACILITIES.

- (1) The governing body of a mental health outpatient facility must provide services and facilities which comply with the following rules:
 - a. Rule 0940-5-4-.04(2) Life Safety Business Occupancies rule;
 - b. Chapter 0940-5-5 Adequacy of Facility Environment and Ancillary Services;
 - c. Chapter 0940-5-6 Minimum Program Requirements for All Facilities; and
 - d. Chapter 0940-5-14 Minimum Program Requirements for Mental Health Outpatient Facilities; and
 - e. If services are to be provided to one (1) or more mobile non-ambulatory person, rule 0940-5-4-.09(2) Mobile Non-Ambulatory rule.

0940-5-1-.01 DEFINITION OF GENERAL TERMS USED IN ALL RULES. As used in Chapters 0940-5-1 through 0940-5-28 of these rules, unless the context indicates otherwise, terms have the following meaning:
(17) Licensed Clinical Psychologist - A psychologist licensed to practice psychology in Tennessee with the certified competency in clinical psychology determined by the State Licensing Board for the Healing Arts and the Board of Examiners in Psychology.

(30) Psychiatrist - A physician who specializes in the assessment and treatment of individuals having psychiatric disorders; is certified by the American Board of Psychiatry and Neurology or has the documented equivalent in education, training and/or experience; and who is fully licensed to practice medicine in the State of Tennessee.

0940-5-1-.02 DEFINITION OF TERMS USED IN MENTAL HEALTH RULES. As used in Chapters 0940-5-14 through 0940-5-19 of these rules, unless the context indicates otherwise, terms have the following meaning:

(2) Individualized Program Plan - A document developed by the treatment staff/team, which identifies the service recipient's problems and specifies goals to be addressed in treatment and the interventions used to accomplish these goals.

(3) Licensed Clinical Psychologist - A psychologist licensed to practice psychology in Tennessee with the certified competency in clinical psychology determined by the State Licensing Board for the Healing Arts and the Board of Examiners in Psychology.

(4) Mental Health Personnel - A staff member who operates under the direct supervision of a mental health professional.

(5) Mental Health Professional - A board eligible or a board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy.

M. UNITS OF SERVICE FOR REPORTING:

Units of service need to be reported by the number of individual or group contacts. A unit of service is defined as 15 minutes.

Mental Health

Standard 1	Measure
Licensure Items	Copy of last state site visit which demonstrates compliance
Standard 2	Measure
Direct service providers must be Master's degree prepared, licensed or license eligible mental health providers including but not limited to Medical Doctor (M.D.), Licensed Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Masters Level Social Worker (L.M.S.W.) seeking L.C.S.W., or Licensed Professional Counselor (L.P.C.).	Staff's file includes: <ul style="list-style-type: none"> • Documentation of compliance
Standard 3	Measure
Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics and implications, including cognitive impairment and generally accepted treatment modalities and practices.	Staff's file includes: <ul style="list-style-type: none"> • Documentation of compliance

ORAL HEALTH SERVICES

Source: 2/1/07 TDOH Policy

A. DEFINITION:

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

The services are provided to people living with HIV/AIDS with the following three goals:

- Control or eliminate oral/dental infection.
- Provide treatment for acute pain, swelling, hemorrhage or trauma.
- Correct a condition, which is preventing a person from eating.

Providers must demonstrate strong linkages with dental providers. (☆1)

Purpose

The purpose of this policy is to establish procedures providing Dental services to eligible Ryan White Services clients.

I. Eligibility Criteria

The following criteria must be met for a client to be eligible for services under Ryan White Services:

- Clients must contact their Medical Care Manager for evaluation and determination of eligibility. Client must be a resident of Tennessee.
- Client must have clinically tested positive for HIV
- Dental services must be provided on an out-patient basis
- Verification in writing from insurance carrier stating the service to be covered by Ryan White, **Part B** is not covered under clients existing insurance policy (☆2)
- Dental services to be provided must be directly related to HIV status and clients health. No cosmetic dental services will be approved. (☆3)

II. Priority

Clients will be served in the order listed below: (☆4)

1. Clients who have initiated but not completed treatment, from an approved dental treatment plan, at the end of the previous grant year.
2. Clients currently on a waiting list. (In the order they were added).
3. First come, first served until funding is exhausted; at that time a waiting list will be established.

III. Procedures

1. Client contacts the Medical Care Manager, by phone or in person, and establishes eligibility for dental services under Ryan White, Part B. If the Medical Care Manager chooses to delegate signature authority for client approval to a Case Manager, a memo must be submitted to Ryan White Services with a copy to the Grantee or the Fiscal Agent.
2. Medical Care Manager or designee explores available resources, (i.e. Insurance, etc.) before certifying a client eligible for services under Ryan White, Part B; establishes client eligibility; then refers client to an approved dental provider.
3. The Medical Care Manager or designee will ensure that both, the provider and client are familiar with the Ryan White Part B Dental Policy and expenditure limitations. All costs in excess of the established expenditure limitations are the sole responsibility of the client.
4. Medical Care Manager or designee completes form PH-3463 and ensures the form is on file with the

designated dental subcontractor. A copy of form PH-3463 must be sent to the approved dental provider.

5. Client receives dental services from an approved dental provider.
6. Approved dental provider must list the tooth number and the scaling quadrant on the HCFA-1500 and the PH-3475 forms
7. Approved dental provider submits an invoice (HCFA-1500) within 30 days from the date of service to the designated dental subcontractor.
8. The designated dental subcontractor verifies receipt of Medical Care Managers referral form and remits payment to the approved dental provider within 60 days of the receipt of the invoice.

IV. Disbursement of Funds

The subcontractor will be responsible for reporting Dental Program activities to the regional Fiscal Agent.

V. Provider Reimbursement

Payment will be contingent upon referral/approval form completed by Medical Care Manager or designee. The dollar amount of annual Dental coverage will be determined by **each region**.

VI. Dental Providers

Subcontractor will provide a list of approved dental providers for use by Medical Care Managers and the person responsible for record keeping and payment. Only dental providers who have been approved by the Fiscal Agent and who are on the approved provider list will receive reimbursement from Ryan White, Part B

VII. Maintenance of Records

A file must be maintained on each client receiving services funded by Ryan White, Part B. The file is to be located at the designated dental subcontractor's office. Included in the file must be a copy of the Patient Eligibility Form/PH-3463, a copy of the paid invoice (HCFA-1500). (☆5)

Client files must be stored in a locked filing cabinet/drawer. Information contained in the client dental record is not to be shared with anyone without prior consent of the client. Record must be maintained for three years.

VIII. Quality Assurance Monitoring / Evaluation

Each subcontractor will receive a Quality Improvement Monitoring Review annually. The QI Monitoring Review will include all components of the contract between the State Ryan White Part B Services and the Fiscal Agent regarding the Dental Program.

Any areas out of compliance with this policy will be brought to the attention of the Fiscal Agent in writing with a copy to the Grantee. An action plan will be developed by the subcontractor and the Fiscal Agent with a time line for completion. A follow-up date will be set at the time of the initial review.

When the follow-up site visit is conducted, if all areas are in compliance, a letter stating the dental subcontractor is in compliance will be submitted by the Fiscal Agent.

If the agency is not in compliance with the contract within 3 months, the state will work with the Fiscal Agent to designate another Dental Program subcontractor. Until another subcontractor is in place, Contact Administrator will be responsible for processing dental invoices.

If no Dental Program subcontractor is in place within 60 days of date removal, the regional Fiscal Agent will be responsible for returning remaining funds designated for dental services to the state Ryan White Part B Office.

Dental Program Definitions

Approved Dental Provider - A provider of dental services who has been approved by the state to provide dental services to HIV positive clients.

Established Clients - Clients who have accessed dental services previously through the Ryan White Services.

Case Manager - An individual responsible for assisting HIV positive persons to access support services available in Tennessee

Medical Care Manager - An individual responsible for assisting HIV positive persons to access medical/dental services available in Tennessee

New Client - Client who has never accessed dental services through Ryan White Part B

Services Directly Related to HIV Status - Dental services which improve the health of the HIV positive person rather than services provided for aesthetic purposes.

UNITS OF SERVICE FOR:

Units of service need to be reported by the number of individual contacts. A unit of service is defined as face to face oral health visits.

Oral Health Services

Standard 1	Measure
1. Providers must demonstrate strong linkages with dental providers.	Discussion with provider on how they coordinate and link
Standard 2	Measure
2. Verification in writing from insurance carrier stating the service to be covered by Ryan White, Part B is not covered under clients existing insurance policy	Client's file includes: <ul style="list-style-type: none"> • Documentation of compliance
Standard 3	Measure
3. Dental services to be provided must be directly related to HIV status and clients health. No cosmetic dental services will be approved.	Client's file includes: <ul style="list-style-type: none"> • Documentation of compliance
Standard 4	Measure
4. Clients will be served in the order listed below: (☆4) <ol style="list-style-type: none"> 1. Clients who have initiated but not completed treatment, from an approved dental treatment plan, at the end of the previous grant year. 2. Clients currently on a waiting list. (In the order they were added). 3. First come, first served until funding is exhausted; at that time a waiting list will be established. 	Discussion with provider, including system used to meet this standard
Standard 5	Measure
5. A file must be maintained on each client receiving services funded by Ryan White, Part B. The file is to be located at the dental subcontractor's office. Included in the file must be a copy of the <input type="checkbox"/> Patient Eligibility Form/PH-3463, a copy of the paid invoice (HCFA-1500).	Client's file includes: <ul style="list-style-type: none"> • Documentation of Eligibility form • Documentation of paid invoice

OUTPATIENT MEDICAL CARE

A. DEFINITION:

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

B. PURPOSE:

The purpose of outpatient medical care is to address the medical and treatment needs of persons who are HIV+ in order to improve health outcomes.

C. ELIGIBILITY:

D. INTAKE AND SCREENING: Completed according to generally accepted medical practice standards and state requirements.

E. ASSESSMENT: Completed according to generally accepted medical practice standards and state requirements.

F. REASSESSMENT: Completed according to generally accepted medical practice standards and state requirements.

G. PLAN OF CARE: Completed according to generally accepted medical practice standards and state requirements.

H. MONITORING: Completed according to generally accepted medical practice standards and state requirements.

I. TERMINATION: Completed according to generally accepted medical practice standards and state requirements.

J. DOCUMENTATION: Completed according to generally accepted medical practice standards and state requirements.

K. STAFF REQUIREMENTS

According to generally accepted medical practice standards and state requirements.

▶ **SUPERVISION: According to generally accepted medical practice standards and state requirements.**

▶ **TRAINING: According to generally accepted medical practice standards and state requirements.**

L. MISC. REQUIREMENTS:

1. **Providers are required to use the latest version of United States Public Health Service (PHS) guidelines. (☆1)**
2. **Providers must demonstrate strong linkages with Part B funded providers, including Medical Care Management.**

M. UNITS OF SERVICE FOR REPORTING:

Units of service need to be reported by the number of individual contacts according to CPT codes.

Outpatient Medical Care

Standard 1	Measure
Providers are required to use the latest version of United States Public Health Service (PHS) guidelines.	Refer to Outpatient Monitoring Tool completed by MPHD
Providers must demonstrate strong linkages with Part B funded providers, including Medical Case Management and Early Intervention Service providers	Agency documentation of MOUs w/ Medical Case Management and EIS agencies

SUBSTANCE ABUSE SERVICES-OUTPATIENT

A. DEFINITION:

Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel. This includes but is not limited to psychiatrists, psychologists, licensed clinical social workers and licensed alcohol and drug abuse counselors.

This service provides clients with HIV/AIDS regular, ongoing alcohol and drug/ substance abuse monitoring and counseling on an individual and group basis in a state licensed outpatient setting or by a licensed practitioner. This does not include case management services or time spent in therapy discussing case management issues such as TennCare/disability eligibility, housing, resource identification and/or referral, financial concerns, transportation, and other community level service needs. (*Tennessee Department of Health, Ryan White Medical Services, Fee Schedule*).

Services may be delivered to non-HIV family members (as defined by the client and/or Tennessee Department of Health, AIDS Support Services guidelines).

B. PURPOSE:

The purpose of substance abuse outpatient services is to address and stabilize substance abuse issues so that a person is able to engage in and maintain participation in HIV medical care.

C. ELIGIBILITY:

D. INTAKE AND SCREENING:

Each client must participate in an initial intake and screening procedure. The purpose of the intake and screening will be to assist in obtaining client baseline data to be used in determining eligibility and potential needs.

0940-5-43-.03 POLICIES AND PROCEDURES

The facility must maintain a written policy and procedure manual which includes the following:

- a. A description of the intake.....process;

AND

I. ELEMENTS

1. The intake procedures are performed using the process approved by the program.
2. The intake process indicates appropriate identification of potential client needs and reflects demographic information needed by the program.
3. The intake process indicates appropriate eligibility for the program. The intake process includes but is not limited to:
 - a. Date of intake
 - b. Ryan White Face Sheets demographic and statistical information
 - c. HIV /AIDS diagnosis and if appropriate, other medical diagnosis
 - d. Client or guardian signature of authorization
4. Intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.
5. Intake process is authorized by the client.
6. The intake process includes the mechanisms to gather at the time of intake and/or secure within an

appropriate time, all needed documentation verifying service eligibility as described in universal standards of care and as described in each service area.

7. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include of statement acknowledging client awareness of services, limitations, Client Rights and Responsibilities and grievance procedures.
 - a. If the client is unable to sign agreement, there needs to be written documentation of the reasons why not and mechanism to later secure needed signature(s).
8. A record of the intake process must be kept and if determined eligible, a client file is created.

E. ASSESSMENT:

After each client is determined eligible for the program, particular client needs for this service must be assessed prior to the initiation of the service. The assessment must include gathering information specific to this service including client stated need, reasons for need, relevant history, client resources and access to alternative resources.

POLICIES AND PROCEDURES.

- (1) The facility must maintain a written policy and procedure manual which includes the following:
 - b. A description of the assessment.....process;

SERVICE RECIPIENT ASSESSMENT REQUIREMENTS.

- (1) The facility must document that the following assessments are completed prior to development of the Individual Program Plan (IPP); re-admission assessments must document the following information from the date of last service:
 - a. Assessment of current functioning according to presenting problem, including history of the presenting problem;
 - b. Basic medical history, including drug usage, a determination of the necessity of a medical evaluation, and a copy, where applicable, of the results of the medical evaluation;
 - c. Screening to identify service recipients who are at high risk for infection with TB according to TB Guidelines, including documentation of the service recipient's risk level, and, if applicable, a tuberculin skin test or equivalent, the results of the tuberculin skin test, the date and result of a chest x-ray, and any drug treatment for TB;
 - d. Assessment information, including employment and educational skills; financial status; emotional and psychological health; social, family, and peer interaction; physical health; legal issues; community living skills and housing needs; and the impact of alcohol and/or drug abuse or dependency in each area of the service recipient's life functioning; and
 - e. A six (6) month history of prescribed medications, over-the-counter medications used frequently, and alcohol or other drugs, including patterns of specific usage for the past thirty (30) days.

F. REASSESSMENT:

Re-assessment is an on-going process that may occur throughout the process of receiving this service. At least once annually the client must complete a re-assessment including enrollment and eligibility, formal assessment of the client's need for this service and review/update of the care plan. The purpose of the reassessment is to address the issues noted during the monitoring phase.

Reassessment must occur at the time the IPP monitoring.

I. ELEMENTS

1. Updating signatures and or documentation from Intake and Screen to include confidential releases, eligibility requirements and contractual agreements per stated standards
2. Updating assessment per stated standards.

3. Updating/revising written plan of care per stated standards.
4. Communication with client regarding services
5. Entries in the written plan of care
6. Client acknowledgement of changes resulting from the reassessment

G. PLAN OF CARE:

A written Plan of Care must be developed prior to the initiation of services and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. As appropriate, the written plan may also serve as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable.

0940-5-43-.06 INDIVIDUAL PROGRAM PLAN REQUIREMENTS.

- (1) An Individual Program Plan (IPP) must be developed and documented for each service recipient within thirty (30) days of admission or by the end of the third face-to-face treatment contact with qualified alcohol and drug abuse personnel, whichever occurs first, and must include:
 - a. The service recipient's name;
 - b. The date of the IPP's development;
 - c. Standardized diagnostic formulation(s) including, but not limited to, the current Diagnostic and Statistical Manual (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD), and ASAM PPC;
 - d. Specified service recipient problems which are to be addressed within the particular service/program component;
 - e. Service recipient goals which are related to specified problems and which are to be addressed within the particular service/program component;
 - f. Interventions addressing goals;
 - g. Planned frequency of contact;
 - h. Signatures of appropriate staff; and
 - i. Documentation of the service recipient's participation in the treatment planning process.

H. MONITORING:

Monitoring is an ongoing process. The purpose of this stage is to observe the progress of the plan of care in order to make revisions to improve the effectiveness of services rendered.

INDIVIDUAL PROGRAM PLAN MONITORING.

- (1) Progress notes which include written documentation of progress or changes occurring within the IPP must be made in the individual service recipient record for each treatment contact.
- (2) The facility must review and, if indicated, revise the IPP at least every ninety (90) days. The revision shall document any of the following which apply:
 - a. Change in goals and objectives based upon service recipient's documented progress or identification of any new problems;
 - b. Change in primary counselor assignment;
 - c. Change in frequency and types of services provided; and
 - d. A statement documenting review and explanation if no changes are made in the IPP.

I. TERMINATION

Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or service staff. Medical Care Manager.

I. ELEMENTS

1. Conditions which result in a client's termination from services may include:
 - a. Attainment of goals
 - b. Non-compliance with stipulations of written plan
 - c. Change in status which results in program ineligibility
 - d. Client desire to terminate services
 - e. Death
2. Client must have the right to access an articulated appeal process when services are terminated; as can be found in the agency's written Grievance Policy.
3. Client must be afforded information regarding transfer to an outside agency.

J. DOCUMENTATION:

Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.

SERVICE RECIPIENT RECORD REQUIREMENTS.

- (4) The individual service recipient record must include the following:
 - a. Documentation of all drugs prescribed or administered to the service recipient as part of the plan of care indicating the date prescribed, type, dosage, frequency, amount, and reason;
 - b. Narrative summary review at least every ninety (90) days of all medications prescribed which includes specific reasons for prescribing and continuation of each medication;
 - c. A discharge summary which states the date of discharge, reasons for discharge, and referral for other services, if appropriate;
 - d. An aftercare plan which specifies the type of contact, planned frequency of contact, and responsible staff; or documentation that the service recipient was offered aftercare but decided not to participate; or documentation that the service recipient dropped out of treatment and is therefore not available for aftercare planning; or verification that the service recipient is admitted for further alcohol and drug treatment services; and
 - e. Documentation of any instance of restraint or restriction with documented justification and authorization.

AND

INDIVIDUAL CLIENT RECORD REQUIREMENTS FOR ALL FACILITIES. The governing body must ensure that an individual client record is maintained for each client being served which minimally include the following information:

- l. The name of the client;
- m. The address of the client;
- n. The telephone number of the client;
- o. The sex of the client;
- p. The date of the client's birth;

- q. The date of the client's admission to the facility;
- r. The source of the client's referral to the facility;
- s. The name, address, and telephone number of an emergency contact person;
- t. If the facility charges fees for its services, a written fee agreement dated and signed by the client (or the client's legal representative) prior to provision of any services other than emergency services. This agreement must include at least the following information;
 - 1. The fee or fees to be paid by the client;
 - 2. The services covered by such fees, and
 - 3. Any additional charges for services not covered by the basic service fee;
- u. Appropriate informed, signed, and dated consent and authorization forms for the release or obtainment of information about the client; and
- v. Documentation that the client or someone acting on behalf of the client has been informed of the client's rights and responsibilities and of the facility's general rules affecting client.

AND

I. ELEMENTS

1. Supporting documentation guidelines must be developed and maintained. Service providers/agencies must have written documentation standards and/or policies and procedures.
2. Service providers /agencies standards and/or policies and procedures must be consistent with all applicable laws, standards and or requirements. (HRSA, local, state and federal entities)
3. Documentation requirements from each section as outlined above (i.e., intake/screening, assessment, reassessment, plan of care, monitoring and termination).

K. STAFF REQUIREMENTS:

PERSONNEL AND STAFFING REQUIREMENTS.

- (1) Direct treatment and/or rehabilitation services must be provided by qualified alcohol and drug abuse personnel.
- (2) A physician must be employed or retained by written agreement to serve as medical consultant to the program.

▶ SUPERVISION:

▶ TRAINING:

PERSONNEL AND STAFFING REQUIREMENTS.

- (4) The facility must provide STD/HIV education to all direct care staff.

AND

PERSONNEL REQUIREMENTS FOR ALL FACILITIES.

- (3) Training and development activities which are appropriate in assisting the staff in meeting the needs of the clients being served must be provided for each staff member. The provision of such activities must be evidenced by documentation in the facility records.

AND

Providers must demonstrate knowledge of HIV/AIDS, its psychosocial dynamics and implications as well as substance abuse, including cognitive impairment and generally accepted treatment modalities and practices

L. MISC. REQUIREMENTS:

APPLICATION OF RULES.

- (1) The governing body of alcohol and drug non-residential rehabilitation treatment facilities must provide services and facilities which comply with the following rules:
 - a. Chapter 0940-5-4-.04(2) Life Safety Business Occupancies rule;
 - b. Chapter 0940-5-5 Adequacy of Facility Environment and Ancillary Services;
 - c. Chapter 0940-5-6 Minimum Program Requirements for All Facilities;
 - d. Chapter 0940-5-43 Minimum Program Requirements for Alcohol and Drug Non-Residential Treatment Facilities; and
 - e. If services are to be provided to one (1) or more mobile non-ambulatory service recipient, Chapter 0940-5-4-.09 Mobile Non-Ambulatory Rule.

AND

Must maintain linkages with one or more residential facilities and appropriate community based programs, and be able to refer or place clients in a residential program, in collaboration with the patient, his/her case manager and primary care physician when that is found to be appropriate.

DEFINITION OF GENERAL TERMS USED IN ALL RULES. As used in Chapters 0940-5-1 through 0940-5-28 of these rules, unless the context indicates otherwise, terms have the following meaning:

(17) Licensed Clinical Psychologist - A psychologist licensed to practice psychology in Tennessee with the certified competency in clinical psychology determined by the State Licensing Board for the Healing Arts and the Board of Examiners in Psychology.

(30) Psychiatrist - A physician who specializes in the assessment and treatment of individuals having psychiatric disorders; is certified by the American Board of Psychiatry and Neurology or has the documented equivalent in education, training and/or experience; and who is fully licensed to practice medicine in the State of Tennessee.

DEFINITIONS

(54) Qualified Alcohol and Other Drug Abuse Personnel - Persons who meet the criteria described in items (a), (b) and (c) as follows:

- a. Currently meet one (1) of the following conditions:
 1. Licensed or certified by the State of Tennessee as a physician, registered nurse, practical nurse, clinical or counseling psychologist, psychological examiner, social worker, alcohol and other drugs of abuse counselor, teacher, professional counselor, or marital and family therapist, or if there is no applicable licensure or certification by the state has a bachelor's degree or above in a behavioral science or human development related area; or
 2. Actively engaged in a recognized course of study or other formal process for meeting criteria of part (1) of item (a) above, and directly supervised by a staff person who meets criteria in part (1) of item (a) above, who is trained and qualified as described in items (b) and (c) below, and who has a minimum of two (2) years experience in his/her area of practice; and
- b. Are qualified by education and/or experience for the specific duties of their position; and
- c. Are trained in alcohol or other drug specific information or skills. (Examples of types of training include, but are not limited to, alcohol or other drug specific in-services, workshops, substance abuse schools, academic coursework and internships, field placement, or residencies).

M. UNITS OF SERVICE FOR REPORTING:

Units of service need to be reported by the number of individual or group contacts. A unit of service is defined as 15 minutes.

Substance Abuse

Standard 1	Measure
Licensure Items	Copy of last state site visit which demonstrates compliance