

CASE MANAGEMENT POLICY

Subject: Emergency Financial Assistance (EFA)

Date: Revised August 16, 2005

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PURPOSE:

To set a minimum requirement for the Emergency Financial Assistance program for AFC funded case managers.

POLICY:

The AIDS Foundation of Chicago receives funding through Title I of the Ryan White CARE Act that provides limited emergency assistance for **Low-income persons** (household income is less than 50% of the median household income in the Chicago metropolitan area for their household size (per the official determination of the U.S. Department of Housing and Urban Development) **or** if there is an immediate financial crisis producing a budget deficit with HIV infection in the Chicago eligible metropolitan area. The principal purpose of this emergency assistance is to assist individuals at risk of losing current housing or utilities and those who are homeless and unable to obtain assistance from any other source.

Assistance may be provided one time per year per individual or household in the rent and/or utility assistance category. Assistance will be provided based on the anniversary date of when the client previously received emergency assistance, i.e., if a client received utility assistance on June 1, 2005, they would not be eligible for assistance until June 1, 2006. AFC staff will monitor the amount of usage of emergency funds for clients and if it is believed that clients are utilizing the service as an entitlement, usage may be restricted and the client may be required to sign a contract restricting future non-emergency uses of the funds with the case manager.

Clients receiving HAP and/or LTRS rent subsidies are Not Eligible for Emergency Financial Assistance Funds.

PROCEDURE:

All AFC funded case managers will complete the emergency financial assistance application with clients who are requesting assistance. AFC will accept all 5-day notices of eviction, utility disconnection notices and letters of homelessness from a shelter or housing advocate for proof of emergency. According to the Health Resources and Services Administration (HRSA) EFA funds are to be used as "Payor of Last Resort"; therefore, case managers must submit documentation verifying they and the client have exhausted all other possible resources.

PRIORITY CATEGORIES:

Any client requesting emergency assistance will be assessed by a case manager and AFC program staff to determine his or her eligibility, including the priority category based on the following criteria:

- Category 1 HIV+ and disabled due to HIV
- Category 2 HIV+ and disabled due to any cause
- Category 3 HIV+ and not disabled

Documentation from a primary medical provider must be submitted with the application verifying that the client is "disabled due to HIV" and unable to work full time. Acceptable proof of HIV disability

includes: a letter stating the disability signed by the client's primary medical provider within the last twelve months and/or a health screening form completed by the physician within the last twelve months.

Depending on the amount of emergency assistance funds available to AFC and the number of clients requesting assistance, from time to time, assistance may be limited to category 1 clients or category 1 and 2 clients only. For information on the categories of assistance available at any time contact an AIDS Foundation program staff member.

MAXIMUM LEVELS OF ASSISTANCE FOR RENT AND/OR UTILITIES

Individuals

Rent or utilities (electric, gas and water): \$800

Households

Rent or utilities (electric, gas and water): \$1,200

If applying as a household all adults living in the household unit must submit proof of their income with the application. Minor children, under the age of 18, are not required to provide proof of income.

In some exceptional cases, assistance will be made available to pay for telephone installation and/or local telephone use.

In cases where documented need exceeds the above limits, the case management agency supervisor and AFC program associate will review the individual's circumstances to determine the level of assistance.

DISCRETIONARY ASSISTANCE CATEGORY (ELIGIBLE TO CASE MANAGED CLIENTS ONLY)

Limited funds may also be available for assistance with emergency purchases of food, medications (with physician approval), furniture and other items. *Written proof of emergency will be required with the full application.* AFC will inform agencies when such funds are available and will establish a maximum allocation per agency. Clients will ONLY be eligible for "discretionary assistance" funds when they have not applied or received an EFA grant in the rent and/or utility assistance category in the last year.

Responsibilities of Client/Applicant

1. Clients may request emergency financial assistance (EFA) funds from an agency in the Northeastern Illinois Case Management Cooperative (NIHCMC) or the AIDS Foundation of Chicago.
2. All applicants for emergency assistance must make an application for assistance through a case management agency in the Northeastern Illinois Case Management Cooperative and be enrolled in the central client registry at AFC.

3. Applicants must provide documentation that their household income is less than 50% of the median household income in the Chicago metropolitan area for their household size (per the official determination of the U.S. Department of Housing and Urban Development) **or** that there is an immediate financial crisis producing a budget deficit (such as loss of wages due to unpaid sick leave, temporary unemployment, or excessive medical bills).
4. Applicants must provide case managers with adequate documentation that they are at risk of losing housing or utilities, or that they are homeless. Proof of pending loss or disconnection can include a utility disconnection notice, 5-day notice or a homeless letter from a shelter or housing advocate. HRSA guidelines do not allow payments for mortgages.
5. Applicants must provide case managers with written verification that no other resources (e.g., HAP, FEMA, LIHEAP, Salvation Army, Red Cross, Township Assistance, Emergency Fund for Needy People) are available to pay for emergency needs.

Responsibilities of Agency/Case Manager

1. The case manager or agency designee will screen applications for eligibility and priority category. If the applicant is not a case managed client, he/she should be offered case management services or referred to AFC or another agency in the Cooperative, regardless of his/her eligibility for EFA.
2. If the client meets the eligibility criteria and priority category but does not wish to enroll in case management services, the case manager should complete an EFA application, including the EFA intake form and with the verifying documentation, present the case to the supervisor or designated agency administrator for on-site approval.
3. The case manager or agency designee will obtain approval and an authorization number from an AFC Program associate.
4. Emergency assistance payments for case managed clients must also be addressed in a timely manner and emergency assistance payments made within 5 working days. Emergency payments for non-case managed clients must also be addressed in a timely manner and payments made within 7 to 10 working days.
5. No payments will be made directly to the applicant/client; all payments will be made directly to a third party/vendor. The agency must have documentation on file (such as receipts) that funds were used for the purpose intended.
6. The agency will submit the request for reimbursement along with documentation of the disbursement and the AFC authorization number within 5 working days of expenditure of funds.
7. Clients who are dissatisfied with the process or results of their application for emergency assistance will be provided the name and number of a contact person at the agency and AFC.

Responsibilities of The AIDS Foundation of Chicago

1. The AIDS Foundation of Chicago will screen non-case managed applicants who contact AFC directly to determine if they meet the eligibility criteria and priority category. All applicants will be advised that they may be eligible to receive case management services regardless of their eligibility for EFA.
2. If the client meets all of the eligibility criteria, AFC will refer them to a NIHCMC agency to complete an EFA intake and application.
3. AFC will maintain and update the client central registry of currently case managed clients as a means of ensuring timely approval of requests.
4. AFC will provide the agency with an authorization number for all approved requests.
5. AFC will provide the agency with a verbal and, in some cases, written explanation for any requests not approved.
6. AFC will process any and all approved reimbursement requests with adequate documentation in a reasonable and timely manner.
7. AFC will notify funded agencies if and when all available emergency financial assistance funds have been expended and/or if eligibility will be temporarily limited to certain categories.
8. AFC will accept all 5-day notices of eviction, utility shut-off notices and letters of homelessness from a shelter, transitional housing program and or a housing advocate.

FORMS:

Emergency Financial Assistance Application

Payor of Last Resort Checklist

AIDS FOUNDATION OF CHICAGO
Northeastern Illinois HIV/AIDS Case Management Cooperative

**AIDS FOUNDATION OF CHICAGO
BUDGET FORM FOR EMERGENCY ASSISTANCE**

Client Name _____ Date _____ Completed by _____

I. HOUSEHOLD INCOME	PRESENT INCOME	POTENTIAL INCOME
Earned income	_____	_____
SSI/SSDI	_____	_____
Public Aid	_____	_____
Unemployment Compensation	_____	_____
Food stamps	_____	_____
Child support	_____	_____
Other	_____	_____
TOTAL	_____	_____

CURRENT LIQUID ASSETS

Savings	_____	_____
Checking	_____	_____
Cash	_____	_____
Life Insurance Policy	_____	_____
Other	_____	_____
TOTAL	_____	_____

II. EXPENSES CURRENT OLD DEBT PRESENT EXPENSES BUDGETED EXPENSES

Rent/mortgage	_____	_____	_____
Electric	_____	_____	_____
Gas	_____	_____	_____
Water	_____	_____	_____
Sewer	_____	_____	_____
Phone	_____	_____	_____
Transportation	_____	_____	_____
Food & Personal	_____	_____	_____
Cleaning/laundry	_____	_____	_____
Recreation	_____	_____	_____
Day care	_____	_____	_____
Car payment	_____	_____	_____
Car insurance	_____	_____	_____
Medical/insurance	_____	_____	_____
Other _____	_____	_____	_____
Totals:	_____	_____	_____

III. BUDGET DEFICIT = ACCUMULATED CURRENT EXPECTED

IV. FINANCIAL SERVICE PLAN (address what steps will be taken to remove debt, address budget deficit, maximize income, etc. - use back, if necessary) _____

Category (Check one)

- ' Category 1 HIV+ and disabled due to HIV
- ' Category 2 HIV+ and disabled due to any cause
- ' Category 3 HIV+ and not disabled

**AIDS FOUNDATION OF CHICAGO
EMERGENCY CLIENT ASSISTANCE REQUEST**

Fill one of these out for **each** request for assistance.

CLIENT REQUEST FOR ASSISTANCE

I am asking the AIDS Foundation of Chicago to help pay my bills. I need \$_____ to pay for: _____ . The payment must be made no later than _____ . The reason I cannot pay for this myself is that I have insufficient funds as I have documented on the attached budget sheet.

I give you permission to send the check directly to the person or company I owe money and to ask for a receipt. (initial or sign here) _____

The information I have given you about my income, my expenses, my savings and my household is true. I understand that in signing this application and requesting this assistance, my name will be placed in AFC's Northeastern Illinois HIV/AIDS Case Management Cooperative Central Registry.

I understand that the Emergency Financial Assistance program is not an entitlement program and that I am not guaranteed to receive assistance every year. I further understand that if I have utilized these funds on a yearly- basis in the past, I may be asked to sign a contract with my case manager agreeing not to re-apply for a designated period of time.

MY SIGNATURE _____

MY PRINTED NAME _____

MY ADDRESS _____

MY PHONE NUMBER _____

MY SOCIAL SECURITY NUMBER _____

MY DATE OF BIRTH _____

TODAY'S DATE _____

ECA Application Checklist: (make sure all of these are included with the application)

- ' ECA Application Page 1-
- ' ECA Application Page 2 (for rent requests, include follow-up housing plan)
- ' ECA Budget Form
- ' ECA Client Request for Assistance Form
- ' ECA Agency Reimbursement Form
- ' Documentation of emergency: (5-day notice, disconnection, homeless letter)
- ' Proof of HIV disability
- ' Proof of income

**FUNDACION DE SIDA DE CHICAGO
SOLICITUD DE ASISTENCIA DE EMERGENCIA**

Llene una de estas aplicaciones por cada solicitud de emergencia.

SOLICITUD DE ASISTENCIA DE EMERGENCIA

Estoy pidiendo a la Fundación de SIDA de Chicago ayuda para pagar gastos de emergencia. Necesito \$_____ para pagar _____. El pago debe hacerse a más tardar _____. La razón por la que no puedo pagar esta cuenta yo mismo, es porque no tengo suficientes ingresos, tal y como ha sido documentado en el presupuesto adjunto.

Yo autorizo que el pago se envíe directamente a la persona o compañía a quien le debo el dinero y a solicitar un recibo/comprobante de pago. (Ponga sus iniciales o firma aquí) _____

La información que he proveído acerca de mis ingresos, mis gastos, mis ahorros y mi familia es correcta. Entiendo que al firmar y solicitar esta asistencia, mi nombre será incluido en el archivo de la Cooperativa de manejo de caso de la Fundación de SIDA de Chicago para facilitar las funciones administrativas.

Yo entiendo que el programa de Asistencia Financiera de Emergencia no es un programa de derecho adquirido y por lo tanto no esta garantizado que reciba esta asistencia cada año. Yo entiendo además que si en el pasado he usado estos fondos de emergencia en exceso, se me podría solicitar firmar un contrato con mi manejador de caso, en el que estoy de acuerdo en no reapplicar por un determinado periodo de tiempo.

FIRMA _____

NOMBRE _____

DIRECCION _____

NUMERO DE TELEFONO _____

NUMERO DE SEGURO SOCIAL _____

FECHA DE NACIMIENTO _____

FECHA _____

ECA- Lista de documentos: (Por favor incluya todas estas formas con su aplicación)

- ' Aplicación de Asistencia de Emergencia-Pagina 1
- ' Aplicación de Asistencia de Emergencia-Pagina 2 (Para solicitud de renta, incluya su plan de Vivienda)
- ' Presupuesto
- ' Forma de Solicitud de Asistencia
- ' Forma de Reembolso
- ' Documentación de emergencia: (forma de desalojo notariada, desconexión, carta de refugio)
- ' Prueba del estado medico
- ' Prueba de ingresos

**AIDS FOUNDATION OF CHICAGO
NORTHEASTERN ILLINOIS HIV/AIDS CASE MANAGEMENT COOPERATIVE
EMERGENCY CLIENT ASSISTANCE INTAKE FORM**

APPLICATION DATE: _____ / _____ / _____ CLIENT ID #: _____
 AGENCY: _____ CASE MANAGER: _____

REFERRAL SOURCE:	PHONE #: () _____
AFFILIATION:	

LAST NAME: _____ **FIRST:** _____ **MI:** _____
DOB: ____/____/____ **GENDER:** M ____ F _____ **PHONE:** () _____
ADDRESS: _____ **CITY:** _____ **COUNTY:** _____ **ZIP:** _____
SS#: _____ - _____ - _____ **MOTHER'S MAIDEN NAME:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____
PHONE: () _____
IS EMERGENCY CONTACT AWARE OF DIAGNOSIS? YES NO (please circle one)

--CHECK ONLY ONE IN EACH OF THE FOLLOWING CATEGORIES--
 --SHADED AREAS ARE FOR **NON-CASE MANAGED** CLIENTS ONLY.--

INCOME SOURCE (CHECK ALL THAT APPLY) YES _____ NO _____ EMPLOYMENT _____ TANF _____ FOOD STAMPS _____ SSI _____ SSDI _____ UNEMPL COMP _____ WORKERS COMP _____ CASE # _____ NO ENTITLEMENTS _____ OTHER _____	ETHNICITY: Hispanic/Latino/a Yes _____ No _____ Mexican _____ Puerto Rican _____ Other Hispanic _____ RACE: WHITE _____ BLACK/AFRICAN AMERICAN _____ ASIAN _____ HAWAIIAN/PACIFIC ISLANDER _____ AMERICAN INDIAN _____ MORE THAN ONE RACE _____ UNKNOWN _____	SEROSTATUS: AIDS DIAGNOSIS _____ HIV+/ NOT AIDS _____ HIV+/ AIDS UNKNOWN _____ HIV NEGATIVE _____ UNKNOWN _____	RISK FACTOR: HOMOSEXUAL/BISEXUAL _____ IDU _____ HOMOSEXUAL/IDU _____ HETEROSEXUAL _____ TRANSFUSION _____ HEMOPHILIA _____ PARENT HIV+ _____ UNKNOWN _____	MONTHLY HOUSEHOLD INCOME \$ _____ TOTAL NUMBER OF INDIVIDUALS IN HOUSEHOLD (ATTACH PROOF OF INCOME)
INSURANCE SOURCE: PRIVATE _____ MEDICAID _____ MEDICARE _____ OTHER PUBLIC _____ MORE THAN ONE _____ NONE _____ CO. _____ GROUP ID# _____ IND. ID# _____	PRIMARY CARE SOURCE: PRIVATE PRACTICE _____ HMO _____ COMMUNITY HEALTH CTR. _____ HOSPITAL CLINIC _____ OTHER CLINIC _____ EMERGENCY ROOM _____ OTHER _____ NONE _____	LIVING ARRANGEMENT: PERMANENT HOUSING _____ NON-PERMANENT HOUSING _____ INSTITUTIONALIZED _____ OTHER _____ UNKNOWN _____	SOURCE OF REFERRAL: CASE MANAGER _____ COURT SYSTEM _____ DCFS _____ FAMILY & FRIENDS _____ HIV COUNSELING _____ AND TESTING SITES _____ HOTLINE _____ MEDIA _____ OTHER AGENCY _____ OTHER UNIT IN PROVIDER AGENCY _____ PRIMARY CARE PROVIDERS _____ STD CLINICS _____ SELF-REFERRAL _____	RENTAL ASSISTANCE: <input type="checkbox"/> I certify that the emergency rental/housing assistance for this client will help to provide access to direct medical or support services, including, but not limited to, residential substance abuse or mental health services. AND/OR <input type="checkbox"/> I certify that emergency rental/housing assistance is transitional in nature and is for the purpose of moving or maintaining an individual or family into a long-term, independent living situation.

**AIDS FOUNDATION OF CHICAGO
NORTHEASTERN ILLINOIS HIV/AIDS CASE MANGAEMENT COOPERATIVE
EMERGENCY FINANCIAL ASSISTANCE “PAYOR OF LAST RESORT” CHECKLIST**

<u>Name of Agency</u>	<u>Date Contacted</u>	<u>Outcome (If not applicable please state)</u>
Salvation Army	_____	_____
American Red Cross	_____	_____
Township General Assistance	_____	_____
Emergency Fund for Needy People	_____	_____
FEMA Funds	_____	_____
LIHEAP	_____	_____
Other _____	_____	_____

I verify that the above information is accurate and that I have tried every resource possible before submitting this application with my case manager.

Case Manager Name: _____ Case Manager Signature: _____

Date: _____

Client Name: _____ Client Signature: _____

Date: _____

Additional Case Manager Comments: _____

Client Name _____

Please complete service plan indicating types of assistance/referrals that can be made through case management services.

REFERRALS NEEDED				
SERVICE/NEED	YES*	NO*	SERVICE REQUESTED	CASE MANAGER COMMENTS
ALTERNATIVE THERAPIES			Y / N	
CASE MANAGEMENT			Y / N	
DAY & RESPITE CARE			Y / N	
DENTAL CARE			Y / N	
DIRECT EMERGENCY ASSISTANCE			Y / N	
DRUG REIMBURSEMENT PROGRAM			Y / N	
ENTITLEMENTS			Y / N	
FAMILY ISSUES			Y / N	
FOOD SERVICE			Y / N	
HOME HEALTH CARE			Y / N	
HOSPICE CARE			Y / N	
HOUSING SERVICE/RESIDENTIAL CARE			Y / N	
<input type="checkbox"/> Shelter Plus Care Program				
<input type="checkbox"/> Affordable Housing Search				
<input type="checkbox"/> Independent Living Program				
<input type="checkbox"/> Referral to Housing Advocate				
<input type="checkbox"/> Employment Assistance				
<input type="checkbox"/> Home Purchasing Program				
<input type="checkbox"/> Public/Assisted Housing				
<input type="checkbox"/> Section 8				
HOUSING SERVICE/RENT SUBSIDIES			Y / N	
<input type="checkbox"/> HAP Program				
INFORMATION DISSEMINATION			Y / N	
INPATIENT CARE			Y / N	
LEGAL SERVICES/ADVOCACY			Y / N	
MENTAL HEALTH SERVICES			Y / N	
PRIMARY CARE			Y / N	
SUBSTANCE ABUSE			Y / N	
TRANSPORTATION			Y / N	
VOCATIONAL/EMPLOYMENT			Y / N	
VOLUNTEER SERVICES			Y / N	

* Columns indicate whether the client indicates a need exists. "Service requested" column reflects the desire a client has to address the need indicated with services