ILLINOIS Department of Public Health

Ryan White Part B Program

AFFIDAVIT OF NO INSURANCE COVERAGE

Client First Name	Middle Initial	Client Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)

The Ryan White Part B Program is required to ensure that the program is the "Payer of Last Resort" for all services it provides. The implementation of the Affordable Care Act has increased access to some form of insurance coverage for all individuals. To ensure compliance with the federal payer of last resort requirements, all program participants that are eligible for insurance coverage through the areas identified below are **required** to enroll in said coverage when available.

There are a variety of options that program participants may qualify for. These options include traditional Medicaid, expanded Medicaid/Managed Care Plans, Medicare, and private insurance including employer based plans, Illinois Insurance Marketplace plans, and private insurance plans outside the marketplace.

If you have any questions, please contact your case manager or local Lead Agent to find the Medical Benefits Coordinator in your area (see back of document for contact listing).

By signing this affidavit, I acknowledge and understand the statements below and agree to comply with any requirement identified herein.

- I understand that I am required to enroll in health coverage through one of the ways listed above, to satisfy federal payer of last resort requirements.
- I understand that failure to meet this requirement could jeopardize my future enrollments due to cost saving requirements.
- I understand that the Illinois Ryan White Part B Program can assist me with the costs of my premiums for any insurance plan that qualifies for this service (see back side of document). If my insurance plan does not meet these requirements, I will be unable to receive this service from the program.
- I understand that if I am categorically ineligible for coverage through the Illinois Insurance Marketplace or exempt under the Affordable Care Act (eligible for Veterans Benefits or a person of American Indian heritage), I still have insurance coverage options available to me and that these options are outlined above.
- I understand that if I am eligible for Medicare coverage but am not enrolled I will incur additional **LIFETIME** penalties for **EACH YEAR** I do not enroll.
- I understand that I will be required to complete and submit this affidavit at every eligibility determination until I obtain eligible insurance coverage.

Client Signature (age 12 and older) **Date**

AFFIDAVIT OF NO INSURANCE COVERAGE

Plan requirements to qualify for Premium Assistance (not to exceed a combined total of $750/month):

1. The Illinois Department of Public Health must be able to pay the insurance company directly.
   a. Your premiums cannot be auto deducted from pay checks, Social Security checks, bank account, credit cards, etc.
   b. You will not be reimbursed for any premium payments you make.
   c. The insurance company must accept 3rd party payments.
2. Your insurance plan must have prescription coverage included.
   a. Plan can also have Dental and/or Vision coverage.
   b. We cannot pay for life insurance portions of plans
3. Your insurance plan must allow CVS Specialty Pharmacy's Mail Order program to fill your prescriptions.
4. Your insurance plan's medication formulary must be representative of the IL Ryan White Part B Program formulary.
5. Medicare Part A or Part B plans are not eligible for assistance.
6. When selecting an insurance plan through the Illinois Insurance Marketplace you must:
   a. Elect to receive any premium tax credit available through the "Advance Premium Tax Credit" option and provide documentation that this option was elected.
   b. Choose only SILVER level plans from one of the approved insurance providers. Information on the approved insurance providers can be found at https://iladap.providecm.net/.

To obtain assistance from your local Medical Benefit Coordinator, contact your case manager or your regional Lead Agent:

SIU School of Medicine - Springfield: 217-545-7683

Champaign Urbana Public Health District: 217-531-5365

UIC College of Medicine Peoria: 309-671-8418

AFC – Chicago and Collar Counties: 312-784-9060

Winnebago County Health Department – Rockford: 815-720-4071

Jackson County Health Department - Murphysboro: 618-684-3143

St. Clair County Health Department – Belleville: 618-233-7703

Please feel free to give us a call if you have any questions.
Contact us at 800-825-3518 if you have questions or concerns about this process.
The Department wide TTY number is 800-547-0466 (for hearing impaired only).

ILLINOIS Department of Public Health

Ryan White Part B Program

DECLARACION DE NO COBERTURA DE SEGURO

Primer Nombre del Cliente	Inicial del 2do nombre	Apellido del Cliente

Número de Seguro Social (Dejar en blanco si el cliente no tiene un número de Seguro Social valido)	Fecha de Nacimiento (mm/dd/aaaa)

El Programa Ryan White Parte B está obligado a garantizar que el programa sea el "Pagador de último recurso" para todos los servicios que brinda. La implementación de la Ley del Cuidado de Salud a Bajo Costo, ha aumentado el acceso a algún tipo de cobertura de seguro para todas las personas. Para garantizar el cumplimiento con los requisitos federales de “pagador de último recurso”, todos los participantes del programa que sean elegibles para la cobertura de seguro a través de las áreas identificadas a continuación **deben** de registrarse en dicha cobertura cuando esté disponible.

Hay una variedad de opciones a las que los participantes del programa pueden calificar. Estas opciones incluyen Medicaid tradicional, planes ampliados de Medicaid / atención administrada, Medicare y seguros privados, incluyendo los planes ofrecidos por el empleador, los planes del Mercado de seguros de Illinois y los planes de seguros privados fuera del mercado.

Si tiene alguna pregunta, comuníquese con su administrador de casos o con su agente principal local para encontrar al Coordinador de beneficios médicos en su área (vea la parte posterior del documento para obtener una lista de contactos).

Al firmar esta declaración jurada, reconozco y comprendo lo indicado a continuación y acepto cumplir con cualquier requisito aquí identificado.

- Entiendo que estoy obligado a registrarme en una de las coberturas de salud enumeradas anteriormente, para cumplir con los requisitos federales de pagador de último recurso.
- Entiendo que el incumplimiento de este requisito podría poner en peligro mis futuras aplicaciones debido a los requisitos de ahorro de costos.
- Entiendo que el Programa Ryan White Parte B de Illinois puede ayudarme con los costos de las primas del plan de seguro que califique para este servicio (vea el reverso del documento). Si mi plan de seguro no cumple con estos requisitos, no podré recibir este servicio del programa.
- Entiendo que de ser categóricamente inelegible para la cobertura a través del Mercado de Seguros de Illinois o estoy exento bajo la Ley del Cuidado de Salud a Bajo Costo (elegible para Beneficios de Veteranos o una persona de herencia india americana), aún tengo opciones de cobertura de seguro disponibles para mí y que estas opciones se encuentran detalladas anteriormente.
- Entiendo que si soy elegible para la cobertura de Medicare, pero no me he registrado, incurriré en multas de **POR VIDA** por **CADA AÑO** que no me registre.
- Entiendo que se me pedirá que complete y presente esta declaración jurada en cada aplicación al Programa hasta que obtenga la cobertura de seguro elegible.

Firma del Cliente (Igual o mayor a 12 años de edad) **Fecha**

DECLARACION DE NO COBERTURA DE SEGURO

Requisitos del plan para calificar a la Asistencia de Pago de Seguro (que no exceda un total combinado de $ 750 por mes:

1. El Departamento de Salud Pública de Illinois debe poder pagar directamente a la compañía de seguros.
    a. Sus primas no pueden ser deducidas automáticamente de cheques de pago, cheques del Seguro Social, cuenta bancaria, tarjetas de crédito, etc.
    b. No se le reembolsarán los pagos de primas que usted realice.
    c. La compañía de seguros debe aceptar pagos de terceros.
2. Su plan de seguro debe tener cobertura de prescripción incluida.
    a. El plan también puede tener cobertura dental y / o de visual.
    b. El programa no puede pagar la parte del "seguro de vida" del plan.
3. Su plan de seguro debe permitir que la "Farmacia de Pedidos por correo de CVS Specialty" procese sus recetas.
4. El formulario de medicamentos de su plan de seguro debe ser representativo del formulario del Programa Ryan White Parte B de Illinois.
5. Los planes de Medicare Parte A o Parte B no son elegibles para asistencia.
6. Al seleccionar un plan de seguro a través del mercado de seguros de Illinois, usted debe de:
    a. Elegir recibir cualquier crédito fiscal de prima disponible a través de la opción "Crédito fiscal anticipado de prima" y proporcione documentación de que esta opción fue elegida.
    b. Elija solo los planes de nivel PLATA de uno de los proveedores de seguros aprobados. La información sobre los proveedores de seguros aprobados se puede encontrar en https://iladap.providecm.net/.

Para obtener ayuda de su Coordinador de beneficios médicos local, comuníquese con su administrador de casos o con su agente principal regional:

SIU Escuela de Medicina - Springfield: 217-545-7683

Distrito de Salud Pública de Champaign Urbana: 217-531-5365

UIC Escuela de Medicina - Peoria: 309-671-8418

AFC – Chicago y condados alrededor: 312-784-9060

Departamento de Salud del Condado de Winnebago – Rockford: 815-720-4071

Departamento de Salud del Condado de Jackson - Murphysboro: 618-684-3143

Departamento de Salud del Condado de St. Clair – Belleville: 618-233-7703

Por favor, no dude en llamarnos si tiene alguna pregunta.
Contáctenos al 800-825-3518 Si tiene preguntas o inquietudes sobre este proceso.
El número TTY del Departamento es 800-547-0466 (sólo para personas con problemas de audición).

Appendix 2. Invoice Template

AFC INVOICE TEMPLATE

BILL TO:
AIDS Foundation of Chicago
200 W. Jackson Blvd. Suite 2200
Chicago, IL 60606

INVOICE NUMBER AFC _____
INVOICE DATE Date _____
BILLING AGENT Name _____

INVOICED TO
RWID# _____

# OF UNITS	SERVICE PROVIDED	UNIT COST	AMOUNT
		SUBTOTAL	
			Pay This Amount

Appendix 3. Sample Linkage Agreement

Memorandum of Agreement

_____
Partner Organization

AND

_____
Partner Organization

Mission:

The mission of _____ (Agency Name) is to identify individuals newly diagnosed with HIV or HIV positive individuals who are not currently engaged in primary medical care for HIV treatment and link them into appropriate HIV care.

Partner Organization Mission:

_____
_____
_____

Scope

The goal of this relationship is to coordinate activities and collaborate to link HIV+ patients to medical care, and support them to remain in care. All parties are bound by the Illinois AIDS Confidentiality Act requirements regarding the release of an individual's HIV information, and HIPAA requirements regarding the release of personal identifying health information. The purpose of this project is to increase patient understanding of the benefits of being in treatment for HIV, while supporting individual choices about providers and treatment decisions.

Appendix 3. Sample Linkage Agreement

Responsibilities

Staff Governed by this MOA:

Agency _____:

Name: _____
Title: _____
Address: _____
Telephone: _____
E-mail Address: _____

Contact Information for Partner Organization Staff Governed by this MOA:

Name: _____
Title: _____
Address: _____
Telephone: _____
E-mail Address: _____

The organizations agree to the following tasks for this MOA (edit as necessary):

_____ (Agency) agrees to:

1. Provide outreach and referrals for medical care at Partner Organization to HIV positive patients when appropriate.
2. Work with patients to continue to orient them to the care system and how their care will be delivered, clarifying various provider roles.
3. Ensure that patients have signed the Release of Information form for Partner Organization staff and services.

_____ (Partner Organization) agrees to:

1. Assist clients in accessing and engaging in HIV medical care.
2. When appropriate (immediate need for housing, transportation, etc), help patient connect with the case management system and other support services such as Behavioral Health, support groups and education groups.

Timeline and Duration of this MOA

This memorandum of agreement shall remain in effect for the period of one year from the date of its signatures below, unless modified in writing prior to this date.

Appendix 3. Sample Linkage Agreement

Confidentiality
All parties are bound by the Illinois AIDS Confidentiality Act requirements regarding the release of an individual's HIV information, and HIPAA requirements regarding the release of personal identifying health information. The purpose of this project is to increase client understanding of the benefits of being in treatment for HIV, while supporting individual choices about providers and treatment decisions.

Both entities agree to:

1. Ensure that clients referred between organizations have signed a HIPAA compliant Release of Information form (ROI) to permit the sharing of information between the two organizations.
2. Help eligible clients connect with the Ryan White case management system when appropriate (immediate need for housing, transportation, etc.).
3. Complete all state and local health department case reporting requirements and information to initiate partner services for all newly confirmed HIV+ individuals.

Communication
Use face-to-face contact, telephone and/or email to clearly communicate expectations of any referrals, including how much feedback is desired of both organizations to meet the requirements of both organizations' funders; if/how each organization will stay actively involved in the client's care.

Termination
Either party may terminate this MOA without cause by delivering written notice to terminate to all entities who signed the agreement below. If not renewed, the MOA will terminate in one year from the dates of the signatures below.

Signatures
On behalf of my organization, I wish to enter into this agreement and contribute to the shared goals of this memorandum.

Signature	**Signature**
Date	**Date**
Title	**Title**
Organization	**Organization**
Signature	**Signature**
Date	**Date**
Title	**Title**
Organization	**Organization**

Appendix 4. Authorization to Release Information Script

Talking Points for
Authorization to Release Information (AFC/IDPH)

This form became effective on September, 2006, and was revised October 31, 2011

This form should be signed by all new clients, as well as continuing clients as soon as possible and no later than at their next scheduled reassessment.

By signing these forms I understand that:

- **My service information (including name) will be reported to the Illinois Department of Public Health's Direct Services Unit and Chicago Department of Public Health for the SOLE purposes of reporting service utilization;**
- My information will be regarded with the highest privacy possible to ensure federal reporting standards. AFC users will remain the same and only two entities at IDPH (the Consortia Coordinator and the Data Coordinator) will have access to the reported information;
- My information will <u>not</u> be given out for surveillance or contact tracing purposes, but will only be reported for the purposes of service utilization tracking;
- My information is used to obtain health care and social services;
- I can terminate services at any time with a written request;
- I have the right to refuse to sign this Authorization form; and
- I have the right to request a copy of this Authorization form

By signing these forms I give my permission to:

- Disclose my health information and case management records to the AIDS Foundation of Chicago and the other cooperative agencies;
- Have my information entered into the central database for the purpose of:
    - Statistical Reports
    - Ensure there is no duplication of services
    - Tracking service linkages and health status over time;
- Have my file reviewed by the AIDS Foundation of Chicago for quality assurance purposes;
- Have my name (IDPH only) or unique coded identifier (all other funding sources), service utilization information and limited demographic information sent to federal grant programs that support the AIDS Foundation of Chicago.

The Consent to Release Information form is utilized to protect your confidentiality and ensure that your HIV status, risk factors, or use of services are not released without your written/documented consent.

Your identifying information will only be released to parties outside of the Cooperative if required by law or federal funding requirements or to prevent harm to yourself or others.

Your identifying information (name, date of birth, and HIV status) cannot be collected without your handwritten consent on the Consent for Release of Information form or the consent of a legal guardian.

You may choose not to sign the Consent for Release of Information. However, if you decline to sign the form, you may jeopardize access to services.

CONSENT TO RELEASE INFORMATION

Subject to the limitations and conditions set forth below, I, _____hereby consent to _____ ("Provider/Case Manager"), acting through its employees or agents, to use and/or disclose my health information and medical records to the AIDS Foundation of Chicago, the Northeastern Illinois HIV/AIDS Case Management Cooperative (the "Cooperative") and/or any agencies that provide services through the Cooperative (collectively the "Recipients"), as follows: (i) in connection with my participation in the centralized client database established by the AIDS Foundation of Chicago (the "Database") and the operation of the client database; (ii) to enable the AIDS Foundation of Chicago and the Cooperative to conduct quality assurance programs for individuals receiving case management services through the Cooperative; (iii) to avoid duplication of services by case management agencies; and (iv) in connection with the submission of reports and other data to funding sources.

In connection with my enrollment in the Database, I hereby give my consent for the following information to be furnished to the AIDS Foundation of Chicago for entry into the Database: my name (when applicable), date of birth, mother's maiden name, and other demographic data. In addition, verification of HIV-positive status (if applicable) and dates of medical and case management service will be released to the AIDS Foundation. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, avoiding duplication of services and coordinating a system for service delivery to persons with HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

I further allow the program staff of the AIDS Foundation of Chicago and its designated Oversight Committees of the Cooperative to review my individual service records as part of the Cooperative's quality assurance program. For the purposes of this consent, I acknowledge and agree that my service records include any and all records generated by any of the Provider agencies that participate in the Cooperative.

Any information I provide for the purposes of receiving services will not be disclosed to any government agency or health department for purposes of surveillance, contact tracing, or any other purpose other than obtaining health care or social services, except (1) with my consent, (2) as required by law, or (3) if necessary, to prevent a serious attempt to inflict harm on myself or others. Security precautions will be maintained to prevent unauthorized access to the Database by anyone other than the program staff of the AIDS Foundation of Chicago.

I give further consent to allow the AIDS Foundation of Chicago to report information that I provide in connection with my enrollment in the Database and in connection with my receipt of services to the federal grant programs that support the AIDS Foundation of Chicago. I understand that such information may be provided either in the aggregate or on an individualized basis. I understand that, in order to protect my privacy, any information that is provided on an individualized basis, with the exception of Part B funded service utilization, will be furnished using unique client codes, without names or other information that identifies me.

I further understand that should I receive service funded under Part B of the Ryan White CARE Act, certain information will be reported to the Direct Services Unit of the Illinois Department of Public Health, including:

- demographic information, including but not limited to name, gender, race, ethnicity, and birth date; service utilization information; HIV/AIDS diagnosis and treatment information, if any; and mental health and/or substance use diagnosis, treatment, and service information, if any.

I understand that this information will be shared for the purposes of evaluating Part B service utilization patterns, on-site service reviews, and when necessary to coordinate services.

I further agree that the Direct Services Unit of the Illinois Department of Public Health may disclose this same type of information to my provider/case manager, and/or the Cooperative.

I can terminate this consent by submitting a written request to any of the Recipients (agencies in the Cooperative) indicating that I no longer desire to receive services through the Cooperative, or my written revocation of this authorization, whichever occurs first.

I understand that I may refuse to sign this consent and that may result in being denied services, if eligibility for services is based on the verification of my diagnosis and the release of that information. I understand that I have the right to receive a copy of this consent. I further understand that I may revoke this consent at any time by providing written notice of my intent to revoke this consent to Provider. This consent cannot be revoked to the extent that action has already been taken based on this consent.

This consent is valid for a period of one year from the date of the actual client signature below.

Provider will not use or disclose personal health information beyond the scope of this authorization without your written consent or authorization. Please note that, subject to applicable law, disclosed information may be subject to re-disclosure by the recipient, and may no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

_____
Signature of Client or Client's Legal Representative

_____
Print Name

_____
Date

_____
Relationship (if signed by person other than client)

CONSENTIMIENTO PARA TRANSFERIR INFORMACION

Sujeto a las limitaciones y condiciones abajo expuestas, yo, _____por medio de la presente, doy mi consentimiento a _____ ("Proveedor/Administrador de Casos"), actuando a través de sus empleados o agentes, a usar y/o revelar información sobre mi salud y mis archivos médicos a AIDS Foundation of Chicago, al Northeastern Illinois HIV/AIDS Case Management Cooperative (la "Cooperativa") y/o cualquier agencia que provee servicios a través de la Cooperativa (colectivamente, los "Destinatarios"), para lo siguiente: (i) en conexión con mi participación en el banco central de datos establecido por AIDS Foundation of Chicago (el "banco de datos") y el manejo del mismo (ii) para permitir a AIDS Foundation of Chicago y a la Cooperativa conducir programas que garanticen la calidad de los servicios para los individuos que reciben manejo de casos a través de la cooperativa; (iii) para evitar duplicación de servicios en las agencias de manejo de casos; y (iv) en conexión con el suministro de reportes y otros datos a las entidades gubernamentales que proveen los fondos.

En conexión con mi inscripción en el banco de datos, a través de este medio, doy mi consentimiento para que la siguiente información sea proporcionada a AIDS Foundation of Chicago para ser ingresada al banco de datos: mi nombre, fecha de nacimiento, mi número de seguro social, el apellido de mi madre, y otros datos demográficos. También entiendo que es mi responsabilidad verificar mi condición con respeto al VIH, (si, aplica) y fechas de tratamiento médico y servicio de manejo de casos que serán sometidos a la Fundación de SIDA de Chicago. Entiendo que esta información va a ser agrupada con la de otros clientes con el propósito de generar reportes estadísticos, evitar la duplicación de servicios y coordinar el sistema de entrega de servicios a personas con VIH, sus familiares y/o sus parejas y específicamente autorizo el uso de esta información para ese propósito.

Además, yo permito a los empleados de AIDS Foundation of Chicago y a los comités designados de la Cooperativa revisar mis archivos de servicios como parte del programa que garantiza la calidad de servicios de la Cooperativa. Como propósito de este consentimiento, yo reconozco y estoy de acuerdo en que mis archivos incluyen cualquier o todos los archivos generados por cualquier agencia proveedora de servicios que forma parte de la Cooperativa.

Ninguna información que yo provea con el propósito de recibir servicios será revelada a ninguna agencia gubernamental ni al departamento de salud con propósitos de vigilancia, ubicación, o cualquier otro propósito que no sea obtener servicios médicos o sociales, exceptuando (1) con mi consentimiento, (2) si es requerido por la ley, o (3) de ser necesario, para prevenir una seria intención de ocasionar daño a otros o a mí mismo. Precauciones de

AIDS Foundation of Chicago
CONSENTIMIENTO PARA TRANSFERIR INFORMACION

seguridad se mantendrán para prevenir el acceso no autorizado al banco de datos por cualquier persona que no sea empleado de AIDS Foundation of Chicago.

Yo doy consentimiento adicional para reportar información que yo provea en conexión con el banco de datos y en conexión con los servicios recibidos a través de fondos federales que apoyan a AIDS Foundation of Chicago. Entiendo que esta información puede ser sometida en grupo o individualmente. Yo entiendo que, con el propósito de proteger mi privacidad, toda información sometida en forma individual, con excepción de los servicios patrocinados por Parte B de Ryan White serán proveídos con códigos individuales sin nombre ni ninguna información que me identifique.

Además, yo entiendo que si llego a recibir servicios bajo Parte B de Ryan White, alguna información será reportada a la Unidad de Servicios Directos del Departamento de Salud Pública de Illinois [Direct Services Unit of the Illinois Department of Public Health], incluyendo:

- información demográfica que incluye pero no está limitada a mi nombre, sexo, raza, número de seguro social, y fecha de nacimiento; información sobre servicios que he utilizado, diagnóstico de VIH/SIDA e información sobre mi tratamiento; información sobre servicios de salud mental o uso de drogas será compartido con el propósito de evaluar servicios proveídos, revisar archivos, o en casos donde el compartir información sea necesario para coordinar servicios.

Entiendo que esta información se compartirá con el propósito de evaluar los patrones de utilización del servicio de la Parte B, revisiones de servicio en el sitio y, cuando sea necesario, para coordinar los servicios.

También estoy de acuerdo en que la Unidad de Servicios Directos del Departamento de Salud Pública de Illinois [Direct Services Unit of the Illinois Department of Public Health] puede revelar este mismo tipo de información a mi proveedor/administrador de casos, y/o al Cooperativa.

Yo puedo poner fin a este consentimiento presentando una solicitud por escrito a cualquiera de los Destinatarios (Agencias en la Cooperativa) indicando que ya no deseo recibir servicios de la Cooperativa o indicando mi revocación escrita a esta autorización, lo que occura primero.

Yo entiendo que puedo negarme a firmar este consentimiento y eso puede resultar en ser negado servicios, si la elegibilidad para los servicios se basa en la verificación de mi diagnóstico y la divulgación de esa información. Yo además entiendo que puedo suspender este consentimiento en cualquier momento presentando una nota por escrito al proveedor de servicios con mi intención de suspender este consentimiento. Este consentimiento no puede ser suspendido en la medida en que ya se haya tomado acción basada en este consentimiento.

Este consentimiento es válido por el periodo de un año a partir de la fecha en que es firmado por el cliente.

El proveedor no usará o revelará información personal de salud más allá del propósito de esta autorización sin su autorización o consentimiento por escrito. Por favor tenga en cuenta que,

AIDS Foundation of Chicago
CONSENTIMIENTO PARA TRANSFERIR INFORMACION

sujeto a la ley que aplica, la información revelada está sujeta a ser revelada a su vez por el que la recibe, y puede entonces no ser considerada información de salud protegida, en conformidad con al acta de transferibilidad y responsabilidad de seguro de salud de 1996 [HIPAA-Health Insurance Portability and Accountability Act of 1996] y las regulaciones promulgadas a partir de entonces.

_____

Firma del cliente o su representante legal

_____

Nombre

_____

Fecha

_____

Parentesco (Si es firmada por otra persona que no es el cliente)

FORM REVISED 05/2019; EFFECTIVE DATE _____

Please read all statements and sign in the space provided to certify that you have read and understand this document. All references to "Program" or "Programs" refers to the Illinois Department of Public Health, Ryan White Part B Program, inclusive of any and all federal funding utilized including Housing Opportunities for Persons with AIDS (HOPWA), and/or successor programs in which you participate or to which you apply for services.

1. I certify that the information I provide to the Program is true and accurate to the best of my knowledge. I understand that I may be disqualified from the Program and/or prosecuted for willfully providing false information.

2. I understand that the information requested by the Program is for the purpose of determining my eligibility for a state and federally funded program to which funding is limited and may expire at any time without extended or alternate funds being available.

3. I understand that eligibility approval does not mean I will receive all services offered by the Program. I understand each service may require additional information, and that I must provide this information for verification before provision of said services.

4. If I am enrolled in the Program, I will be granted an eligibility period of no more than six months. Upon the conclusion of my eligibility period, I will be required to reapply and must provide updated eligibility information to continue accessing services. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my Recertification Application every (6 months) as per Federal Guidelines.

5. I agree to notify, or to have my Case Manager (if applicable) notify the Program of any change in circumstances affecting my participation in, or eligibility for, the Program within thirty (30) days of the change. This includes any changes in income, address or insurance coverage. I understand changes in my situation will be periodically evaluated to determine continued eligibility for the Program.

6. I understand that all mailed correspondence sent by the Program will be sent to the address I have on file with the program only if I have consented to receive mail.

7. I authorize the Program to release my enrollment, eligibility, service utilization, and any other information necessary to facilitate my enrollment in the program and the provision of services to my physicians on file, program service providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, and\or other entities that are under contract with the program with the understanding that my status will never be disclosed to entities not affiliated with the Ryan White Part B Program in the bullet point list below.

8. If I experience discrimination because of the release or disclosure of medical related information, I may contact the Illinois Department of Human Rights at (217) 785-5100 or (312) 814-6200. This agency is responsible for enforcing the Illinois Human Rights Act which provides certain protections for persons with disabilities.

9. I acknowledge that my health insurance premiums (if applicable) are being paid by the Program via a contractual third-party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the Program for any unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.

10. I agree to indemnify and hold the Illinois Department of Public Health (IDPH) harmless from any and all claims for making premium reimbursement payments directly to the IDPH or any entity under contract with the IDPH in connection with Program Services. I agree to indemnify and hold the IDPH, or any entity under contract with the IDPH in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from IDPH or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program(s).

11. I agree to reimburse IDPH for any and all premium reimbursement payments that are paid to me in error during my enrollment.

12. I understand that my records are protected under the Health Insurance Portability and Accountability Act, Pub.L 104-491, 110 Stat. 1936, enacted August 21, 1996, and Illinois Statute 410 ILCS 305 relating to confidentiality of medical information, and cannot be disclosed to any other entity except those referenced herein without my written consent. I do not have to consent to the release of this information. However, if I refuse to sign this authorization, I will be ineligible to receive services through this Program.

13. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of 24 months from the date this form is signed, or until such time as I inform the administrator of the Program(s), in writing, of my wish to terminate services in the Program(s). I also understand that I will still be required to sign a new authorization form every 6 months to continue Ryan White Services. I also understand that each time I sign a new reauthorize on a 6-month basis for renewal purposes that any and all previous authorization(s) become null and void.

14. I authorize the Program to release information related to my enrollment, eligibility, service utilization, and any other information the program determines necessary to facilitate my enrollment into the program and the provision of services to the following entities:
    a. Case Management providers funded by the Program. This includes but is not limited to both medical and non-medical case management providers, medical benefit coordinators/benefit specialists, client representatives, and peer navigators.
    b. Certified Application Counselors (CAC) licensed under the authority of the Program.
    c. Members of my medical care team including, but not limited to, the physicians, physician assistants, nurses, nurse practitioners, mental health providers, substance abuse providers, oral health care providers, and any professional staff working under their authority.
    d. Entities with a grant or contractual relationship with the Program, including the grantee or contractor's sub-recipients/sub-contractors in contractual relationships to carry out activities covered by the Program. This includes the Program's regional lead agencies, contracted community-based organizations, contracted dispensing pharmacy, and contracted third party payer for insurance premiums and client out of pocket medical costs.
    e. Individuals or entities listed on my eligibility assessment as assisting me with my enrollment and eligibility.
    f. IL Department of Insurance (insurance coordination), Employment Security (income verification), Health and Family Services (Medicaid verification), the Centers for Medicare & Medicaid Services and other program/sections within the IL Department of Public Health per Illinois Statute 410 ILCS 305.
    g. Any grantee or subrecipient of any part of the Ryan White Care Act for the purposes of service coordination and to prevent duplication of information and services.
    h. Entities employed or authorized by the IL Department of Public Health to conduct reengagement and outreach activities in instances when I may have a break in my enrollment to ensure I have not fallen out of medical care. These activities will take place during the **24 months covered by this authorization**.

THIS SECTION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY**.

THIS SECTION GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of the Illinois Department of Public Health's (IDPH) Ryan White Part B Program to protect the privacy of your personal health information.

When IDPH provides you with pharmaceutical and/or premium assistance, medical case management, mental or physical health, dental, or social services, IDPH receives and maintains personal health information about you. IDPH may also receive and maintain financial and billing information about you. To help IDPH provide these comprehensive core and supportive care services to you, IDPH may contract with companies, social service agencies, or individuals. These contractors may also receive and maintain your personal information. IDPH will use and share only the minimum necessary health information that our staff and contractors need to do their jobs. IDPH and its contractors are required by law to (1) maintain the privacy of protected health information; (2) to provide you with notice of IDPH's legal duties and privacy practices with respect to your protected health information; and (3) to notify affected individuals of a breach of unsecured protected health information.

This Notice describes how IDPH may use and disclose your information. It also describes your rights and IDPH's legal obligations with respect to your information. IDPH is required to follow the terms of this Notice until the Notice is replaced. IDPH reserves the right to change the terms of this Notice at any time. If IDPH makes changes to this Notice, the new Notice will be available in IDPH offices, upon request, and on our website: https://dph.illinois.gov. Any changes to our practices will apply to all of your personal health information maintained by IDPH.

How IDPH May Use and Disclose Your Health Information

IDPH may share your information without your authorization in the following ways:

Treatment: IDPH can use your health information and share it with other professionals who are treating you in order to enhance coordination of comprehensive care services. For example: IDPH may disclose your personal health information to your doctor, at the doctor's request, for treatment by your doctor.

Payment: IDPH can use and share your information for payment purposes. For example: IDPH may use or disclose your personal health information to provide eligibility information to your doctor when you receive treatment; to pay for claims for covered health care services; to pay for insurance premiums if eligible; to assist with payment of approved medical/pharmaceutical out-of-pocket costs; or to recover costs from other medical insurance or probate estates.

Health Care Operations: IDPH can use and share your health information for IDPH operations, to improve your care, and to contact you when necessary. For example: IDPH or its contractors may use or disclose your personal health information (1) to conduct quality assessment and improvement activities; (2) to review applications for services; (3) to engage in care coordination or case management; (4) to manage, plan or develop IDPH's services and budget; (5) to coordinate services with another public benefit program; (6) to create or provide individualized service or treatment plans; or (7) to cooperate with State and federal auditors.

Health Services: IDPH or its contractors may contact you to remind you of appointments or to give you information about treatment alternatives or other health-related benefits and services that may be helpful to you or your family.

IDPH is allowed, and in some instances required, to share your information in other ways such as for public health and research. IDPH must meet conditions in the law before it can share your information for these purposes.

Public Health and Safety Issues: IDPH can share health information about you with public health authorities for public health activities such as: preventing or controlling disease, injury, or disability; keeping vital records; avoiding a serious threat to the health or safety of a person or the public; and reporting suspected abuse, neglect, or domestic violence to governmental or social services agencies. IDPH also can share your health information with a governmental agency authorized to oversee government health care programs.

Research: IDPH can use or share your information for health research in limited circumstances where the information will be protected by the researchers.

As Required by Law: IDPH will share information about you if State or federal laws require it, including with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) for a compliance review or complaint investigation or with a personal representative appointed by you or designated by law.

Lawsuits and Legal Actions: IDPH can share health information about you in response to a court or administrative order, or in response to a subpoena.

Public Health Activities and Public Health Reporting: IDPH is permitted to disclose protected health information for public health activities (such as surveillance and investigation), interventions and activities related to public health oversight; and to coordinate care and treatment with other IDPH Health Protection Entity's (e.g., Sexually Transmitted Disease Office) activities.

Other Agencies: IDPH can share your information with another agency administering a government program providing public benefits, with respect to eligibility or enrollment information, and to better coordinate, administer and manage government programs and for treatment and care coordination of the Department's program.

IDPH follows the HIPAA guidelines. IDPH also follows any federal or State law that gives greater privacy protections than HIPAA. For example, IDPH follows the Illinois Mental Health and Developmental Disabilities Confidentiality Act concerning mental health records, 740 ILCS 110; the Illinois Personal Information Protection Act which protects "personal information" that is not otherwise lawfully made available to the general public from federal, State, or local government records, 815 ILCS 530; the federal Confidentiality of Alcohol and Drug Abuse Patient Records Act concerning the disclosure of drug or alcohol information, 42 U.S.C §290dd-2; 42 CFR Part 2; and the federal Family Educational Rights and Privacy Act concerning the privacy of education records, 20 U.S.C. §1232g; 34 CFR Part 99; 34 CFR Part 99

Our Responsibilities:

IDPH is required by law to maintain the privacy and security of your protected health information. IDPH will notify you as required by law when there is a breach of your unsecured protected health information. In some circumstances IDPH's business associate may provide the notification to you.

IDPH must follow the duties and privacy practices described in this Notice and give you a copy of it.

IDPH will not use or share your information for any purposes not described in this Notice without your written permission. If you do authorize IDPH to use or disclose your health information, in most cases, you may revoke your written authorization at any time. Your revocation will be effective from the date IDPH receives the revocation. (Authorization and Revocation forms are available on IDPH's Ryan White Part B website.)

IDPH is required to obtain your authorization prior to using or disclosing psychotherapy notes, except under the limited treatment, payment, and health care exceptions of 45 CFR § 164.508(a)(2).

IDPH does not market or sell your protected health information. However, IDPH would be required to obtain your authorization prior to selling any of your protected health information or disclosing any of your protected health information for marketing purposes.

Your Rights:

Communicate Confidentially: You can ask in writing that IDPH communicate with you by a reasonable alternative means or at a reasonable alternative location. For example, you may request that IDPH communicate with you by e-mail rather than by telephone, through a translator, or at home instead of your place of work. IDPH will agree to all reasonable requests.

Request a Copy of this Privacy Notice: You are entitled to a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. An electronic version of this Notice of Privacy Practices is also available on the IDPH website: www.idph.state.il.us

Inspect and Amend Protected Health Info: You are entitled to inspect and copy your protected health information at any time. At the time of inspection, you may request an amendment to your information. IDPH reserves the right to deny your request for amendment.

Choose Someone to Act on Your Behalf: You may give someone a medical power of attorney, or a legal guardian may be appointed for you to exercise your rights and make choices about your health. Before IDPH takes any action, IDPH will confirm the person has this authority and can act on your behalf.

Right to Accounting of Disclosures: You are entitled to receive an accounting of disclosures of protected health information as provided by 45 C.F.R. 164.528.

File a Complaint: If you believe your privacy rights have been violated by IDPH, you have the right to complain to IDPH or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the IDPH Chief Privacy Officer, within 180 days of the suspected violation, at the address where you receive services listed below or you may file a complaint with the United States Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201; or calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. IDPH will not retaliate against you for filing a complaint with either IDPH or with the U.S. Department of Health and Human Services.

Your Choices: You have the right to request that IDPH restrict the uses or disclosures of your protected health information to carry out treatment, payment, for health care operations. Your requests must be clearly expressed. IDPH is not required to agree to your requests. IDPH does not engage in fundraising. However, you may opt out of receiving any fundraising communication from IDPH.

Privacy Officer

To request additional copies of this notice or to receive more information about IDPH's privacy practices or your rights, please contact the Chief Privacy Officer at the following address:

Illinois Department of Public Health
535 West Jefferson Street, Fifth Floor
Springfield, IL 62761
Telephone – 217-557-2556

With my signature, I authorize the Program and the entities identified in item 14 of this document to share my information with the additional entities listed below and I understand that I must list these contacts on each submission of this form in order to allow the Program to continue to share my information with them.

_____
Individual Name

(_____) _____ - _____ Is this individual aware of your status? ☐ Yes ☐ No
Telephone

_____
Individual Name

(_____) _____ - _____ Is this individual aware of your status? ☐ Yes ☐ No
Telephone

I hereby acknowledge that I have received a copy of this document and recognize that I will be required to sign this document at each eligibility determination.

Client First Name	**Middle Initial**	**Client Last Name**

Social Security Number (Leave blank if no valid SS number for client)	**Date of Birth (mm/dd/yyyy)**

Client Signature (age 12 and older) **Date**

Parent/Guardian (if under 12) or Legal Representative **Date**

Autorización de divulgación de información de salud y Aviso de Prácticas de Privacidad

Por favor lea todas las declaraciones y firme en el espacio provisto para certificar que usted ha leído y entendido esta autorización. Todas las referencias al "Programa" o "Programas" se refieren al Programa Ryan White Parte B del Departamento de Salud Pública de Illinois, para todos y cada uno de los fondos federales utilizados, incluyendo las Oportunidades de Vivienda para Personas con SIDA (HOPWA), y / o los programas sucesores en los que participa o a los que solicita servicios.

1. Certifico que la información que proporciono al Programa es verdadera y precisa de acuerdo a mi conocimiento. Entiendo que puedo ser descalificado del Programa y / o procesado por proporcionar información falsa intencionalmente.
2. Entiendo que la información solicitada por el Programa tiene el propósito de determinar mi elegibilidad para un programa financiado por el estado y el gobierno federal para el cual el financiamiento es limitado y puede caducar en cualquier momento sin que haya fondos extendidos o alternativos disponibles
3. Entiendo que la aprobación de mi aplicación no significa que recibiré todos los servicios ofrecidos por el Programa. Entiendo que cada servicio puede requerir información adicional, y que debo proporcionar esta información para verificación antes de la prestación de dichos servicios.
4. Si estoy inscrito en el Programa, se me otorgará un período aprobado de no más de seis meses. Al finalizar este período, se me solicitará que vuelva a presentar una aplicación y debo proporcionar información actualizada para saber si soy elegible para continuar accediendo a los servicios. Estoy de acuerdo en presentar información periódica sobre mi elegibilidad continua para participar en el programa (s), incluidos mis comprobantes de ingreso económico, comprobante de residencia, disponibilidad de cobertura de seguro de salud y una versión actualizada y firmada de este formulario con mi Solicitud de Recertificación cada (6) meses) según las normas federales.
5. Estoy de acuerdo en notificar, o hacer que mi Administrador de Casos (si corresponde) notifique al Programa sobre cualquier cambio en circunstancias que afecten mi participación o elegibilidad para el Programa dentro de los treinta (30) días posteriores al cambio. Esto incluye cualquier cambio en ingresos económicos, dirección o cobertura de seguro. Entiendo que dichos cambios se evaluarán periódicamente para determinar la elegibilidad continua para el Programa.
6. Entiendo que toda correspondencia enviada por correo por el Programa se enviará a la dirección que tengo registrada en el programa solo si he dado mi consentimiento para recibir correo.
7. Autorizo al Programa a divulgar información de mi registro, elegibilidad, utilización de servicio y cualquier otra información necesaria para facilitar mi inscripción en el programa y la prestación de servicios a mis médicos en archivo, proveedores de servicios del programa, centros de tratamiento, administradores de beneficios de farmacia, administradores externos, aseguradores de salud y / u otras entidades que están bajo contrato con el programa, entendiendo de que mi estado nunca se divulgará a entidades que no estén afiliadas al Programa Ryan White Parte B en la lista a continuación.
8. Si llego a sufrir discriminación debido a la divulgación de información médica relacionada, puedo comunicarme con el Departamento de Derechos Humanos de Illinois al (217) 785-5100 o (312) 814-6200. Esta agencia es responsable de hacer cumplir la Ley de Derechos Humanos de Illinois que proporciona ciertas protecciones para personas con discapacidad.
9. Reconozco que mis primas de seguro de salud (si corresponde) están siendo pagadas por el Programa a través de una fuente contractual de pago de terceros. En consideración a lo mismo, por la presente autorizo y ordeno a mi aseguradora de salud que reembolse directamente al Programa por cualquier pago de primas no utilizadas en caso de que mi póliza de seguro termine o sea cancelada por cualquier motivo, incluyendo, entre otros, inelegibilidad futura, muerte, cancelación voluntaria, cancelación involuntaria, o terminación por operaciones de ley.
10. Acepto indemnizar y eximir al Departamento de Salud Pública de Illinois (IDPH) de cualquier reclamo por pagos de reembolso de primas directamente a IDPH o a cualquier entidad bajo contrato con IDPH en relación con los Servicios del Programa. Estoy de acuerdo en indemnizar y mantener a IDPH, o cualquier entidad bajo contrato con IDPH en relación con los Servicios del Programa, eximidos de cualquier reclamo por recibir pagos de reembolso de la prima directamente de IDPH o de mi aseguradora de salud. Este acuerdo será vinculante para mis administradores, ejecutores, herederos, sucesores y cesionarios y permanecerá en pleno vigor y efecto durante el período de tiempo en el que estoy inscrito en el Programa (s).
11. Acepto reembolsar a IDPH todos y cada uno de los pagos de reembolso de primas que me fueran pagados por error durante mi inscripción.
12. Entiendo que mis registros están protegidos por la Ley de Responsabilidad y Portabilidad del Seguro de Salud, Pub.L 104-491, 110 Stat. 1936, promulgada el 21 de agosto de 1996, y el Estatuto de Illinois 410 ILCS 305 relacionado con la confidencialidad de la información médica, y no pueden ser divulgados a ninguna otra entidad, excepto a las que se mencionan en este documento sin mi consentimiento por escrito. No estoy obligado a dar mi consentimiento para la divulgación de esta información. Sin embargo, si me niego a firmar esta autorización, no seré elegible para recibir servicios a través de este Programa.

13. Entiendo que puedo revocar esta autorización en cualquier momento por escrito. Sin embargo, la liberación seguirá siendo válida por un período de 24 meses a partir de la fecha en que se firme este formulario, o hasta el momento en que informe al administrador del Programa, por escrito, de mi deseo de terminar los servicios en el Programa (s). También entiendo que tendré que firmar un nuevo formulario de autorización cada 6 meses para continuar con los servicios de Ryan White. También entiendo que cada vez que firmo una nueva autorización cada 6 meses para propósitos de renovación, cualquier y todas las autorizaciones previas quedarán nulas y sin efecto.

14. Autorizo al Programa a divulgar información relacionada con mi registro, elegibilidad, utilización del servicio y cualquier otra información que el programa considere necesaria para facilitar mi inscripción en el programa y la prestación de servicios a las siguientes entidades:
    a. Administradores de casos financiados por el programa. Esto incluye, entre otros, proveedores médicos y no médicos de administración de casos, coordinadores de beneficios médicos / especialistas en beneficios, representantes de clientes y asistentes.
    b. Asesores Certificados de Solicitudes (CAC) licenciados bajo la autoridad del Programa.
    c. Los miembros de mi equipo de atención médica, incluidos, entre otros, los médicos, asistentes médicos, enfermeros (as), enfermeros (as) especializadas, proveedores de salud mental, proveedores de abuso de substancias, proveedores de atención de salud bucal y cualquier personal profesional que trabaje bajo su autoridad.
    d. Entidades con una subvención o relación contractual con el Programa, incluidos los beneficiarios secundarios o subcontratistas / subcontratistas en relaciones contractuales para llevar a cabo las actividades cubiertas por el Programa. Esto incluye las agencias líderes regionales del Programa, las organizaciones comunitarias contratadas, la farmacia dispensadora contratada y el pagador externo contratado para las primas de seguro y costos médicos de los clientes.
    e. Personas o entidades enumeradas en mi aplicación de elegibilidad que me ayudan con mi aplicación.
    f. Departamento de Seguros de Illinois (coordinación de seguros), Seguridad de Empleo (verificación de ingresos), Servicios de Salud y Familia (verificación de Medicaid), Centros de Servicios de Medicare y Medicaid y otros programas / secciones dentro del Departamento de Salud Pública de Illinois según los Estatutos de Illinois 410 ILCS 305.
    g. Cualquier concesionario o subreceptor bajo “Ryan White Care Act” con el propósito de coordinar el servicio y evitar la duplicación de información y servicios.
    h. Entidades empleadas o autorizadas por el Departamento de Salud Pública de Illinois para llevar a cabo actividades de reincorporación y difusión en casos de tener una interrupción en mi inscripción, para garantizar que no haya dejado de recibir atención médica. Estas actividades se desarrollarán durante los 24 meses cubiertos por esta autorización.

ESTE AVISO DESCRIBE CÓMO PUEDE SER UTILIZADA Y DIVULGADA SU INFORMACIÓN MÉDICA, Y CÓMO PUEDE OBTENER ACCESO A ESTA INFORMACIÓN. **POR FAVOR REVISELO CUIDADOSAMENTE**.

ESTE AVISO LE OFRECE INFORMACIÓN REQUERIDA POR LEY sobre los deberes y las prácticas de privacidad del Programa Ryan White Parte B del Departamento de Salud Pública de Illinois (IDPH) para proteger la privacidad de su información médica personal.

Cuando IDPH le proporciona asistencia farmacéutica y / o de prima de Seguro, gestión de casos médicos, salud mental o física, servicios dentales o sociales, IDPH recibe y mantiene información personal sobre su salud. IDPH también puede recibir y mantener información financiera y de facturación sobre usted. Para ayudar a IDPH a brindarle estos servicios integrales de atención básica y de apoyo, IDPH puede contratar a compañías, agencias de servicios sociales o individuos. Estos contratistas también pueden recibir y mantener su información personal. IDPH utilizará y compartirá solo la información médica mínima necesaria que nuestro personal y contratistas necesitan para hacer su trabajo. IDPH y sus contratistas están obligados por ley a (1) mantener la privacidad de información médica protegida; (2) proporcionarle un aviso de los deberes legales y las prácticas de privacidad de IDPH con respecto a su información de salud protegida; y (3) notificar a las personas afectadas de una violación de información médica protegida no segura.

Este Aviso describe cómo IDPH puede usar y divulgar su información. También describe sus derechos y las obligaciones legales de IDPH con respecto a su información. Se requiere que IDPH siga los términos de este Aviso hasta que el mismo sea reemplazado. IDPH se reserva el derecho de cambiar los términos de este Aviso en cualquier momento. Si IDPH realiza cambios en este Aviso, el

nuevo Aviso estará disponible en las oficinas de IDPH, previa solicitud, y en nuestro sitio web: https://dph.illinois.gov. Cualquier cambio en nuestras prácticas será aplicado a toda la información médica suya mantenida por IDPH.

Cómo puede IDPH usar y divulgar su información de salud

IDPH puede compartir su información sin su autorización de las siguientes maneras:

Tratamiento: IDPH puede usar su información médica y compartirla con otros profesionales que lo están tratando para mejorar la coordinación de los servicios de atención integral. Por ejemplo: IDPH puede divulgar su información de salud personal a su médico, a solicitud del médico, para que su médico le brinde tratamiento.

Pago: IDPH puede usar y compartir su información para fines de pago. Por ejemplo: IDPH puede usar o divulgar su información de salud personal para proporcionar información de elegibilidad a su médico cuando recibe tratamiento; para pagar reclamaciones por servicios de atención médica cubiertos; para pagar las primas de seguro si es elegible; para ayudar con pagos de gastos médicos / farmacéuticos de bolsillo, aprobados; o para recuperar los costos de otros seguros médicos o Estados de Sucesión.

Operaciones de cuidado de la salud: IDPH puede usar y compartir su información de salud para las operaciones de IDPH, para mejorar su atención y para contactarlo cuando sea necesario. Por ejemplo: IDPH o sus contratistas pueden usar o divulgar su información personal de salud (1) para llevar a cabo evaluaciones de calidad y actividades de mejora; (2) revisar las solicitudes de servicios; (3) participar en la coordinación de atención o gestión de casos; (4) para administrar, planificar o desarrollar los servicios y el presupuesto de IDPH; (5) coordinar servicios con otro programa de beneficio público; (6) para crear o proporcionar servicios individualizados o planes de tratamiento; o (7) para cooperar con auditores estatales y federales.

Servicios de salud: IDPH o sus contratistas pueden contactarlo para recordarle citas o brindarle información sobre alternativas de tratamiento u otros beneficios y servicios relacionados a la salud que puedan ser útiles para usted o su familia.

IDPH tiene permitido, y en algunos casos es requerido, a compartir su información de otras maneras, como para salud pública e investigación. IDPH debe cumplir con las condiciones de la ley antes de poder compartir su información para estos fines.

Problemas de salud y seguridad pública: IDPH puede compartir su información de salud con las autoridades de salud pública para actividades de salud pública como: prevenir o controlar enfermedades, lesiones o discapacidades; mantener registros vitales; evitar una amenaza grave para la salud o la seguridad de una persona o del público; y reportar sospechas de abuso, negligencia o violencia doméstica a agencias gubernamentales o de servicios sociales. IDPH también puede compartir su información de salud con una agencia gubernamental autorizada para supervisar los programas de atención médica del gobierno.

Investigación: IDPH puede usar o compartir su información para investigaciones en salud, en circunstancias limitadas donde la información estará protegida por los investigadores.

Según lo exija la ley: IDPH compartirá información sobre usted si las leyes estatales o federales lo exigen, incluido en la Ley Federal de Portabilidad y Responsabilidad del Seguro Médico de 1996 (HIPAA) para una revisión de cumplimiento o una investigación de una queja o con un representante personal designado por usted o designado por ley.

Demandas judiciales y acciones legales: IDPH puede compartir información médica sobre usted en respuesta a una orden judicial o administrativa, o en respuesta a una citación.

Actividades de salud pública e informes de salud pública: IDPH está autorizado a divulgar información de salud protegida para actividades de salud pública (como vigilancia e investigación), intervenciones y actividades relacionadas con la supervisión de la salud pública; y para coordinar la atención y el tratamiento con otras actividades de la Entidad de Protección de la Salud de IDPH (por ejemplo, la Oficina de Enfermedades de Transmisión Sexual).

Otras agencias: IDPH puede compartir su información con otra agencia que administre un programa gubernamental y brinde beneficios públicos, con respecto a la elegibilidad o información de registro, y para coordinar, administrar y manejar mejor los programas gubernamentales para el tratamiento y la coordinación de atención del programa del Departamento.

IDPH sigue las pautas de HIPAA. IDPH también cumple con cualquier ley federal o estatal que otorgue mayor protección de la privacidad que HIPAA. Por ejemplo, IDPH sigue la Ley de Confidencialidad de Discapacidades del Desarrollo y Salud Mental de Illinois con respecto a los registros de salud mental, 740 ILCS 110; la Ley de Protección de Información Personal de Illinois que protege la

"información personal" , de registros del gobierno federal, estatal o local que legalmente no estaría de otro modo a disposición del público en general, 815 ILCS 530; la Ley Federal de Confidencialidad de Abuso de Drogas y Alcohol, Registros de Pacientes en relación con la divulgación de información sobre drogas o alcohol, 42 U.S.C §290dd-2; 42 CFR Parte 2; y la Ley Federal de Derechos Educativos y Privacidad de la Familia concerniente a la privacidad de los registros educativos, 20 U.S.C. §1232g; 34 CFR Parte 99; 34 CFR Parte 99

Nuestras responsabilidades:

IDPH está obligado por ley a mantener la privacidad y seguridad de su información médica protegida. IDPH le notificará según lo exija la ley cuando exista una violación de su información médica protegida no asegurada. En algunas circunstancias, los socios comerciales de IDPH pueden proporcionarle la notificación

IDPH debe cumplir con los deberes y prácticas de privacidad descritos en este Aviso y entregarle una copia.

IDPH no utilizará ni compartirá su información para ningún propósito no descrito en este Aviso sin su permiso por escrito. Si usted autoriza a IDPH a usar o divulgar su información médica, en la mayoría de los casos, puede revocar su autorización por escrito en cualquier momento. Su revocación será efectiva a partir de la fecha en que IDPH reciba la revocación. (Los formularios de Autorización y Revocación están disponibles en el sitio web de Ryan White Parte B de IDPH).

Se requiere que IDPH obtenga su autorización antes de usar o divulgar notas de psicoterapia, excepto bajo las excepciones limitadas de tratamiento, pago y atención médica de 45 CFR § 164.508 (a) (2).

IDPH no comercializa ni vende su información de salud protegida. Sin embargo, IDPH requeriría obtener su autorización antes de vender su información médica protegida o divulgar su información médica protegida con fines comerciales.

Sus derechos:

Comunicarse de manera confidencial: Puede solicitar por escrito que IDPH se comunique con usted por un medio alternativo razonable o en una ubicación alternativa razonable. Por ejemplo, puede solicitar que IDPH se comunique con usted por correo electrónico en lugar de hacerlo por teléfono, a través de un traductor, o en su casa en lugar de su zona de trabajo. IDPH aceptará toda solicitud razonable.

Solicitar una copia de este Aviso de privacidad: Tiene derecho a recibir una copia impresa de este Aviso en cualquier momento, incluso si usted ha optado por recibir el Aviso de manera electrónica. También está disponible una versión electrónica de este Aviso de prácticas de privacidad en el sitio web de IDPH: www.idph.state.il.us

Inspeccionar y modificar información de salud protegida: Tiene derecho a inspeccionar y copiar su información de salud protegida en cualquier momento. Durante la inspección puede solicitar la modificación de su información. IDPH se reserva el derecho de rechazar su solicitud de enmienda.

Elegir a alguien para que actúe en su nombre: Puede otorgar a alguien un poder médico, o un tutor legal puede ser designado por usted para ejercer sus derechos y tomar decisiones sobre su salud. Antes de que IDPH realice alguna acción, IDPH confirmará que la persona tiene esta autoridad y puede actuar en su nombre.

Derecho contabilizar las divulgaciones: Tiene derecho a recibir una contabilidad de divulgaciones de información médica protegida según lo dispuesto por 45 C.F.R. 164.528.

Presentar una queja: Si cree que IDPH ha violado sus derechos de privacidad, tiene derecho a presentar una queja ante IDPH o ante el Secretario del Departamento de Salud y Servicios Humanos de los EE. UU. Puede presentar una queja ante el Director de Privacidad de IDPH, dentro de los 180 días de la sospecha de infracción, en la dirección donde recibe los servicios enumerados a continuación, o puede presentar una queja ante el Departamento de Salud y Servicios Humanos de los Estados Unidos, Oficina de Derechos Civiles enviando una carta a 200 Independence Avenue, SW, Washington, DC 20201; o llamando al 1-877-696-6775, o visitando www.hhs.gov/ocr/privacy/hipaa/complaints/. IDPH no tomará represalias contra usted por presentar una queja con IDPH o con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Sus opciones: Tiene el derecho de solicitar que IDPH restrinja los usos o divulgaciones de su información médica protegida para llevar a cabo el tratamiento, el pago y las operaciones de atención médica. Sus peticiones deben ser expresadas claramente. IDPH no está obligado a aceptar su solicitud.

IDPH no participa en recaudación de fondos. Sin embargo, puede optar por no recibir ninguna comunicación de recaudación de fondos de IDPH.

Oficial de Privacidad

Para solicitar copias adicionales de este aviso o para recibir más información sobre las prácticas de privacidad de IDPH o sus derechos, comuníquese con el Director de Privacidad en la siguiente dirección:

Kyle Stone
Illinois Department of Public Health
535 West Jefferson Street, Fifth Floor
Springfield, IL 62761
Telephone – 217-557-2556

Primer Nombre (impreso)	Inicial del 2do nombre	Apellido (impreso)

Número de Seguro Social (Dejar en blanco si el cliente no tiene un número de Seguro Social valido)	Fecha de Nacimiento (mm/dd/aaaa)

Con mi firma, autorizo al Programa y a las entidades identificadas en el punto 14 de este documento a compartir mi información con las entidades adicionales listadas a continuación y entiendo que debo incluir estos contactos en cada envío de este formulario para permitir que el Programa pueda continuar compartiendo mi información con ellos.

_____
Nombre del Individuo

(_____) _____ - _____ ¿Está consciente esta persona de su estado? ☐ Si ☐ No
Teléfono

_____
Nombre del Individuo

(_____) _____ - _____ ¿ Está consciente esta persona de su estado? ☐ Si ☐ No
Teléfono

Por la presente reconozco que he recibido una copia del Aviso de prácticas de privacidad de IDPH. También reconozco que se me solicitará que envíe la página firmada de Práctica de privacidad completa para determinación de elegibilidad cada 6 meses.

Firma del cliente (Igual o mayor a 12 años de edad) **Fecha**

Padre/Guardian Legal (Si menor a 12 años de edad) o Representante Legal **Fecha**

Appendix 7. Foreign Language Translation Request Form

Foreign Language Translation Request Form

Case Management Agency Name: _____

Case Manager Name: _____

Date Completed: _____Requested date and time of service: _____

Foreign Language Needed: _____

Client Name: _____

Visit Type: Intake _____ Reassessment _____ On-going case management contact _____

Issues to be addressed in case management encounter: (Please include a brief narrative regarding the areas of service detailed in the encounter)

_____

_____

_____

_____

Will the case manager be requesting this service again for this client?

Yes _____ No _____

Anticipated frequency of translation service request for this client: _____

AFC Staff Signature: _____

Date: _____

Vendor: _____

Complete this form for every individual translation request and fax to Intake Manager at the AIDS Foundation (312) 784-9052 for approval. Service may not be rendered without prior approval.

Appendix 8. Sign Language Interpretation Request Form

Sign Language Interpretation Request Form

Case Management Agency Name: _____

Case Manager Name: _____

Date Completed: _____Requested date and time of service: _____

Client Name: _____

Visit Type: Intake _____ Reassessment _____ On-going case management contact _____

Issues to be addressed in case management encounter: (Please include a brief narrative regarding the areas of service detailed in the encounter)

_____

_____

_____

_____

Will the case manager be requesting this service again for this client?

Yes _____ No _____

Anticipated frequency of translation service request for this client: _____

AFC Staff Signature: _____

Date: _____

Vendor: _____

Complete this form for every individual translation request and fax to Intake Manager at the AIDS Foundation (312) 784-9052 for approval. Service may not be rendered without prior approval.

Appendix 9. Incident Reporting Form

Incident Reporting Form

Use this form to report any workplace accident, injury, incident, close call or illness.
Return completed form to the Operations Supervisor, or Management.

This is documenting:

____ physical injury to or by the individual that requires a physician's treatment or admission to a hospital, or
____ the death of any person, or
____ emergency mental health treatment for the individual, or
____ the intervention of law enforcement, or
____ report of child abuse pursuant to Illinois Statutes 325 ILCS 5 Abused and Neglected Child Reporting Act or a report of dependent adult abuse pursuant to (320 ILCS 20/) Elder Abuse and Neglect Act., or
____ Constitutes a prescription medication error or a pattern of medication errors
____ a member's location being unknown by provider staff who are assigned protective oversight.

Details of person injured or involved (to be filled in by person injured / involved if possible)

Person Completing Report:_____ Date:_____

Person(s) Involved:_____

Equipment or Truck ID:_____

Event Details: Name of Individual served: _____

Date of Event:_____ Location of Event:_____

Time of Event:_____ Witnesses:_____

Description of Events (Describe tasks being performed and sequence of events):

_____

_____

_____

_____

_____

*If more space is required please use the back of this sheet

Was event / injury caused by an unsafe act (activity or movement) or an unsafe condition (machinery or weather)? Please explain:

_____

_____

Appendix 9. Incident Reporting Form

TO BE COMPLETED ONLY IF LOST TIME/INJURY OR FIRST AID WAS REQUIRED	
Type of injury sustained:	
Cause of lost time/ injury or first aid:	
Was medical treatment necessary?	Yes_____ No_____ If yes, name of hospital or physician:

Action taken by organization to handle the situation:

_____

_____

_____

_____

_____

Resolution or follow up:

_____

_____

_____

_____

_____

Signature of Employee:_____ Date:_____

Signature of Supervisor:_____ Date:_____

ILLINOIS Department of Public Health

Ryan White Program

Partner Services Acknowledgement

THIS NOTICE PROVIDES YOU WITH INFORMATION about the Partner Services activities of the Illinois Department of Public Health's (IDPH) Ryan White Program.

At every eligibility determination and subsequent case manager encounter, your Case Manager will provide an opportunity to discuss and participate in an activity called Partner Services. It is most important to know that Partner Services participation is **completely voluntary**. Partner Services activities include discussing behaviors/encounters with your case manager that may have put your partner(s) at risk for being exposed to HIV. Partner Services may activate organically during your discussions with your case manager when discussing partner activities. Partner Services in its simplest form involves collecting information on any partners who have potentially been exposed to HIV and contacting those partners to notify them of their potential exposure in order to get tested.

Remember, it is your voluntary choice if you share partner information with your case manager; and if discussed then then please know that you have options for how to inform your partner of the potential exposure. This form is intended ensure you are informed of what Partner Services involves, when it would occur, and options you have for informing your partner(s).

- ✓ **At no time will your name or any of your information be shared with the partner! In addition, at no time will your decision to decline partner services impact your participation in the Ryan White Program or your access to services.**

Please know that these activities do not have to be initiated by your case manager. You can request Partner Services from your Case Manager at any time during your enrollment in the Program.

During the conversation, your Case Manager may request certain information regarding your partner(s). This information can include name, date of birth, physical description, and any locating information such as address or phone numbers. Sharing this information is critical in allowing your case manager to properly assist you and to ensure that your partner is located and tested.

If you provide your partner(s) information, three options of notification are available to you. You will need to elect a notification method for each partner you provide:

1. Provider Notification – After sharing a partner's information, you may decide that Provider Notification feels most comfortable. Provider Notification allows your Case Manager to provide the partner's information to an authorized Disease Intervention Specialist (DIS). This DIS worker will attempt to locate, notify, and offer testing services to the partner. This process will begin promptly following selection of this option. With this option you do not have to speak to your partner.

   The DIS Worker will **NOT** share your name or information with the partner. While the DIS worker will never share your information, there is no guarantee a partner will not be able to deduce the identity of a partner.

2. **Contract Notification –** You and your case manager may determine that Contract Notification, **YOU** are notifying the partner of their potential exposure and encouraging them to get tested, might feel like the most appropriate notification method. Your case manager will provide you with guidance and practice of notification techniques to help get you comfortable in conducting the notification. This option requires that you talk directly to the partner, inform them of their potential exposure to HIV and encourage them to get tested. The partner can access one of the free HIV testing providers throughout the state.

   There is a timeframe for when you need to talk with your partner. With a Contract Notification, you and your Case Manager will agree upon a deadline, which is usually 30 days from the day the partner information was

provided. Within that timeframe you need to speak to your partner and contact your Case Manager to provide him/her with the results of your notification. If you are unable to speak to your partner or you do not follow up with your Case Manager by the agreed upon date, the Case Manager is required to then share the partner information with an authorized Disease Intervention Specialist to attempt to locate, notify, and offer testing services to the partner.

3. **Dual Notification –** If Provider and Contract Notification do not feel like the right notification methods you can work with your Case Manager to complete Dual Notification. Dual Notifications allow for **you** to notify the partner with assistance from your Case Manager. Your case manager will support you with guidance and practice of notification techniques to get you comfortable in conducting the notification. You and your Case Manager will agree on a date for the notification, within 30 days. This option requires that you talk directly to the partner, with the assistance of your Case Manager, inform them of their potential exposure to HIV and encourage them to get tested. Some case management locations offer free HIV testing so check with your case manager about these options. The partner can access one of the free HIV testing providers throughout the state.

   If you are unable to talk to your partner during the session or at any point during the session you are not able to provide the partner with the necessary and correct information, the Case Manager will step in to inform the partner of their potential exposure and encourage the partner to get tested.

   If you are not able to bring your partner in on the agreed upon date, the Case Manager will provide the partner's information to an authorized Disease Intervention Specialist (DIS). This DIS worker, just like in the other options, who will attempt to locate, notify, and offer testing services to the partner. They will not share your name or information with the partner.

ACKNOWLEDGMENT OF RECEIPT

Client First Name	**Client Middle Initial**	**Client Last Name**

Social Security Number (Leave blank if no valid SS number for client)	**Date of Birth** (mm/dd/yyyy)

By signing below, I acknowledge the following:

1. My Case Manager provided me information about Partner Services.
2. I understand that participating in Partner Services is completely voluntary.
3. I understand what Partner Services activities include and, if I choose to participate, what notification methods are available to me.

Client Signature Date

Signature of Parent of Minor or Legal Guardian (if necessary) Date

Appendix 11. Sample Agency Grievance Procedure Rights and Responsibilities

SAMPLE AGENCY
Client Grievance Procedure Rights and Responsibilities

AGENCY believes in the dignity and worth of all individuals and holds that all persons have certain rights and responsibilities. Our goal as an agency is to ensure that all staff treats each individual we serve with the respect, dignity, and honor that benefits them. We also hold that each person seeking services from Erie should fully understand their rights, the rules and the regulations of the agency.

AGENCY has been contracted to provide comprehensive case management services to individuals diagnosed with HIV/AIDS. Comprehensive case management is defined to mean a standardized process of client centered assessment case planning, service coordination, referral, advocacy, and follow up through which the multiple service needs of persons affected by HIV disease are met.

AGENCY recognizes that clients have the following protection:
1. To remain anonymous, even though this may disqualify you from certain services.
2. To decline services at anytime.
3. To know at all times how and where to register complaints.
4. To know that all personal information is confidential and cannot be released without your consent.
5. To have freedom from mental and physical abuse and to have their civil rights respected.
6. To obtain the services of another organization without the consent of this organization and continue to receive non-duplicated care at that organization with or without help from AGENCY staff.
7. To not be excluded from services on the basis of race, ethnicity, sex, sexual orientation, physical disability, social and/or economic status/group member affiliation.
8. To appeal any fees assessed by the agency or to make an appeal for the reduction or waiver of fees assessed based on documented circumstances affecting the ability to pay.

Client's Responsibilities:
1. Provide all information about his/her health as completely and accurately as possible.
2. Respect the privacy of other clients' and families.
3. Keep all information learned about other clients' and families in the strictest confidence.
4. Keep appointments, and when unable to do so for any reason, notify the appropriate staff.
5. You should maintain the level of contact agreed upon with your provider.
6. Be honest and open about your situation, and inform the case manager and/or medical provider if any changes in your situation.

By participating fully in the case management/primary care relationship, you can obtain the best possible service we can provide.

Grievance Procedure:
In the event a client expresses a grievance with clinical or direct service case managers, the client has the right to speak to the following AGENCY staff. **INSERT NAMES/TITLE OF STAFF HERE**

Staff Name	Title	Contact Information

Appendix 11. Sample Agency Grievance Procedure Rights & Responsibilities

The following procedure for a complaint or concerns should be followed:
1. The complaint should be addressed in writing. The issue will be attempted to be resolved and addressed.
2. The final step at AGENCY will be to discuss the concerns with AGENCY Program Director.
3. If the client does not reach a satisfactory resolution by following the above procedure, or if they are not comfortable filing a grievance directly with AGENCY, the client may file a grievance with the Center for Conflict Resolution, 866-227-3212, at any step during the procedure outlined above.

I have read these rights and responsibilities listed above, or have had them read and explained to me and I fully understand them. I certify by my signature that I have received a copy of them for my future reference.

Case Manager / Staff Witness Signature	Date
Client Signature	Date

Appendix 12. Grievance Tracking Form

AIDS FOUNDATION OF CHICAGO
Northeastern Illinois HIV/AIDS Case Management Cooperative
Grievance Tracking Form

Client: _____ **Client Tract ID:** _____

Case Manager Name:_____

Case Management Agency: _____

Client receives case management services? _____

Client received a copy of or signed the grievance procedure?_____ Date:_____

Client followed the agency grievance procedure? _____

Agency has been contacted by AFC staff?_____

Further action required by AFC staff: _____

Complaint/Inquiry:
Describe the nature of the complaint, include dates and time that the incident occurred and all agency staff that were involved.

Final Outcome:
What did the agency do to resolve the complaint/inquiry?

Additional Comments:

_____ _____
Case Manager Signature Date

_____ _____
Client Signature Date

Appendix 13: AFC Service Complaint Inquiry Form

SERVICE COMPLAINT/INQUIRY
(For AFC STAFF USE ONLY)

Date of Complaint _____ AFC Staff Taking Complaint _____

Client Name _____

Client Address _____

City _____ Zip Code _____ Phone # (_____) _____

Name of caller (if other than client) _____

Relationship to Client _____ Phone # (_____) _____

Does client receive case management services? - Yes _____ No _____

Case manager _____ Agency _____

Did client receive a copy of or sign the agency grievance procedure? Yes _____ No _____

Has the client followed the agency grievance procedure? Yes ____ No ____

Service Complaint/Inquiry-Describe the nature of the complaint, including dates that the incident occurred and all agency staff that were involved. Include any action steps client has already taken to resolve grievance.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Appendix 13: AFC Service Complaint Inquiry Form

ACTION TAKEN BY AFC STAFF

Date Agency was contacted by AFC Staff _____

Name of Agency Staff Contacted _____ Title _____

Date Agency will provide written response to AFC _____

Date Agency responded to complaint/inquiry _____

Final Outcome – What did the agency do to resolve the complaint/inquiry?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Is any further action required by AFC staff? Yes _____ No _____
Comments:

_____

_____

_____

_____

_____

_____

AFC Staff Signature_____

Appendix 14. Confidentiality Violation Report Form

Ryan White Case Management Program
Electronic Health Record Confidentiality and Compliance Report

Provide Enterprise functions as an Electronic Health Record (EHR) that contains Federal and Stated covered documentation and information required in our Program's daily operations. Violation of this confidentiality is an extreme matter, and if continued could result in termination and/or civil liability.

This documentation must be completed, and returned to the AFC Ryan White Program. These will be kept as part of the Internal Compliance file, and may be used for reference in performance standards.

Compliance Violation Information

Provide User in violation:_____

Date violation occurred:_____ Date Violation reported:____

Please provide a summary of the violation:

Corrective Action Plan Summary

User Signature: _____ Date:_____

_____

Supervisor Signature:_____ Date:_____

Appendix 15. Client Satisfaction Survey Template

Client Satisfaction Survey Template

Please note that the Client Satisfaction Survey is not included because it changes year-to-year

HEALTH LITERACY

Question	Scoring	Response
READ TO SUBJECT: This information is on the back of a container of a point of ice cream.		
1. If you eat the entire container, how many calories will you eat?	***Answer:*** *1,000 is the only correct answer*	_____
2. If you are allowed to eat 60 grams of carbohydrates as a snack, how much ice cream could you have?	***Answer:*** *Any of the following is correct: 1 cup (or any amount up to 1 cup), half the container. Note: If patient answers "two servings," ask "How much ice cream would that be if you were to measure it into a bowl?"*	_____
3. Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 g of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day?	***Answer:*** *33 is the only correct answer*	_____
4. If you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?	***Answer:*** *10% is the only correct answer*	_____
READ TO SUBJECT: Pretend that you are allergic to the following substances: penicillin, peanuts, latex gloves, and bee stings.		
5. Is it safe for you to eat this ice cream?	***Answer: No***	_____
6. (Ask only if the patient responds "no" to question 5): Why not?	***Answer:*** *Because it has peanut oil.*	_____
		Total Score: _____
Interpretation: **Score of 0-1 suggests high likelihood (50% or more) of limited literacy.** **Score of 2-3 indicates the possibility of limited literacy.** **Score of 4-6 almost always indicates adequate literacy.**		

Nutrition Facts

Serving Size	½ cup
Servings per container	4

Amount per serving

Calories	250	Fat Cal	120

	%DV
Total Fat 13g	20%
Sat Fat 9g	40%
Cholesterol 28mg	12%
Sodium 55mg	2%
Total Carbohydrate 30g	12%
Dietary Fiber 2g	
Sugars 23g	
Protein 4g	8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.

Appendix 17. Risk Assessment Tool

Risk Assessment

1. How often would you say you have condomless (unprotected) vaginal, anal or oral sex?
   a. Never c. Often e. *Don't Know*
   b. Some of the time d. All of the time f. Refused g. Not Applicable
2. How often do you use lubrication during sexual intercourse?
   a. Never c. Often e. *Don't Know*
   b. Some of the time d. All of the time f. Refused g. Not Applicable
3. Which of the following sexually transmitted infections are curable? (check all that apply)
   a. Chlamydia d. Hepatitis C g. Herpes
   b. Hepatitis B e. Syphilis h. *Don't Know*
   c. Gonorrhea f. Human Papilloma Virus i. Refused
4. Which of the following sexually transmitted infections are not curable? (check all that apply)
   a. Chlamydia d. Hepatitis C g. Herpes
   b. Hepatitis B e. Syphilis h. *Don't Know*
   c. Gonorrhea f. Human Papilloma Virus i. Refused
5. Have you ever exchanged sex for money, drugs, alcohol, a place to stay, or material goods?
   a. Yes c. *Don't Know*
   b. No d. Refused
6. How often have you used drugs or alcohol before or during sex?
   a. Never c. Often e. *Don't Know*
   b. Some of the time d. All of the time f. Refused

7. Have you used a needle to inject drugs into your veins or under your skin, including steroids?
   a. Yes c. *Don't Know*
   b. No d. Refused
8. Have any of your current or past sex partners ever inject drugs into their veins or under their skin, including steroids?
   c. Yes c. *Don't Know*
   d. No d. Refused
9. Have you shared needles for drugs or any other use with your sexual partners?
   a. Yes c. *Don't Know*
   b. No d. Refused
10. How often do you discuss your HIV status with your sexual partners?
    a. Never c. Often e. *Don't Know*
    b. Some of the time d. All of the time f. Refused
11. How likely are you to have condomless (unprotected) sex if your viral load is undetectable?
    a. Never c. Often e. *Don't Know*
    b. Some of the time d. All of the time f. Refused
12. How likely are you to have condomless (unprotected) sex with another HIV+ partner?
    a. Never c. Often e. *Don't Know*
    b. Some of the time d. All of the time f. Refused
13. How likely are you to have condomless (unprotected) sex with a negative-partner?
    a. Never c. Often e. *Don't Know*
    b. Some of the time d. All of the time f. Refused
14. How likely are you to have condomless (unprotected) sex with a negative-partner, if they were on PrEP)?
    a. Never c. Often e. *Don't Know*
    b. Some of the time d. All of the time f. Refused

Appendix 17. EVALUACIÓN DE RIESGO

EVALUACIÓN DE RIESGO

1. ¿Con que frecuencia dirías que tienes sex sexo vaginal, anal u oral sin protección?

   a. Nunca c. Muchas veces e. No saben

   b. De vez en cuando d. Todo el tiempo f. Se negó

2. ¿Con qué frecuencia utilizas lubricación durante relaciones sexuales?

   a. Nunca c. Muchas veces e. No saben

   b. De vez en cuando d. Todo el tiempo f. Se negó

3. ¿Cuáles de las siguientes infecciones de transmisión sexual son curables?

   a. Chlamydia d. Hepatitis C g. Herpes

   b. Hepatitis B e. sífilis h. No sé

   c. Gonorrea f. Virus de papiloma humano i. Se negó

4. ¿Cuál de las siguientes infecciones de transmisión sexual no son curables?

   a. Chlamydia d. Hepatitis C g. Herpes

   b. Hepatitis B e. sífilis h. No sé

   c. Gonorrea f. Virus de papiloma humano i. Se negó

5. ¿Ha intercambiado sexo por dinero, drogas, alcohol, un lugar para quedarse o bienes materiales?

   a. Sí c. No sé

   b. No d. Se negó

6. ¿Con qué frecuencia usted ha utilizado drogas o alcohol antes o durante el sexo?

   a. Nunca c. Muchas veces e. No sabe

   b. De vez en cuando d. Todo el tiempo f. Se negó

7. ¿Ha usado una aguja para inyectarse en las venas o debajo de la piel drogas, incluyendo esteroides?

   a. Sí c. No sé

   b. No d. Se negó

8. ¿Ha tenido parejas sexuales actuales o antiguas, donde ellos se inyectaron drogas en las venas o debajo de la piel, incluyendo esteroides?

   a. Sí c. No sé

   b. No d. Se negó

9. ¿Ha compartido agujas para el uso de drogas o cualquier otro uso con sus parejas sexuales?

   a. Sí c. No sé

   b. No d. Se negó

10. ¿Con qué frecuencia discute su estatus de VIH con su pareja?

    a. Nunca c. Muchas veces e. No saben

    b. De vez en cuando d. Todo el tiempo f. Se negó

11. ¿Qué probabilidades hay de tener relaciones sexuales (sin protección) si su carga viral es indetectable?

    a. Nunca c. Muchas veces e. No saben

    b. De vez en cuando d. Todo el tiempo f. Se negó

12. ¿Qué probabilidades hay de tener relaciones sexuales (sin protección) si su pareja es VIH-positivo?

    a. Nunca c. Muchas veces e. No saben

    b. De vez en cuando d. Todo el tiempo f. Se negó

13. ¿Qué probabilidades hay de que tener relaciones sexuales (sin protección) si su pareja es VIH-negativa?

    a. Nunca c. Muchas veces e. No saben

    b. De vez en cuando d. Todo el tiempo f. Se negó

14. ¿Qué probabilidades hay de que tener relaciones sexuales (sin protección) si su pareja es VIH negativa, y estuviera tomando profilaxis pre-exposición (PrEP)?

    a. Nunca c. Muchas veces e. No saben

    b. De vez en cuando d. Todo el tiempo f. Se negó

AFC Ryan White Case Management Level of Need Analysis

Client name: _____ Case manager name: _____

Instructions: Identify your client's level of need by answering the questions below that best fits your client's situation. Please check the appropriate box after each question.

Section one:

1. Does the client need reminders and assistance to remain adherent to HIV medication? (2 points)
   ☐ Yes ☐ No
2. Does client need frequent medical care for HIV and/or co-morbid conditions requiring them to need frequent contact for medical and social service appointments? (2 points)
   ☐ Yes ☐ No
3. Does client have physical or mental disabilities (does not qualify for DRS) and need special care and assistance? (3 points)
   ☐ Yes ☐ No
4. Does client need health education and social support to remain adherent to care plan goals? (1 point)
   ☐ Yes ☐ No
5. Does client have an unstable housing situation which is directly linked to non-adherence to medication and/or appointments? (3 points)
   ☐ Yes ☐ No
6. Does client experience mental health challenges that affects their ability to complete activities of daily living? (2 points)
   ☐ Yes ☐ No
7. Does client experience substance abuse challenges that affects their ability to complete activities of daily living? (2 points)
   ☐ Yes ☐ No
8. Is the client pregnant and need support for medical visits? (3 points)
   ☐ Yes ☐ No
9. Is the client experiencing medical complications that creates a need for assistance with referrals to specialty care or durable medical equipment? (2 points)
   ☐ Yes ☐ No
10. Is the client in need of assistance with end of life plans and/or coordination of services for palliative/hospice care? (1 point)
    ☐ Yes ☐ No

Please add up total score below

Total score: 0

AFC Ryan White Case Management Level of Need Analysis

Section two:

1. Does client need assistance enrolling into ADAP? (1 point)
   ☐ Yes ☐ No
2. Does client need assistance enrolling into insurance programs? (2 points)
   ☐ Yes ☐ No
3. Does client need assistance with public benefits such as: Link, Medicaid, etc.? (2 points)
   ☐ Yes ☐ No
4. Does client need Emergency Financial Assistance to maintain/secure housing? (3 points)
   ☐ Yes ☐ No
5. Is client aging and in good health but needs referrals to supportive services? (2 points)
   ☐ Yes ☐ No
6. Has client been treated for mental health and/or substance abuse issues, but needs supportive services such as medical transportation? (1 point)
   ☐ Yes ☐ No
7. Does client need special care that is met with DRS (traditional or MCO) home services and only needs assistance remaining eligible for Ryan White services? (1 point)
   ☐ Yes ☐ No
8. Is client pregnant and needs supportive services related to HIV, such as: transportation, food, referrals, etc.? (2 points)
   ☐ Yes ☐ No

Total:

Section one: 0 / 21 points

Section two: 0 /14 points

Case manager signature: _____ Date: _____

AFC Ryan White Case Management Level of Need Analysis

Level of Need	
Medical case management *If client scored 1 or more points in section one, client is eligible for medical case management services*	Client needs help getting linked to health care, psychosocial, and other services. This includes coordination and follow-up of health and supportive services. Treatment adherence counseling, assessments, service plans, coordination, and monitoring are necessary for client to remain in good health.
Non-medical case management *If client scored 0 points in section one but scored at least one point in section two, client is eligible for non-medical case management services*	Client needs services to provide assistance in obtaining medical, social, community, legal, financial, and other needed services. This includes benefit/entitlement counseling and referral activities to help clients obtain access to programs which they may be eligible.

Client Screening & Placement Form

Client ID: _____ Contact Date: _____

Agency: _____ Staff Name: _____

First Name: _____ Last Name: _____

CODE	DEMOGRAPHICS

DOB **1. What is your date of birth?** _____
month day year

Gender **2. What is your gender?**
1 - Male
2 - Female
3 - Transgender (Male to Female)
4 - Transgender (Female to Male)
5 - Other (Describe: _____)
6 - Doesn't know
7 - Refused to answer

Rlshp **3. What is your current relationship status?**
1 - Single, Never Married
2 - Divorced
3 - Widowed
4 - Married
5 - Engaged
6 - Partnered
7 - Separated
8- Refused to Answer

Address **4. What is your address?**
Street _____
City _____ State Illinois Zip Code ___

Phone # **5. What is your phone number?**
Home _____ Other _____
Cellular _____

Hispanic **6. Are you Hispanic or Latino?**
1 - Yes, Hispanic /Latino
2 - No, Non-Hispanic / Latino
7 - Doesn't Know
8- Refused to Answer

Race **7. What is your race?**
1 - American Indian/Alsakan Native
2 - Asian
3 - Black / African American
4 - Native Hawaiian / Pacific Islander
5 - White
7 - Doesn't Know
8- Refused to Answer

Country **8. What country were you born in?** _____

Language **9. What is your primary language?** _____
Note: If primary language is English, skip to next section. If primary language is other than English, go to question 10.

Eng. Prof **10. Do you consider yourself to have limited English proficiency?**

1 - Yes
2 - No
7 - Doesn't Know
8- Refused to Answer

CODE	GENERAL HEALTH
GH1	**1. When did you first test HIV-positive?** Month Day Year
GH2	**2. When did you last see a medical provider for HIV-related medical reasons? This could include a check-up with an HIV medical provider or another primary care provider whom you may have seen for HIV-related reasons.** Month Day Year
GH3	**3. Are you currently taking HIV medications, also known as antiretroviral therapy?** 1 - Yes 2 - No 7 - Doesn't Know 8- Refused to Answer
GH4	**4. In general, would you say your health is:** 1 - Excellent 2 - Very Good 3 - Good 4 - Fair 5 - Poor 7 - Doesn't Know 8- Refused to Answer
CODE???	**5. Compared to one year ago, how would you rate your health in general now?** 1 - Much better now than one year ago 2 - Somewhat better now than one year ago 3 - About the same as one year ago 4 - Somewhat worse now than one year ago 5 - Much worse now than one year ago 7 - Doesn't Know 8 - Refused to Answer

CODE	DISCLOSURE & SOCIAL SUPPORT
DSS6	**6. Among your close FRIENDS, how many know that you are HIV positive?** 1 - None 2 - A few 3 - About half 4 - Most 5 - All 7 - Doesn't Know 8 - Refused to Answer 9 - Not applicable, no close friends

DSS7 **7. Among your close FAMILY, how many know that you are HIV positive?**

1 - None
2 - A few
3 - About half
4 - Most
5 - All
7 - Doesn't Know
8 - Refused to Answer
9 - Not applicable, no close friends

DSS8 **8. Are there people who are close to you (family, friends, etc.) whom you want to tell that you are HIV+ but have not?**

1 - Yes
2 - No
7 - Doesn't Know
8- Refused to Answer

DSS9 **9. Do you agree with the following statement? There are other people in my life that I am close to who are also HIV positive:**

1 - Yes (Skip to Question 9a)
2 - No
7 - Doesn't Know
8- Refused to Answer

DSS9a **9a. Of these people, are some taking HIV medications that you know of?**

1 - Yes (Skip to Question 9a)
2 - No
7 - Doesn't Know
8- Refused to Answer

DSS10 **10. Do you agree or disagree with the following statement? "There are people I can depend on to help me if I really need it."**

1 - Strongly Agree
2 - Agree
3 - Neither agree nor disagree
4 - Disagree
5 - Strongly disagree
7 - Doesn't Know
8 - Refused to Answer

Note: If client says "Agree", ask "Would you say that you Strongly Agree or just Agree?
Note: If client says "Disagree", ask "Would you say that you Disagree Agree or just Disagree?

CODE	STIGMA

Instructions: The following questions are about your experiences living with HIV and how other people have reacted or how they might react if they knew you are HIV-positive. I am going to read some statements, and for each I want you to tell me whether it is true for you. The choices I would like you to use are "not at all, rarely, sometimes, or often. " Here is the first one…

S11 **11. I've felt people avoid me because I have HIV. Would you say that for you this is true "not at all, rarely, sometimes, or often?"**

1 - Not At All	2 - Rarely	3 - Sometimes	4 - Often	7 - Don't Know	8- Refused

S12 **12. I've feared I would lose my friends if they learned about my HIV.**

1 - Not At All	2 - Rarely	3 - Sometimes	4 - Often	7 - Don't Know	8- Refused

S13 **13. I've thought other people were uncomfortable being with me because of my HIV.**

1 - Not At All	2 - Rarely	3 - Sometimes	4 - Often	7 - Don't Know	8- Refused

CODE	STIGMA

S14 **14. I've avoided getting treatment because someone might find out about my HIV.**

1 - Not At All	2 - Rarely	3 - Sometimes	4 - Often	7 - Don't Know	8- Refused

CODE	BELIEFS ABOUT MEDICATIONS

Part 1 For All Clients: We are interested in your thoughts about taking medications. Please say whether you agree or disagree with each of the following statements about the general use of medications for any medical reasons.

BAM15 **15. Doctors prescribe too many medications.**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

BAM16 **16. Medications do more harm than good.**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

BAM16 **17. Doctors place too much trust in medications.**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

Note: If client says "Agree", ask "Would you say that you Strongly Agree or just Agree?
Note: If client says "Disagree", ask "Would you say that you Disagree Agree or just Disagree?

Part 2 for clients on ARVs only

BAM18vA 18. Now I am going to ask you some questions about your HIV treatment and HIV medications. Thinking back over the past 30 days, please rate your ability to take all your HIV medications as prescribed. Would you say Very poor, poor, fair, good, very good, or excellent?

1 - Very Poor
2 - Poor
3 - Fair
4 - Good
5 - Very good
6 - Excellent
7 - Doesn't Know
8- Refused to Answer

Part 3 for clients NOT ARVs: Now I would like to ask you about your thoughts about taking HIV medications. Even though you are not taking HIV medications, please say whether you agree or disagree with the following statements about what it would be like for you to take HIV medications.

BAM18vB **18. Taking HIV medications on a schedule would be easy for me.**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

BAM19vB **19. I never want to take HIV medications**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

BAM20vB **20. I would not want people to know that I am taking HIV medications.**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

CODE	SUBSTANCE ABUSE

INSTRUCTIONS: I am going to change topics and ask you about alcohol and drug use. Remember that your responses are confidential.

SAMISS1 **1. How often do you have a drink containing alcohol? (Alcoholic drinks include one beer, one glass of wine, a mixed drink of hard liquor, or one wine cooler. Each of these counts as one drink, unless they have double shots, which would equal two drinks.) (If client does not drink, go to question #4.)**

0 - Never
1 - Monthly or less
2 - 2-4 times per month
3 - 2-3 times per week
4 - 4 or more times per week
7 - Doesn't Know
8- Refused to Answer

SAMISS2 **2. How many drinks do you have on a typical day when you are drinking?**

0 - 1-2 drinks per day
1 - 3-4 drinks per day
2 - 5-6 drinks per day
3 - 7-9 drinks per day
4 - 10 or moer drinks per day
7 - Doesn't Know
8- Refused to Answer

CODE	SUBSTANCE ABUSE (Cont.)

SAMISS3 **3. How often do you have four or more drinks on one occasion?**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

SAMISS4 **4. During the past 12 months, how often did you use non-prescription drugs to get high or to change the way you feel?**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

SAMISS5 **5. During the past 12 months, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel?**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

CODE	SUBSTANCE ABUSE (Cont.)

SAMISS6 **6. During the past 12 months, how often did you drink or use drugs more than you meant to?**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

SAMISS7 **7. How often did you feel you wanted or needed to cut down on your drinking or drug use inthe past 12 months, and not been able to?**

1 - Strongly Agree	2 - Agree	3 - Neither Agree / Disagree	4 - Disagree	5 - Strongly Disagree	7 - Don't Know	8- Refused

DATA ENTRY

Client considered positive for substance use symptoms if ANY of the following criteria are met:

The sum of responses for Questions 1-3 is ≥ 5 Q1-3= ____
The sum of responses for Questions 4-5 is ≥ 3 Q4-5= ____
The sum of responses for Questions 6-7 is ≥ 1 Q6-7= ____

SU **Did client screen positive for substance abuse symptoms?**
1 - Yes ___ 2 - No ___

CODE	MENTAL HEALTH

Now I am going to ask you some questions about your well-being or psychological health.

SAMISS8 **8. During the past 12 months, were you ever on medication/antidepressants for depression or nerve problems?**

1 - Yes	2 - No	7 - Don't Know	8- Refused

SAMISS9 **9. During the past 12 months, was there ever a time when you felt sad, blue, or depressed for 2 weeks or more in a row?**

1 - Yes	2 - No	7 - Don't Know	8- Refused

SAMISS10 **10. During the past 12 months, was there ever a time lasting 2 weeks or more when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?**

1 - Yes	2 - No	7 - Don't Know	8- Refused

CODE	MENTAL HEALTH (Cont.)

SAMISS11 **11. During the past 12 months, did you ever have a period lasting 1 month or longer when most of the time you felt worried and anxious?**

1 - Yes	2 - No	7 - Don't Know	8- Refused

CODE	MENTAL HEALTH (Cont.)

SAMISS12 **12. During the past 12 months, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?**

1 - Yes	2 - No	7 - Don't Know	8- Refused

SAMISS13 **13. During the past 12 months, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you feltfaint, or you couldn't catch your breath? (IF respondent volunteers"only when having a heart attack or due to physical causes," mark "NO".)**

1 - Yes	2 - No	7 - Don't Know	8- Refused

DATA ENTRY

Patient considered positive for symptoms of mental illness if he/she responded yes to any mental health question.

MH Yes **Did client screen positive for mental illness symptoms?**
1 - Yes ___ 2 - No ___

MH Yes **Did client screen positive for co-occurring mental health substance use disorders?**
1 - Yes ___ 2 - No _____

CODE	SERVICES NEEDED

I am going to read to you a list of services and resources. Please tell me which ones are ones that you currently need. (Screener check Yes or No for each)

Code	I need….	1 - Yes	2 - No	7 - Don't Know	8- Refused
SVC22	22. Case management services, such as assistance in obtaining medical, legal, financial, and other needed services				
SVC23	23. Housing or shelter				
SVC24	24. Food or other basic needs				
SVC25	25. Dental services				
SVC26	26. HIV-Related Medical services				
SVC27	27. Non HIV-related medical services				
SVC28	28. Pharmacy or medication services (for HIV or non HIV reasons)				
SVC29	29. Mental Health services				
SVC30	30. Vocational/Job Training				
SVC31	31. Assistance with Benefits and Entitlements, such as Medicaid, SSI				
SVC32	32. Drug or alcohol abuse treatment				

NOTE: If caller identifies more than one need, ask:

SVC33 Of those services, which one is the most urgent for you now?

Document Here:

CODE	FOLLOW-UP INTERVIEW				
	Follow Up Questions	**1 - Yes**	**2 - No**	**7 - Don't Know**	**8- Refused**
FUI1	**1. The AIDS Foundation of Chicago may want to call you back in ____ the coming year or so to conduct a follow-up interview. Would it be alright if we called you back at that time?**				
FUI2	**2. Just to confirm, you can be reached at this telephone number: (READ BACK TELEPHONE NUMBER). Is this correct?**				
FUI3	**3. Are there any other alternative phone numbers where you can be reached? If Yes, answer 3a.**				

FUI3a **What is the number, area code first.** _____

ACA Passport for Enrollment Assistance Coordination

Bring this form and all documentation listed below to your appointment with your Medical Benefits Coordinator or Medical Case Manager. You can also use this form if you are self-enrolling over the phone at 800-318-2596 or through the healthcare.gov website.

Your Name: _____ DOB: _____

Your Social Security #: _____ Phone #: _____

Case Manager: _____

Documents to bring to my appointment for ACA Enrollment:

- State ID or other form of identification with my picture
- Most recent year's tax forms- Federal 1040
- Pay Stubs or checks from jobs dated w/in the last 90 days (if you or someone in the household is currently working)
- Social security cards or Numbers (for all household members listed in your taxes)
- Proof of immigration status (if not US citizen &/or if status has changed since recently)
- Piece of mail such as government mail, phone or utility bill, rent or lease receipt w/my current address dated w/in the last 90 days.
- List of medications including dosage, physicians, specialist, and clinics\hospitals you use (for all tax household members)

MY MEDICATIONS:

1.	**5.**
2.	**6.**
3.	**7.**

- **My household's monthly income is _____ & the annual income is _____**
- **My spouse is named: _____ & I have _____ as dependents**
- **My primary care provider is: _____ at _____ clinic/hospital.**
- **My specialist physician is: _____ at _____ clinic/hospital.**
- **Other specialist I see: _____ at _____ clinic/hospital.**
- **My psychiatrist/mental health provider is: _____ at _____ clinic/hospital.**
- **My current Insurance is: _____.**
- **My (or my spouse's job) offers _____ insurance at $ _____ /month to cover me.**

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

By signing this form, I understand that as long as I am employed under the role defined below I am a mandated reporter as outlined in the Mandated Reporting section of the Illinois Ryan White Part B Program manual.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report activity covered in this section. I know that if I willfully fail to report any activity covered in this section, I will face disciplinary action up to and including termination of employment and potential legal action.

I also understand that if I am subject to licensing under other regulations including but not limited to the Illinois Nursing Act of 1987, the Medical Practice Act of 1987 the Dental Practice Act of 1987, The School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willingly fail to report activities covered under these regulations.

By signing this form, I affirm that I have read this statement and have knowledge and understanding of the reporting requirements and regulations which apply to me.

_____

Name of Employee (print)

_____

Employee Agency and Role (print)

_____

Signature of Employee **Date**

ILLINOIS Department of Public Health

Ryan White Part B Program

CONOCIMIENTO DE LA CONDICION DE REPORTERO OBLIGATORIO

Al firmar este formulario, entiendo que al estar empleado en la función que se define a continuación, soy un reportero obligatorio según se describe en la sección de Informes Obligatorios del manual del Programa Ryan White Part B de Illinois.

Además, entiendo que la calidad de comunicación privilegiada entre mi paciente o cliente y mi persona no es motivo para no informar la actividad cubierta en esta sección. Entiendo que, si voluntariamente no informo cualquier actividad cubierta en esta sección, enfrentaré una acción disciplinaria que puede incluir la terminación del empleo y una posible acción legal.

También entiendo que si estoy sujeto a una licencia según otras regulaciones, entre las que se incluyen la Ley de enfermería de Illinois de 1987, la Ley de práctica médica de 1987, la Ley de práctica dental de 1987, el Código escolar, la Ley de práctica de acupuntura, la Optometría de Illinois. Ley de Práctica de 1987, Ley de Terapia Física de Illinois, Ley de Práctica de Asistentes Médicos de 1987, Ley de Práctica Médica Podológica de 1987, Ley de Licencia de Psicólogo Clínico, Ley de Práctica Social y Trabajo Social Clínico, Ley de Práctica de Entrenadores Atléticos de Illinois, el Acta de Práctica de Servicios Dietéticos y de Nutrición, el Acta de Terapia Familiar y Matrimonial, el Acta de Práctica Naprapática, el Acta de Práctica de Cuidado Respiratorio, el Acta de Licenciamiento de Consejería Profesional y Asesora Profesional Clínica, el Acta de Práctica de Patología del Habla y Lenguaje de Illinois, puede que este sujeto a la suspensión o revocación de dicha licencia si voluntariamente no informo las actividades cubiertas por estas regulaciones.

Al firmar este formulario, afirmo que he leído esta declaración y que tengo conocimiento y comprensión de los requisitos y regulaciones de información que aplican a mi persona.

_____

Nombre del empleado (letra de imprenta)

_____

Agencia de empleo y cargo (imprimir)

_____

Firma del empleado **Fecha**

ILLINOIS Department of Public Health

Ryan White Part B Program

HOUSEHOLD INCOME STATEMENT

Client First Name	Middle Initial	Client Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)

Separate section must be filled out for each legal household member age 18 and over – even if they do not earn income

All sources in **BOLD and with an asterisk that have an amount or are answered with a YES require additional supporting documentation**

Client		Additional Legal Household Member over age 18	
		Name:	
CURRENT MONTHLY INCOME (cannot leave blank)		**CURRENT MONTHLY INCOME (cannot leave blank)**	
Wages, salaries, cash, tips	*	**Wages, salaries, cash, tips, etc.**	*
Do you receive pay stubs (yes/no)?	*	**Do you receive pay stubs (yes/no)?**	*
Alimony or spousal support received		Alimony or spousal support received	
Self-employed, business income or loss	*	**Self-employed, business income or loss**	*
IRA Distributions		IRA Distributions	
Pensions and annuities (veteran or employer based pensions, retirement or disabilities)	*	**Pensions and annuities (veteran or employer based pensions, retirement or disabilities)**	*
Rental, real estate, partnerships, S Corporations, trusts		Rental, real estate, partnerships, S Corporations, trusts	
Farm income or loss		Farm income or loss	
Unemployment Income	*	**Unemployment Income**	*
Retirement from Social Security (SSA)	*	**Retirement from Social Security (SSA)**	*
Disability from Social Security (SSDI)	*	**Disability from Social Security (SSDI)**	*
Supplemental Income from Social Security (SSI)		Supplemental Income from Social Security (SSI)	
Other income (jury duty, gambling, etc.)	*	**Other income (jury duty, gambling, etc.)**	*
Child Support, workers compensation		Child Support, workers compensation	
Did you file a tax return (yes/no)?		**Did this person file a tax return separately (yes/no)?**	

Comments (Additional room for comments on back):

Client Signature **Date**

ILLINOIS Department of Public Health

Ryan White Part B Program

HOUSEHOLD INCOME STATEMENT

This page is only required if there are more than one additional legal household member over age 18.

Additional Legal Household Member over age 18		**Additional Legal Household Member over age 18**	
Name:		**Name:**	
CURRENT MONTHLY INCOME (cannot leave blank)		**CURRENT MONTHLY INCOME (cannot leave blank)**	
Wages, salaries, cash, tips	*	**Wages, salaries, cash, tips, etc.**	*
Do you receive pay stubs (yes/no)?	*	**Do you receive pay stubs (yes/no)?**	*
Alimony or spousal support received		Alimony or spousal support received	
Self-employed, business income or loss	*	**Self-employed, business income or loss**	*
IRA Distributions		IRA Distributions	
Pensions and annuities (veteran or employer based pensions, retirement or disabilities)	*	**Pensions and annuities (veteran or employer based pensions, retirement or disabilities)**	*
Rental, real estate, partnerships, S Corporations, trusts		Rental, real estate, partnerships, S Corporations, trusts	
Farm income or loss		Farm income or loss	
Unemployment Income	*	**Unemployment Income**	*
Retirement from Social Security (SSA)	*	**Retirement from Social Security (SSA)**	*
Disability from Social Security (SSDI)	*	**Disability from Social Security (SSDI)**	*
Supplemental Income from Social Security (SSI)		Supplemental Income from Social Security (SSI)	
Other income (jury duty, gambling, etc.)	*	**Other income (jury duty, gambling, etc.)**	*
Child Support, workers compensation		Child Support, workers compensation	
Did you file a tax return (yes/no)?		**Did this person file a tax return separately (yes/no)?**	

Comments (Additional room for comments on back):

Client Signature **Date**

ILLINOIS Department of Public Health

Ryan White Part B Program

DECLARACION DE INGRESOS

Primer Nombre del Cliente	Segundo	Apellido del Cliente

Numero de Seguro Social (se puede dejar en blanco si no posee un numero)	Fecha de Nacimiento (mm/dd/yyyy)

Cada miembro legal del hogar de 18 años o más tiene que completar una sección por separado - incluso si no tiene ingreso

Todos los campos sombreados o con *asteriscos* con un monto o una "S" requieren documentación acreditativa ADICIONAL

Cliente		**Miembro adicional de la residencia**	
		Nombre:	
Ingreso Mensual Actual (Esta sección no se puede dejar en blanco)		**Ingreso Mensual Actual (Esta sección no se puede dejar en blanco)**	
Sueldos, salarios, efectivo, propinas	*	**Sueldos, salarios, efectivo, propinas**	*
¿Recibe usted recibos de nómina (si/no)?	* Si	**¿Recibe usted recibos de nómina (si/no)?**	* Si
Pensión alimenticia/manutención conyugal recibida		Pensión alimenticia/manutención conyugal recibida	
Ingresos/pérdidas del trabajo por cuenta propia/empresa	*	**Ingresos/pérdidas del trabajo por cuenta propia/empresa**	*
Distribuciones de IRA (Cuenta de retiro individual)		Distribuciones de IRA (Cuenta de retiro individual)	
Pensiones y anualidades(Veteranos o pensiones, jubilaciones o discapacidad financiados por el empleador)	*	**Pensiones y anualidades(Veteranos o pensiones, jubilaciones o discapacidad financiados por el empleador)**	*
Bienes raíces para renta, sociedades, Sociedades Anónimas S, fideicomisos, etc.		Rental, real estate, partnerships, S Corporations, trusts	
Ingresos o pérdidas agrícolas		Ingresos o pérdidas agrícolas	
Ingresos de desempleo	*	**Ingresos de desempleo**	*
Jubilación del Seguro Social (SSA)	*	**Jubilación del Seguro Social (SSA)**	*
Discapacidad del Seguro Social (SSDI)	*	**Discapacidad del Seguro Social (SSDI)**	*
Ingreso Suplementario del Seguro Social (SSI)		Ingreso Suplementario del Seguro Social (SSI)	
Otros ingresos (retribución por servicio de jurado, ganancias de juegos de azar)	*	**Otros ingresos (retribución por servicio de jurado, ganancias de juegos de azar)**	*
Ingresos de manutención infantil, indemnización de empleador		Ingresos de manutención infantil, indemnización de empleador	
¿Usted ha presentado una Declaración de impuestos?	Si	**¿Usted ha presentado una Declaración de impuestos?**	Si
Comentarios:			

ILLINOIS Department of Public Health

Ryan White Part B Program

DECLARACION DE INGRESOS

Firma del Cliente **Fecha**

Esta página solo se requiere si hay más miembros que deben declarar ingresos

Miembro adicional de la residencia mayor de 18 años		**Miembro adicional de la residencia mayor de 18 años**	
Nombre:		**Nombre:**	
Ingreso Mensual Actual (Esta sección no se puede dejar en blanco)		**Ingreso Mensual Actual (Esta sección no se puede dejar en blanco)**	
Sueldos, salarios, efectivo, propinas	*	**Sueldos, salarios, efectivo, propinas**	*
¿Recibe usted recibos de nómina (si/no)?	* Si	**¿Recibe usted recibos de nómina (si/no)?**	* Si
Pensión alimenticia/manutención conyugal recibida		Pensión alimenticia/manutención conyugal recibida	
Ingresos/pérdidas del trabajo por cuenta propia/empresa	*	**Ingresos/pérdidas del trabajo por cuenta propia/empresa**	*
Distribuciones de IRA (Cuenta de retiro individual)		Distribuciones de IRA (Cuenta de retiro individual)	
Pensiones y anualidades(Veteranos o pensiones, jubilaciones o discapacidad financiados por el empleador)	*	**Pensiones y anualidades(Veteranos o pensiones, jubilaciones o discapacidad financiados por el empleador)**	*
Bienes raíces para renta, sociedades, Sociedades Anónimas S, fideicomisos, etc.		Bienes raíces para renta, sociedades, Sociedades Anónimas S, fideicomisos, etc.	
Ingresos o pérdidas agrícolas		Ingresos o pérdidas agrícolas	
Ingresos de desempleo	*	**Ingresos de desempleo**	*
Jubilación del Seguro Social (SSA)	*	**Jubilación del Seguro Social (SSA)**	*
Discapacidad del Seguro Social (SSDI)	*	**Discapacidad del Seguro Social (SSDI)**	*
Ingreso Suplementario del Seguro Social (SSI)		Ingreso Suplementario del Seguro Social (SSI)	
Otros ingresos (retribución por servicio de jurado, ganancias de juegos de azar)	*	**Otros ingresos (retribución por servicio de jurado, ganancias de juegos de azar)**	*
Ingresos de manutención infantil, indemnización de empleador		Ingresos de manutención infantil, indemnización de empleador	
¿Usted ha presentado una Declaración de impuestos?	Si	**¿Usted ha presentado una Declaración de impuestos?**	Si
Comentarios:			

Firma del Cliente (Requerido) **Fecha**

Ryan White Initial Assessment/Reassessment Checklist
(To be completed at intake for all Ryan White clients)

Forms/Documentation	**Date Completed/Received**
Client Screening Form/Placement Screening Form (from AFC)	_____
AFC Consent to Release Information (AFC form)	_____
RW Authorization to Release Form	_____
Eligibility Assessment	_____
Care Plan	_____
Medical Update Form to Physician (AFC form)	Date Sent: _____
	Date Received: _____
Client Photo ID (Driver's License/State ID)	_____
Client Proof of Residency (Any 2 of the following)	_____

- Utility bill with client name and current address
- Driver's license or state ID with current address
- Documents issued by the state or federal government (i.e., a motor vehicle registration form, a current Illinois voter registration card, or a current Medicaid card)
- Current rental or lease agreement with client name

Client Proof of Income _____

- Current pay stubs – 1 months' worth
- Most recent W2 forms
- Unemployment Benefits Statements
- Most recent SSI benefits statement
- Most recent Tax returns.
- If the client did not file taxes a copy of the Mock MAGI (Modified Adjusted Gross Income) Form
- For clients with no income, a mock MAGI form, signed and dated by client and CM

Client copy of CD4 and Viral Load within the past 6months _____

Client Proof of HIV Status (Part A Clients) _____

Client's name must be on any of the following:

- Medical Assessment with diagnosis identified
- Official lab result with any detectable viral load
- Positive ELISA & Western Blot
- Positive Serology assay
- Positive DNA PCR assay
- Client Rights and Responsibilities (Agency Form) _____
- Client Grievance Policy (Agency Form) _____
- HIPAA Policy (when applicable) (Agency Form) _____

Client Intake and Reassessment Form

Date:

CLIENT PROFILE:

Client First Name:	Client Last Name:
Also Known As:	Suffix:
Social Security Number:	

DEMOGRAPHIC INFORMATION

Date of Birth:				Current Age:	
Gender:	◯ Male	◯ Female	◯ Transgender Female to Male	◯ Transgender Male to Female	
Birth Gender:			◯ Male	◯ Female	
◯ Married	◯ Single	◯ Divorced	◯ Widowed	◯ Legally Separated	◯ Civil Union
Veteran's Status		◯ Yes	◯ No		

RACE (Check all that apply)

◯ Alaskan Native	◯ Pacific Islander
◯ Asian	◯ White
◯ Black / African-American	◯ Other
◯ Native American	◯ Unknown / Unreported
◯ Native Hawaiian	

ETHNICITY

◯ Hispanic	◯ Non-Hispanic

LANGUAGE & EDUCATION

Primary Language:	Country of Origin:

◯ Married	◯ Single	◯ Divorced	◯ Widowed	◯ Legally Separated	◯ Civil Union

RESIDENTIAL & CONTACT INFORMATION

Current Address:	
City, State, Zip Code:	Okay to send mail: ◯ Yes ◯ No
Mailing Address:	
City, State, Zip Code:	Okay to send mail: ◯ Yes ◯ No
ADAP Medication Shipping Address:	
City, State, Zip Code:	Okay to send meds: ◯ Yes ◯ No

Primary Phone Number:	◯ Home	◯ Mobile	◯ If Mobile, okay to text
Secondary Phone Number:	◯ Home	◯ Mobile	◯ If Mobile, okay to text
Email Address:	◯ Yes, Email		◯ No, Don't Email

RESIDENCE INFORMATION (Current Residence Type)

◯ Apartment or home that you rent	◯ Permanent housing for formerly homeless persons
◯ Condo you own or house that you own	◯ Place not meant for habitation
◯ Domestic violence shelter	◯ Psychiatric hospital or other psychiatric facilities – short term
◯ Emergency shelter	◯ Psychiatric hospital or other psychiatric facilities – long term
◯ Foster Care home or foster care group home	◯ Psychiatric hospital or other psychiatric facilities – long term
◯ Homeless from emergency shelters	◯ Place not meant for habitation
◯ Homeless from the streets	◯ Staying or living in FAMILY member's room apartment of house or house
◯ Hospital (Non – Psychiatric)	◯ Staying or living in FRIEND'S member's room apartment of house or house
◯ Hotel or motel paid for without emergency voucher	◯ Substance Abuse facility or detox center
◯ Jail prison or Juvenile detention facility	◯ Transitional housing for homeless person
◯ Other Describe Here:	

HOUSEHOLD Who do you live with?

Person #1

First Name:		Last Name:
Relationship to you:	Phone Number:	◯ Okay to contact
Do you claim this person as a dependent or spouse on your tax returns?		◯ Yes ◯ No
Date of Birth:	Gender: ◯ Male ◯ Female	Ethnicity:
Proof of Income:		

Person #2

First Name:		Last Name:
Relationship to you:	Phone Number:	◯ Okay to contact
Do you claim this person as a dependent or spouse on your tax returns?		◯ Yes ◯ No
Date of Birth:	Gender: ◯ Male ◯ Female	Ethnicity:
Proof of Income:		

EMPLOYMENT STATUS

◯ Full-time	◯ Part-Time	◯ Unemployed/Lay-Off	◯ Self-Employed
◯ Retired	◯ Temporary / Contract	◯ Temporary Medical Disability	

INCOME

◯ Alimony / Spousal Support: $	◯ Exempt Interest Dividend (1099-INT box 8): $
◯ Business or self-employed income/loss (Schedule C or C-EZ): $	◯Taxable Refund State/Local Income Taxes: $
◯ Capital Gain/Loss (Schedule D): $	◯ Taxable Interest (1099-INT Form): $
◯ Ordinary Dividends (1099-INT 1a):$	◯ Tax-Exempt Interest (1099 INT box 8):$
◯ Other Gains/Loss (Form 4797): $	◯ Wages, Salaries, Tips (W-2):$

INCOME (continued)

◯ IRA Distribution taxable amount: $	◯ Supplemental Social Security Income: $
◯ Pension and Annuities: $	◯ Other Child Support $
◯ Rental Real Estate Trusts (Schedule E): $	◯ Other Workman's Compensation $
◯ Farm Income/Loss (Schedule F): $	◯ Other Describe:
◯ Retirement Income from Social Security: $	◯ Unemployment Income: $
◯ Social Security Disability (SSDI): $	

CURRENT HOUSEHOLD INCOME

◯ Alimony paid: $	◯ IRA deduction: $
◯ Business Expenses (2106 or 2106-EZ): $	◯ Penalty on early withdrawer of savings $
◯ Educator expenses: $	◯ Self-employed health insurance deduction: $
◯ Deductible from self-employment tax (Schedule SE): $	◯ Self-employed SEP, SIMPLE Plans: $
◯ Domestic production Activities (form 8903): $	◯ Self-employed health insurance deduction: $
◯ Health Saving Account (8889): $	◯ Student loan Interest deduction $
◯ Moving Expenses (3903): $	◯ Tuition and Fees (form 1817): $

DISEASE STATUS

Current Disease Status: ◯ CDC Defined AIDS ◯ HIV Positive / Not AIDS

Date HIV Diagnosed: _____

Date AIDS Diagnosed: _____

IDENTIFIED RISK FACTORS

◯ Blood Transfusion	◯ Men Who Have Sex with Other Men
◯ Hemophilia	◯ Mother-at-Risk (Perinatal)
◯ Heterosexual Contact	◯ Others
◯ Intravenous Drug Use	◯ Undetermined

ANTIRETROVIRAL THERAPY (ART)

Therapy:	◯ Dual	◯ HAART	◯ None	◯ Salvage	◯ Single	◯ Unknown

PHYSICIAN INFORMATION

Primary Care Physician Name:	
Primary Care Facility:	
HIV Physician Name:	
HIV Facility Name:	

BENEFITS

Medicare Status:	◯ Active	◯ Applied	◯ No Benefit

If Medicare Active,

Medicare Coverage:	◯ Part A	◯ Part B	◯ Part C	◯ Part A & B
Medicare Part D:	◯ Active	◯ Applied	◯ No Benefit	
Plan Name:				
Member ID#				
Bin #				
Benefit Phone #				
Medical Supplement Status:	◯ Active	◯ Applied	◯ No Benefit	
Plan Type:	◯ A ◯ B ◯ C ◯ D	◯ F ◯ G	◯ K ◯ L ◯ M ◯ N	
Plan Name:				
Member ID#				
Bin #				
Benefit Phone #				
Medicaid:	◯ Yes	◯ No		

INSURANCE

Primary Private Insurance:	◯ Active	◯ Applied	◯ COBRA	◯ No Benefit

If Active,

Plan Name:		
Member ID#		
Group #:		
Benefit Phone #		
Is the Policy issued through an employer?	◯ Yes	◯ No
Pharmacy coverage included?	◯ Yes	◯ No

If COBRA,

Start Date:		
End Date:		
Plan Name:		
Member ID#		
Group #:		
Benefit Phone #		
Is the Policy issued through an employer?	◯ Yes	◯ No
Pharmacy coverage included?	◯ Yes	◯ No

PRESCRIPTION ONLY BENEFIT PLAN STATUS

Prescription Only:	◯ Active	◯ Applied	◯ No Benefit

If Prescription Only Active,

Rx Plan Name:			
Rx Member ID#			
Rx Group #:			
Rx Benefit #			
Rx BIN #			
Benefit Phone #			
Premium Assistance requested?		◯ Yes	◯ No
Are your premiums auto-deducted?		◯ Yes	◯ No
Premium Amount: $			
Are you overdue on a premium payment		◯ Yes	◯ No
Premium Payment Frequency:			
Premium Payee information:			

DENTAL CARE ONLY BENEFIT STATUS

Dental Care Only Status:	◯ Active	◯ Applied	◯ COBRA	◯ No Benefit
Plan Name:				
Member ID#				
Group #:				
Benefit Phone #				

If Dental is COBRA,

Start Date:	
End Date:	
Plan Name:	
Member ID#	
Group #:	
Benefit Phone #	

VISION ONLY BENEFIT STATUS

Vision Care Only Status:	◯ Active	◯ Applied	◯ COBRA	◯ No Benefit
Plan Name:				
Member ID#				
Group #:				
Benefit Phone #				

If Vision is COBRA

Start Date:	
End Date:	
Plan Name:	
Member ID#	
Group #:	
Benefit Phone #	

AIDS FOUNDATION OF CHICAGO
NORTHEASTERN ILLINOIS HIV/AIDS CASE MANAGEMENT COOPERATIVE

DATE: ____ ____ / ____ ____ / ____ ____ CLIENT ID #: _____

Client Eligibility Determination for Medical Case Management or Supportive Services Case Management:

LAST NAME:_____ **FIRST NAME**: _____ **MIDDLE INIT:**_____

DOB: ____ / ____/ ____ **SS#**: ____ - _____ - _____ ☐ Don't know/have SS# ☐ Refused SS#

Geographic Eligibility:

STREET ADDRESS: _____ CITY: _____ COUNTY: _____ ZIP: _____

CRITERIA: **CM SCORE**

DATE OF HIV DIAGNOSIS (MM/DD/YYYY	_____/_____/_____	(18 months or less add 20 points)	_____
IF LESS THAN 18 MONTHS, ARE YOU EXPERIENCING DIFFICULTY DEALING WITH YOUR HIV DIAGNOSIS?	____Yes ____No	(If yes add 5 points)	
DO YOU CURRENTLY HAVE A REGULAR PLACE TO GO FOR YOUR HIV MEDICAL CARE?	____ Yes ____ No	(If no add 10 points)	_____
IF NO, WHY ARE YOU NOT SEEING A MEDICAL CARE PROVIDER FOR YOUR HIV?			
(TIME 1) DATE OF LAST HIV-RELATED MEDICAL APPOINTMENT? (TIME 2) DATE OF NEXT TO LAST HIV-RELATED MEDICAL APPOINTMENT, IF APPLICABLE?	_____/____/_____ _____/____/_____	NUMBER OF MONTHS BETWEEN TIME 1 AND TIME 2: _____ MONTHS (IF THE NUMBER OF MONTHS IS GREATER THAN 3, ADD 10 POINTS)	_____
ARE YOU CURRENTLY PRESCRIBED MEDICATIONS FOR HIV?	____ Yes ____ No		
IF YES, Thinking back over the past 30 days, rate your ability to take all your HIV medications as prescribed. Would you say very poor, poor, fair, good, very good, or excellent? Circle one. 1 – Excellent 2 – Very Good 3 – Good 4 – Fair 5 – Poor 6 – Very Poor 0 – Don't Know 0 - Refused			_____

Please describe some of the reasons you have missed doses of your HIV medications:

_____

_____

IF NO, REASON NOT ON HAART: _____ Client Refused _____ Intolerance due to side effects _____ Not ready (as determined by clinician) Other reason _____ _____ Unknown	_____ HAART payment assistance unavailable _____ Not medically indicated	
HOW WOULD YOU ASSESS YOUR KNOWLEDGE OF HOW HIV IMPACTS YOUR BODY?	_____ No understanding of HIV disease (5 pts) _____ Basic understanding of HIV disease (3 pts) _____ Comprehensive understanding of HIV disease (0 pts)	_____
IN GENERAL, WOULD YOU SAY YOUR HEALTH IS:	_____ Excellent (0 pts) _____ Very good (0 pts) _____ Good (3 pts) _____ Fair (4 pts) _____ Poor (5 pts)	_____
MEDICAL CONDITIONS THAT A DOCTOR, NURSE, OR OTHER MEDICAL PROVIDER HAS TOLD YOU THAT YOU HAVE:	_____ No Health History _____ Hepatitis _____ Hepatitis C _____ Arthritis _____ Epilepsy _____ STI _____ Hypertension _____ Paralysis _____ Asthma _____ Liver Disease _____ Tuberculosis _____ Diabetes _____ Heart Disease _____ Obesity _____ Stroke _____ Cancer _____ Obesity _____ Endocarditis/Infection Of Heart Valve _____ Other permanent numbness	1 point for every co-morbid condition _____
ARE YOU OR YOUR PARTNER CURRENTLY PREGNANT?	_____ Yes (5 PTS) _____ No (0 PTS) _____ Refused	_____
IF, PREGNANT ARE YOU RECEIVING OR HAVE YOU RECEIVED PRENATAL CARE:	_____ Yes (5 PTS) _____ No (0 PTS) _____ Refused (0 points if not pregnant)	_____
HAVE YOU BEEN INCARCERATED IN THE LAST 12 MONTHS?	_____ Yes (5 PTS) _____ No (0 PTS) _____ Refused	_____
SUBSTANCE USE SCORE	Did client screen positive for substance abuse symptoms? 1- Yes (5 points) 2- No (0 points)	_____
MENTAL HEALTH SCORE	Did client screen positive for mental illness symptoms? 1- Yes (5 points) 2- No (0 points)	_____
CO-OCCURING SU/MI	Did client screen positive for co-occurring mental health/substance use disorders? 1- Yes (5 points) 2- No (0 points)	_____
	TOTAL CM SCORE	_____

Scoring for the Case Management Eligibility Scale:

The following criteria make someone automatically eligible for Medical Case Management:

- Being HIV diagnosed within the last 6 months
- Not having an HIV primary care provider
- Co-occurring substance use issue and mental health issue

*Clients must score a minimum of a **70** **(at a non-AFC organization, or a 60 at AFC)**to be eligible for Medical Case Management services. Clients who score below a 70 (or 60 at AFC) and do not meet the criteria listed above are Supportive Service clients.*

SUBSTANCE ABUSE

I am going to change topics and ask you some sensitive questions about alcohol and drug use. Remember that your responses are confidential and you have the right to refuse to answer.

	Yes	No	
1. Have you felt the need to **Cut down** on your drinking or drug use?	1	0	____
2. Do you feel **Annoyed** by people complaining about your drinking or dug use?	1	0	____
3. Do you ever feel **Guilty** about your drinking or drug use?	1	0	____
4. Do you ever drink an **Eye-opener** in the morning to relieve shakes?	1	0	____
Two or more affirmative responses suggest that the client has a substance problem and the client receives 5 points in the table above.	Total		____
Client refused to answer. (Add 0 points)			____

MENTAL HEALTH

Now I am going to ask you some questions about your well-being or psychological health.

	Yes	No	
1. During the past 12 months, were you ever on medication/antidepressants for depression or nerve problems?	1	0	____
2. During the past 12 months, did you ever have a period lasting 1 month or longer when most of the time you felt worried and anxious?	1	0	____
Any affirmative responses suggest that the client has symptoms for mental health issues and the client receives 5 points in the table above.	Total		____

SUPPORTIVE SERVICES NEEDS ASESSMENT (non-scored assessment)

Income Sources:

INCOME STABILITY: _____ Has steady source of income _____ Minimal unstable income _____ No current income

Insurance Sources:

_____No Insurance

CM Complete

AIDS FOUNDATION OF CHICAGO MEDICAL UPDATE FORM

DATE:_____/_____/__

First Name: _____ **MI**: ___ **Last Name**: _____

DOB:_____/_____/ ___ ___ ___

Case Manager: _____ **Agency**: _____

Phone Number: _____ **Fax Number**:_____

Provider Name_____

Provider Hospital/Clinic Affiliation: _____

Provider Hospital/Clinic Address: _____

Client's Current HIV Status (check only one):

☐ **HIV Positive/not AIDS** ☐ **HIV Positive/AIDS Status Unknown** ☐ **CDC-Defined AIDS**

Date of HIV Diagnosis:_____/_____/ _____ ____

Date of AIDS Diagnosis (if applicable):_____/_____/ _____ ____

Is this form being utilized to document proof of HIV status? ☐ **Yes** ☐ **No**

If "Yes", this form must be signed by the appropriate medical provider (i.e. MD, NP, PA).

Provider Signature: _____

****

Is the patient currently prescribed antiretroviral therapy (ART)? Yes ___ No ___

If no, why? _____

To your knowledge, is the patient currently adherent to antiretroviral therapy (ART)? Yes ___ No ___

If no, why? _____

Last CD4 Count: _____ **Date of Last CD4 Count**:_____/_____/ ___ ___ ___ ___ ___

Last Viral Load Count: _____ **Date of Last Viral Load Test**:_____/_____/ ___ ___ ___

Please select all of the patient's opportunistic infections within the last six months:

____ Candidiasis (besides Oral Thrush)	____Cryptococcal Disease	____Cytomegalovirus (CMV)
____ Pneumocystic Carinii Pneumonia (PCP)	____ Lymphoma	____ Tuberculosis
____Retinitis ____ Toxoplasmosis	____Syphilis	____ Wasting
____ Recurrent genital Herpes	____ Kaposi Sarcoma	____ Mycobacterium Tuberculosis
____ Human Papilloma Virus (HPV)	____ None	____ Unknown
____ Myobacterium Avium Complex (MAC)	____ Histoplasmosis	

Is the patient currently taking any PCP prophylaxis? Yes ___ No ___ No, Not Indicated ___
Vaccinated against hepatitis A? (Complete Series) Yes ___ No ___ Documented Immunity ___
Vaccinated against hepatitis B? (Complete Series) Yes ___ No ___ Documented Immunity ___
Screened for Hepatitis C Yes ___ No ___ If "yes", What year? ___
Vaccinated against Pneumoccoccal Pneumonia? Yes ___ No ___ If "Yes", What Year? ___

Was client seen by a clinical care provider during the last six months? Yes ___ NO ___

Total # of kept appointments in the last year:___ **Total # of missed appointments in the last year: ___**

Top Three Case Management Goals (to be completed by case manager):

1. _____
2. _____
3. _____

CM Copied

Top Three Clinical Goals (to be completed by clinic/provider staff):

1. _____
2. _____
3. _____

Primary Care and Clinical Needs for Case Manager to address:

___Health/Medication Insurance (i.e. ADAP, Medicaid, County Cares, Managed Care)
___Health Literacy
___Mental Health
___Resource Identification/Referral
___General Care Coordination
___Housing
___None
___Medication Management
___Substance Use
___Lost to Care
___Risk Reduction Counseling
___Domestic/Relationship/Family Concerns
___Unknown

What counseling has been provided to the client by the clinical staff during this 6 month reporting period?

___Adherence Counseling
___Substance Abuse Evaluation
___Family planning/contraception
___Treatment/Medication Adherence
___Mental Health Evaluation
___HIV Risk Counseling
___Nutritional Counseling
___Smoking Cessation

Case conference requested?

Regarding the following: **Yes ___** **No ___** **By:**___Case Manager ___Provider___

Completing Provider/Clinical Staff Signature:

Provider/Clinical Staff Name/Title:

Date:

Medical Case Management Care Plan Format

The below elements must be used in all care plans created

Item	Description
Problem Statement (Why)	Statement describing the underlying concerns or barriers a client may have
Goal (What)	Statement describing what areas of the problem are going to be addressed to overcome the concerns or barriers a client may have
Tasks (How)	Statements describing how the goal will be accomplished by when and by whom

Format

Problem Statement

Goal A

Task 1 with person responsible and time frame
Task 2 with person responsible and time frame
Task 3 with person responsible and time frame

Example

Problem Statement: Client is unable to _____ due to ____

Goal: Client will improve _____ by _____ in the next ___ months

Task 1: Case manager will refer client to ____ in the next ___ weeks
Task 2: Client will ____ in the next ____ weeks
Task 3: Client will ___ in the next ___ months

Case Management Discharge Summary

Date:	
Originating Agency Name:	
Case Manager Name:	
Client Name:	
Client ID:	
Client Notification Date:	

CASE MANAGEMENT EXIT REASONS

X	Select one or more of the following reasons.
	Client disengaged after service began
	Client withdrew before service began
	Whereabouts unknown with no contacts in more than six months.
	Moved out of EMA service area
	Moved to assisted living / nursing facility.
	Incarceration
	Deceased
	Transferred to SSCM
	Transferred to MCM
	Transferred to DRS
	Transferred to PACPI
	DCFS Placement
	Not HIV Positive
	Duplicate Enrollment
	Violence/Threat/Theft/Violation of confidentiality of other clients or Violation of any other aspects of the agency policies.
	Client request / refused services / services are not needed

VIOLATION OF RULES

	Client received the Rights & Responsibilities
	Client received the Grievance Procedures

LOST TO CARE

Yes/No	Lost to Care
	Did the case manager send a certified letter to the client PRIOR to closing the case?

DISCHARGE SUMMARY QUESTIONS:

1. Where the goals and objectives in the service plan achieved?

	Yes
	No
	Don't Know
	N/A

If goals and objectives were not achieved, explain why:

2. Does the participant need further support or other services to assist him/her in maintaining well-being?

	Yes
	No
	Don't Know
	N/A

If yes, list recommendations/referrals made for support and other services:

3. At discharge/transfer/closure/termination from case management, was the client receiving medical care?

	Yes
	No
	Don't Know
	N/A

If yes, describe how participant will continue to access medical care:

Medical Provider Name:
Hospital Affiliate
Phone Number:

4. At discharge/transfer/closure/termination from case management, was the client taking medication?

	Yes
	No
	Don't Know
	N/A

If yes, describe how the client will continue to access medications:

TRANSFER INFORMATION (This is not entered into the client level database. Please notify the AFC to make the case assignment)

New Agency Name:	
Date of Contact:	
Case Manager Name:	
Effective Transfer Date:	
Document Checklist Fax/Email Date:	
Program Type:	
Additional Program Type:	

The following documents must be provided to the new agency:

- Letter notifying the client; detailed reason/scenario of incident
- Client full contact information
- HIV diagnosis documentation
- Most current enrollment form
- Most recent assessment/re-assessment
- Updated eligibility documentation
- Most recent benefits information
- Authorization to Release Information (AFC & IDPH),
- Care Plan with an overview of current case notes/open issues, etc.

SIGNATURES:

Case Manager Signature _____ Date _____

Supervisor Signature _____ Date _____

Karnofsky Acuity Assessment Scale Tool

The following scoring rubric measures functional impairment of HIV Continuity of Care dimensions.

Medical / clinical	Transportation
Basic necessities/life skills	HIV-related legal
Mental health	Cultural / linguistic needs
Substance use	Self-sufficiency in daily functioning
Housing / living situation	HIV education and risk reduction
Support situation	Employment / income
Insurance benefits	Medication adherence

Karnofsky Score Dimensions & Frequency of Contact

Ranked Need	Score Description
1 - Low	Normal activity. No complaints/signs of disease. Requires no assistance. Compliant with medical/treatment. MCM only needed to maintain eligibility.
2	Normal activity. Slight symptoms/signs of disease. Client executes services on their own. May need occasional assistance. Requires only MCM services. Client will initiate request for additional services.
3	Normal activity with effort. Some symptoms/signs of disease. Client mostly compliant medical/treatment. Has other service needs. May utilize MCM services.
4	Can take care of self but not engaged in normal work/personal activities. Mostly compliant with appointments but needs reminders and follow-up. Client receives MCM services with at least one other service.
5	Requires occasional assistance. Can take care of most needs. Needs appointment reminders or will miss appointments; follow up on how to obtain services. Client receives CM services with at least one other service.
6	Requires frequent help and medical care. Client needs reminders and misses appointments. Is not aware of services and/or is not able to seek out assistance on their own. Client receives MCM services with at least one other service.
7	Disabled, needing special care/assistance. Client's health has deteriorated. Misses appointments. Often non-compliant with services. Or is not able to see out assistance on their own. Utilizes multiple services.
8	Severely disabled. Hospital admission indicated but no risk of death. Has a Personal Assistant (PA) or needs constant coordination to receive services. Utilizes multiple services.
9	Very ill requiring hospitalization and supportive measures/treatment urgently. Client's health is very poor. Cannot care for daily needs. Has a Personal Assistant (PA) or needs constant coordination to receive services. Utilizes multiple RW services.
10 – High	Approaching death with rapidly progressive fatal disease processes. Client is near death and should receive focus as the client's physician recommends.

Date:

Case Management Agency Name:

Case Manager Name:

Client Name:

+++++ OFFICE USE ONLY ++++

Karnofsky Score:

Notes/Comments:

SAMPLE A
Referral Introduction Letter Template

Date

Dear ***(name)***

I am writing to refer ***(client's name, include any other necessary information to verify identity such as date of birth or social security number)*** to ***(Agency Name)*** to receive ***(clarify the service you are referring them for)***.

Enclosed is a completed referral form for your service. I am currently acting as a case manager for ***(enter client name)*** through the Northeastern Illinois HIV/AIDS Case Management Cooperative at ***(Case Management Agency Name)***. My role of case manager involves completing an assessment and then, in discussion with the client, drawing together a comprehensive care plan that addresses the clients' needs in the categories of medical and support services. This care plan will be monitored and reviewed periodically to ensure that barriers to progression are being addressed and that interagency communication is supporting client efforts and the achievement of care plan goals.

As part of the care planning and assessment process the need for ***(clients' need)*** has been identified and your service has been identified as most appropriate service to address this need. ***(It may be appropriate to provide a rationale for the appropriateness of the referral i.e., motivation, attendance, family needs etc.).*** If you have any questions in relation to any aspect of the care plan, service delivery, or my role as case manager, please do not hesitate to contact me. I look forward to hearing from you.

Sincerely,
(name)
(role/position)
(service/project)
(contact details: phone, email and address)

AIDS FOUNDATION OF CHICAGO
NORTHEASTERN ILLINOIS HIV/AIDS CASE MANAGEMENT COOPERATIVE
Referral Plan Form

Referral Verification Format: (this is a suggested format only. This document is not required to be in client charts, however this information must be captured in the client chart AND entered into the electronic client database)

Client Information:

FIRST NAME: _____**MIDDLE INITIAL:**_____**LAST NAME:**_____

DOB: ____ / ____/ ____ **SS#**: ____ - _____ - _____ ☐ Don't know/have SS# ☐ Refused SS#

Referral Date: ____ / ____/ ____

Referral Recipient: (Agency receiving the referral) _____

Referral Source: _____

Refer From Provider: _____

Refer from User (Case Manager): _____

Location: _____

Referral Status: ☐ **Referral Made** ☐ **Turned Away**

Date referral was acknowledged by client: ____ / ____/ ____

Referral Result Date: ____ / ____/ ____

[redacted]

Pending

Referral Status Comments:

_____

Medical Case Management Case Conferencing Agenda

Date:
Client:
Staff Present:

Agenda Topics:

1. Client Case Staffing:
    a. Medical
        i. New infections (HIV and non-HIV related)
        ii. Hospitalizations
        iii. CD4/Viral Load
        iv. Appointment adherence
        v. Medication maintenance
    b. Oral Health
    c. Substance Use
    d. Psychological/Mental Health Issues
    e. Housing Concerns
    f. Food and Nutrition
    g. Income and Benefits
    h. Family and Support Networks
    i. Risk Reduction
    j. Other Challenges
    k. Discharges

2. Services/Resources Needed

3. Referrals

4. Old/New Issues

5. Additional Information/Announcements

Notes:

Case Conferencing Staffing Form

Program: Medical Case Management

Case Manager: _____

Name of Client: _____

Date	Issue/Status	Goals/Intervention	Person Responsible
	Medical:		
	New Infections:		
	Hospitalizations:		
	CD4/Viral Load:		
	Appointment Adherence:		
	Medication Maintenance:		
	Oral Health:		
	Substance Abuse:		
	Psychological/Mental Health:		
	Housing Concerns:		
	Food and Nutrition:		
	Income and Benefits:		
	Family and Support Networks:		
	Risk Reduction:		
	Other Challenges:		
	Discharges:		

CLIENT RIGHTS, RESPONSIBILITIES AND GRIEVANCE PROCEDURES

Client First Name	Middle Initial	Client Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)

RIGHTS

- You have the right to be treated with respect, dignity, consideration, and compassion.
- You have the right to receive timely, respectful, high quality services from the staff of all providers free of discrimination based on race, sex/gender, ethnicity, national origin, religion, age, values or beliefs, sexual orientation, physical and/or mental ability, or marital status.
- You have a right to participate in developing your individualized Care Plan.
- You have the right to receive current information and education about HIV, services, medications, and treatment options available to you.
- You have the right to reach an agreement with your case manager about the frequency of contact you will have, either in person or over the telephone.
- You have the right to have your case management records be treated confidentially at all times.
- You have the right to request copies of all signed documents and to review your entire service record with the exception of your medical and non-medical case management notes.
- You have the right to appeal decisions with which you do not agree by following the grievance procedures outlined below.
- You have the right to not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

RESPONSIBILITIES

- You are responsible for treating other program participants and service provider staff with respect and courtesy at all times. Threatening or abusive behavior or language will not be tolerated, and services may be suspended or terminated, and some cases referred to appropriate law enforcement.
- You are responsible for protecting the confidentiality of other program participants you may encounter during your enrollment in the program.
- You are responsible for participating in developing your individualized care plan.
- You are responsible for notifying the Program of any concerns regarding your care plan or changes in your service needs.
- You are responsible for keeping your appointments or call 24-48 hours in advance to cancel or change an appointment.
- You are responsible for informing the Program of changes in your address, phone number, income, or insurance coverage and responding to the case manager's calls or letters in a timely manner.
- You are responsible for providing the Program with any requests for payment of bills or invoices within 30 days of the statement date.
- You are responsible for applying for all other service programs and obtain any available health coverage the Program asks of you to ensure the program maintains its status as the payer of last resort.
- You are responsible for properly filing your taxes each year and must provide the Program with your current tax returns if you are receiving premium assistance for an Illinois Insurance Marketplace plan.

- You are responsible for staying in care by visiting your doctor regularly and taking your prescribed medication to improve and maintain your health and well-being.
- You are responsible for recertifying your eligibility with the Program at minimum every six months by providing all documentation needed to complete and submit an Eligibility Assessment through your case manager, your eligibility specialist, or online at https://iladap.providecm.net.
- You may be responsible for a portion of the cost of the services you receive from the Program.

GRIEVANCE PROCEDURE

An appeal may be filed by you or your representative who has just cause for protest, complaint, or disagreement with a decision regarding eligibility for the provision of services through the Illinois Ryan White Part B program. There are two methods to initiate a formal appeal.

Regional Level

If you have been deemed ineligible for services by a sub recipient or grantee at the regional level, you will need to follow the grievance procedures set forth and provided to you by the sub recipient or grantee.

State Level

If you have been deemed ineligible for Medication Assistance or Premium Assistance services, you will need to follow the grievance procedures outlined below:

1. You, or your representative, must supply to the Program, in writing, the reason that the Program should reconsider the initial decision to deny services. This must be supplied to the Program within 10 business days of the initial denial. The formal appeal must include your name, address, social security number (if applicable), date of birth, a detailed description of the issue or cause for appeal, and associated documentation available.
2. The Program will review the appeal, and a decision will be rendered within 5 business days. If you were enrolled in the program at the time of denial, you may qualify for a temporary enrollment to allow for one medication shipment while the Program considers the appeal.
3. If additional documentation is requested, you will have 10 business days to supply new documentation for the Program to consider. Once this documentation has been supplied, the Program will render a decision within 10 business days. If at the end of the 10 business days you fail to provide the new documentation, you will be closed from the program. If you have elected to receive mail from the Program, a letter will be sent to you with the Program's determination. All determinations made by the Program during this phase are final.

/ /

Client Signature (age 12 and older) **Date**

/ /

Parent or Guardian Signature (under age 12) **Date**

ILLINOIS Department of Public Health

Ryan White Part B Program

DERECHOS DEL CLIENTE, RESPONSABILIDADES Y PROCEDIMIENTO DE RECLAMOS

Nombre del Cliente	Segundo Nombre	Apellido del Cliente

Número de Seguro Social (si no posee uno, puede dejar este espacio en blanco)	Fecha de Nacimiento (mm/dd/aaaa)

DERECHOS

- Tiene derecho a ser tratado con respeto, dignidad, consideración y compasión.
- Tiene derecho a recibir servicios oportunos, respetuosos y de alta calidad por parte del personal de todos los proveedores sin discriminación por motivos de raza, sexo / género, origen étnico, nacionalidad, religión, edad, valores o creencias, orientación sexual, física y / o habilidad mental, o estado civil.
- Tiene derecho a participar en el desarrollo de su Plan de atención individualizado.
- Tiene derecho a recibir información y educación actual sobre el VIH, los servicios, los medicamentos y las opciones de tratamiento disponibles para usted.
- Tiene derecho a llegar a un acuerdo con su administrador de casos sobre la frecuencia de contacto que tendrá, ya sea en persona o por teléfono.
- Tiene derecho a que sus registros de administración de casos sean tratados de manera confidencial en todo momento.
- Tiene el derecho de solicitar copias de todos los documentos firmados y de revisar todo su registro de servicio, con la excepción de sus notas de administración de casos médicos y no médicos.
- Tiene derecho a apelar las decisiones con las que no está de acuerdo al seguir los procedimientos de quejas descritos a continuación.
- Tiene derecho a no ser sometido a amenazas, abusos físicos, sexuales, verbales o emocionales.

RESPONSABILIDADES

- Usted es responsable de tratar a los demás participantes del programa y al personal del proveedor de servicios con respeto y cortesía en todo momento. No se tolerará la conducta o el lenguaje amenazador o abusivo, y los servicios pueden suspenderse o terminarse, y algunos casos se remiten a las autoridades apropiadas.
- Usted es responsable de proteger la confidencialidad de otros participantes del programa que pueda encontrar durante su inscripción en el programa.
- Usted es responsable de participar en el desarrollo de su plan de atención individualizado.
- Usted es responsable de notificar al Programa sobre cualquier inquietud relacionada con su plan de atención o cambios en sus necesidades de servicio.
- Usted es responsable de cumplir con sus citas o llamar de 24 a 48 horas antes para cancelar o cambiar una cita.
- Usted es responsable de informar al Programa sobre los cambios en su dirección, número de teléfono, ingresos o cobertura de seguro y responder a las llamadas o cartas del administrador de casos de manera oportuna.
- Usted es responsable de proporcionar al Programa cualquier solicitud de pago de facturas o facturas dentro de los 30 días posteriores a la fecha del estado de cuenta.
- Usted es responsable de solicitar todos los demás programas de servicio y obtener cualquier cobertura de salud disponible que el Programa le solicite para asegurarse de que el programa mantenga su estado como pagador de último recurso.
- Usted es responsable de presentar correctamente sus impuestos cada año y debe proporcionar al Programa sus declaraciones de impuestos actuales si está recibiendo asistencia con la prima para un plan del Mercado de Seguros de Illinois.

- Usted es responsable de permanecer bajo los servicios de atención y cuidados del programa visitando a su médico regularmente y tomando sus medicamentos recetados para mejorar y mantener su salud y bienestar.
- Usted es responsable de volver a certificar su elegibilidad con el Programa por mínimo cada seis meses al proporcionar toda la documentación necesaria para completar y enviar una Evaluación de elegibilidad a través de su administrador de casos, su especialista en elegibilidad o en línea en https://iladap.providecm.net.
- Usted Puede ser responsable de una parte del costo de los servicios que recibe del Programa.

PROCEDIMIENTOS DE RECLAMOS

Una apelación puede ser presentada por usted o su representante si tiene una causa justificada de protesta, queja o desacuerdo con una decisión con respecto a la elegibilidad para la prestación de servicios a través del programa Ryan White Part B de Illinois. Existen dos métodos para iniciar una apelación formal.

Nivel Regional

Si un sub-receptor o concesionario a nivel regional lo considera inelegible para recibir servicios, deberá seguir los procedimientos de reclamo establecidos y proporcionados por el sub-receptor o concesionario.

Nivel Estatal

Si ha sido considerado no elegible para los Servicios de Asistencia con Medicamentos o Asistencia de Primas de Seguro, deberá seguir los procedimientos de reclamo descritos a continuación:

1. Usted o su representante deben proporcionar al Programa, por escrito, la razón por la que el Programa debe reconsiderar la decisión inicial de negar servicios. Esto se debe proporcionar al Programa dentro de los 10 días hábiles posteriores a la denegación inicial. La apelación formal debe incluir su nombre, dirección, número de seguro social (si corresponde), fecha de nacimiento, una descripción detallada del problema o la causa de la apelación y la documentación asociada disponible.

2. El Programa revisará la apelación y se tomará una decisión dentro de los 5 días hábiles. Si estaba inscrito en el programa en el momento de la denegación, puede calificar para una inscripción temporal para permitir un envío de medicamentos mientras el Programa considera la apelación.

3. Si se solicita documentación adicional, tendrá 10 días hábiles para proporcionar nueva documentación para que el Programa la considere. Una vez que se haya proporcionado esta documentación, el Programa emitirá una decisión dentro de los 10 días hábiles. Si al final de los 10 días hábiles no proporciona la nueva documentación, usted será descalificado del programa. Si ha elegido recibir correo del Programa, se le enviará una carta con la determinación del Programa. Todas las determinaciones hechas por el Programa durante esta fase son finales.

Firma del cliente (mayores de 12 años) **Fecha**

Firma del padre o tutor (menor de 12 años) **Fecha**

DRS Electronic Billing Verification Form

I verify that I have completed electronic entry of my agency's DRS billing submission via Client Track for the month of _____. I have run a copy of the DRS billing form to verify that my DRS billing is being accurately reflected in the report.

Date:

Name:

Agency Name:

_____ _____

Staff Signature Date

Send only by fax to:
AFC Fax 312-334-0924

DRS Retroactive Billing Electronic Verification Form

I verify that I have completed electronic entry of my agency's DRS retroactive billing for the month of _____ via Client Track. I have verified that my agency has not previously been reimbursed for these clients. I have requested and reviewed a copy of the DRS back billing form pulled from Client Track to verify that my DRS back billings is being accurately reflected in the report.

Date:

Name:

Agency Name:

_____ _____

Staff Signature Date

Send only by fax to:
AFC Fax 312-334-0924

EMPLOYEE OATH OF CONFIDENTIALITY

All information, written or unwritten, reported to the Illinois Department of Public Health, HIV/AIDS Section, Ryan White Part B Program, hereafter referred to as the Program, is strictly confidential with access governed by state and federal laws. Information can only be released in accordance with state and federal statutes and Department rules and regulations.

I hereby acknowledge that I have received a copy of the AIDS Confidentiality Act, the STD Control Act, and corresponding relevant Administrative Codes, and the Confidentiality and Security Policy. I agree to abide by the appropriate laws, rules, regulations and policies regarding the security and confidentiality of protected information.

Furthermore, I understand that unauthorized disclosure of confidential or protected information may subject me to appropriate disciplinary actions by the State, up to and including discharge from my position and that such disclosure may also be a crime or result in civil liability.

By signing this form, I affirm that I understand the state and federal statutes, departmental rules, regulations and confidentiality policies that govern the security and confidentiality of protected information. I also agree to abide by the provisions contained therein. I understand that I have a duty to inquire of my supervisor(s) as to the nature and extent of the confidentiality of any documents or information prior to disclosure if I am unsure regarding a particular document or item, of information. I also understand that a copy of this signed statement will be placed in my personnel file upon employment or at least once during employment with the Program.

Employee Signature Date

Employee Printed Name

Employee Title

Supervisor Signature Date

EMERGENCY FLEXIBLE FINANCIAL FUND POLICY

Subject: Emergency Flexible Financial Fund

Date: **January 8th, 2020**

PURPOSE:

To set minimum eligibility criteria and standardize the process for distribution of Emergency Flexible Financial Fund dollars to clients participating in the AIDS Foundation of Chicago Service Provider System.

POLICY:

The AIDS Foundation of Chicago receives funding through All Chicago that provides emergency flexible financial assistance to low income people in crisis and transition in the Chicago area (only).The funds are last resort, one time payments for items such as bus passes, ID's, work clothing, beds, medicine, eye exams or glasses, food, child care, rent, utilities etc. The cap for this assistance is $300 per household, once per year *(In the cases of extreme need the Service Provider may request approval of expenditures beyond the cap from AFC Staff, approval is not guaranteed and based on funding availability).*

PROCEDURE: Eligible Expenditures:

Expenditures must remove the threat of crisis in a cost-efficient manner:

1. Special items needed for a medical condition but not covered by any medical plan, such as humidifiers, bath chairs, handrails, air conditioners, syringes, orthopedic shoes, medical alert necklaces, lubricants and bandages
2. Important documentation, such as ID's, testing fees etc.
3. Essential home items, such as beds, refrigerators, blankets and linens for fire and flood victims or relocating families or for maintenance of good health (related to sleeping or eating).
4. Special clothing items for work or school, such as uniforms, coats and steel-toe boots
5. CTA / RTA passes to school, work, medical appointments & public aid appointments
6. Child care and child items
7. Gift cards for special dietary items not found at food pantries & personal hygiene items
8. Eye glasses and eye exams required for work or school
9. Phone bills when a medical condition requires phone service to the home
10. Medications prescribed by a physician.
11. Special items for families affected by violence and/or abuse, such as replacement locks, bus tickets out of state and child items
12. Other expenditures that prevent or avert crisis, must be approved by AFC staff before they are made.

Process to obtain assistance:

All Service Providers must complete the Emergency Fund application with clients who are requesting assistance. Staff will complete the application for the client requesting assistance and provide a detailed explanation of the emergency/crisis situation and provide the appropriate documentation. ***The client narrative must be specific in terms of the request for assistance and amount needed to resolve the crisis,*** which is an emergency situation that cannot be resolved by any other agency or means. The items are to be reasonably priced and not have upgrades or luxury features. The cap amount is $300 but

actual payment amounts will be determined by the documentation submitted and situation described in the narrative.

AFC will accept applications from Service Providers based on the designated calendar dates that will be provided at the start of the year. Applications received on those dates will be reviewed for eligibility. Service Providers will be notified within 2 business days if the request has been determined eligible.

Responsibilities of Client/Applicant

1. Clients may request Emergency Flexible Financial assistance from AFC Service Providers.

2. Applicants must provide Service Providers with adequate documentation that there is an emergency situation that cannot be resolved by any other means.

3. Applicants must provide documentation that their household income is less than 50% of the median household income in the Chicago area for their household size (per the official determination of the U.S. Department of Housing and Urban Development).

Responsibilities of Service Provider

1. The Service Provider will meet with clients to obtain necessary documentation including invoices for desired items and review for eligibility. The payment amount should reflect a tax exempt amount. The case manager must show their agencies tax exempt letter when requesting an invoice.

2. The Service Provider will indicate in the application and inform AFC Staff of desired payee/vendor. The Service Provider must confirm that the desired payee/vendor is willing to accept the check from AFC prior to submitting the application.

3. Service Provider will make arrangements to obtain check from AFC or have it mailed to Service Provider agency.

4. Service Provider will use check to pay the third party/vendor (purchase gift card, transit card)

5. The agency must have documentation on file (such as a receipt) that assistance was used for the purpose intended and these receipts must be sent to AFC Staff within **5 business days** of receipt.

Responsibilities of AFC:

1. AFC will cut a check to the appropriate third party/vendor and inform the Service Provider when it is available. No payments will be made directly to the applicant/client; all payments will be made directly to a third party/vendor (store gift card, transit card).

Clients who are dissatisfied with the process or results of their application for Emergency Fund will be provided the name and number of the Housing Stabilization Director, Alma Arroyo, 312-334-0966

AFC EMERGENCY FLEXIBLE FINANCIAL FUND PROGRAM

Documentation Overview

Subject: Emergency Flexible Financial Fund
Date: **January 8th, 2020**

PURPOSE:

The Emergency Fund Program application requires the following forms be submitted in order for an application to be reviewed for eligibility. This document will provide a brief overview of each form, assisting the Service Provider in helping their clients gather and complete all needed forms when submitting an Emergency Fund Program application.

AFC Forms & Supporting Documentation Needed:

- AFC Vendor Request Form
- Vendor Invoice
- Documentation of Current Income
- AFC Consent to Enroll in Central Database Form
- AFC Consent to Release Information Form (2 pages)

All Chicago Forms Needed:

- Emergency Flexible Financial Fund- Client Service Form 2020 (2 pages)
- Chicago Homeless Management Information System-Client Consent for Data Sharing (3 pages)
- Homeless Management Information System (HMIS)-Supplemental Client Consent for Sharing of Certain Disability Data and Health Information (2 pages)

Emergency Flexible Financial Fund - Client Service Form (2020)

Date: _____/_____/_____ **Partner Agency: _____AFC_____**

Client Information

First Name	Last Name	DOB	SSN (Last 4 digits only) DK REF DNC	Hispanic Y or N DK REF DNC	Race (circle all that apply) AI/AN A BL/AA NH/OP W Other DK REF DNC	Sex M F TF TM DK REF DNC GNC

Street Address _____ Zip Code _____

Phone # 1 _____ Phone # 2 _____

Monthly Household Income $_____ **Referral Source: HPCC External Internal Self**

Does the client have a disability? Yes No **Is the client a Veteran? Yes No**

2. Household Information (include everyone else *besides* the client who lives in the household)

First Name	Last Name	AGE	Hispanic Y or N DK REF DNC	Race (list all that apply in the spaces below) AI/AN A BL/AA NH/OP W Other DK REF DNC	Sex M F TF TM DK REF DNC GNC

CODE:			
	DK = Client Doesn't Know	AI/AN = American Indian/Alaskan Native	M = Male
	REF = Client Refused	A = Asian	F = Female
	DNC = Data Not Collected	BL/AA = Black/African American	TF = Trans Female
	GNC = Gender Non-Conforming	NH/OP = Native Hawaiian/Other Pacific Islander	TM = Trans Male
		W = White	

3. Program Eligibility: Have you received these funds in the last 12 months? Y N

4. Homeless Prevention Services

Reason for assistance	Security Deposit/ Rental Application Fee	Rent	Mortgage	Utility
1. To maintain current residence.	$	$	$	$
2. To move from residence to other permanent housing.	$	$	$	$
3. To move from a shelter to permanent housing.	$	$	$	$

5. Additional Financial Crisis Assistance

Type and Amount of assistance: Amount

- ☐ **Moving costs** $_____
- ☐ **Storage costs** $ _____
- ☐ **Medical items** $_____
- ☐ **Documents** $_____
- ☐ **Child items** $_____
- ☐ **Home items** $_____
- ☐ **Transportation** $_____
- ☐ **Child care** $_____
- ☐ **Adult clothing** $_____
- ☐ **Car repair** $_____
- ☐ **Food** $_____
- ☐ **Hygiene** $_____
- ☐ **Training Cost** $_____

☐ **Other: _____** $_____

Case Total: $_____

6. Case Information

Reason for assistance (Select only one):

- ☐ **Natural disaster**
- ☐ **Victimization by criminal activity**
- ☐ **Eviction**
- ☐ **Medical disability or emergency**
- ☐ **Homelessness**
- ☐ **Work hours decreased/Lost job/Laid off**
- ☐ **Moving**
- ☐ **Domestic Violence**
- ☐ **Displacement by private or government action**
- ☐ **Illegal landlord action**
- ☐ **Maintain/Enter subsidized housing**
- ☐ **Car Repair**
- ☐ **Death in family**
- ☐ **New baby**
- ☐ **Loss or delay of public benefits**
- ☐ **New job**
- ☐ **Household increase/decrease**
- ☐ **Imprisonment**
- ☐ **Displacement due to foreclosure**
- ☐ **Impoverished**

☐ **Other:_____**

2

Please write a brief narrative detailing the crisis that caused the client's situation and the impact of the assistance. Be sure to include any case management or referrals you provided to the client. (Note: This information will be shared with staff of the Emergency Fund)

Upon approval, I understand that payment will be made on my behalf for the financial assistance described in Sections 4 & 5.

If approved, I understand that as part of receiving assistance I will be contacted and asked about the impact of this assistance. I agree to participate in the follow-up when contacted by the service provider.

I attest that all the information I have provided above and all the documentation I submit to complete this application for homeless prevention and/or crisis assistance is accurate and true to the best of my knowledge.

By signing my name below, I am confirming and agreeing to all the above statements.

Client Signature _____ **Date** _____

Case Manager Signature _____ **Date** _____

AFC EMERGENCY FLEXIBLE FINANCIAL FUND PROGRAM

AFC VENDOR REQUEST FORM

Vendor Name:
Address:
City State Zip:
Requested Amount:

I understand that any assistance provided must only be used for the above vendor and that I must obtain a receipt.
(Client Initials) _____

I understand that the Emergency Flexible Financial Fund program is a last resort, one-time, crisis solution payment and that I am not guaranteed to receive assistance.
(Client Initials) _____

I verify that the above information is accurate to the best of my knowledge.

Client Signature _____

Printed Name_____

Date _____

Service Provider Signature_____

Printed Name _____

Date _____

VENDOR INVOICE MUST BE ATTACHED

AFC CONSENT TO ENROLL IN CENTRAL DATABASE

I, *(enter client's name)* _____, consent to enroll in the centralized client database established by the AIDS Foundation of Chicago (the "Database") to assist and monitor the enrollment of persons receiving financial assistance through the AFC Emergency Fund Program application.

In connection with my enrollment in the Database, I hereby allow the following information to be furnished to the AIDS Foundation of Chicago for entry into the Database: my name (where applicable), date of birth, any positive or negative HIV status and other demographic data. In addition depending on funding source; services or financial assistance received may be reported. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, avoiding duplication of services and coordinating a system for service delivery to persons with or at risk of HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

_____
Signature of Client or Client's Legal Representative

_____
Print Name

_____
Date

_____
Relationship (if signed by person other than Client)

AFC EMERGENCY FLEXIBLE FINANCIAL FUND PROGRAM

AFC CONSENT TO RELEASE INFORMATION

Subject to the limitations and conditions set forth below, I, _____hereby consent to _____ ("Provider/Housing Advocate"), acting through its employees or agents, to use and/or disclose my health information and medical records to the AIDS Foundation of Chicago, the Emergency Fund and/or any sub-contracted agencies that provide services through them, as follows: (i) in connection with my participation in the centralized client database established by the AIDS Foundation of Chicago (the "Database") and the operation of the client database; (ii) to allow sharing of my case management agency with my housing advocate. (iii) to allow sharing of my rent mortgage or utility assistance enrollments with my case management agency. (iv) to enable the AIDS Foundation of Chicago and the Cooperative to conduct quality assurance programs for individuals receiving case management services through the Cooperative; (iiv) to avoid duplication of services by case management agencies; and (vi) in connection with the submission of reports and other data to funding sources.

In connection with my enrollment in the Database, I hereby give my consent for the following information to be furnished to the AIDS Foundation of Chicago for entry into the Database: my name (when applicable), date of birth, and other demographic data. In addition, verification of HIV positive status (if applicable) and dates of medical and case management service will be released to the AIDS Foundation. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, avoiding duplication of services and coordinating a system for service delivery to persons with HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

I further allow the program staff of the AIDS Foundation of Chicago and its designated Oversight Committee to review my individual service records as part of the funder's quality assurance program. For the purposes of this consent, I acknowledge and agree that my service records include any and all records generated by any of the Provider agencies that participate in the Ryan White Northeastern Illinois Cooperative, AFC Supportive Housing Programs or Financial Assistance Programs.

Any information I provide for the purposes of receiving services will not be disclosed to any government agency or health department for purposes of surveillance, contact tracing, or any other purpose other than obtaining health care, housing, financial assistance or social services, except (1) with my consent, (2) as required by law, or (3) if necessary, to prevent a serious attempt to inflict harm on myself or others. Security precautions will be maintained to prevent unauthorized access to the Database by anyone other than the program staff of the AIDS Foundation of Chicago.

I give further consent to allow the AIDS Foundation of Chicago to report information that I provide in connection with my enrollment in the Database and in connection with my receipt of services to the federal grant programs that support the AIDS Foundation of Chicago. I understand that such information may be provided either in the aggregate or on an individualized basis. I understand that, in order to protect my privacy, any information that is provided on an individualized basis, with the exception of Title II funded service utilization, will be furnished using unique client codes, without names or other information that identifies me.

I further understand that should I receive service funded under Part A and B of the Ryan White CARE Act or IDPH HOPWA, certain information will be reported to the Direct Services Unit of the Illinois Department of Public Health and the Chicago Department of Public Health, including:

- demographic information, including but not limited to name, gender, race, ethnicity, and birth date; service utilization information; HIV/AIDS diagnosis and treatment information, if any; and mental health and/or substance use diagnosis, treatment, and service information, if any.

I understand that this information will be shared for the purposes of evaluating Part A and B and IDPH HOPWA service utilization patterns, on-site service reviews, and when necessary to coordinate services.

I can terminate this consent by submitting a written request to any of the Recipients (agencies in the Cooperative) indicating that I no longer desire to receive services through the Cooperative, or my written revocation of this authorization, whichever occurs first.

I understand that I have the right to receive a copy of this consent. I further understand that I may revoke this consent at any time by providing written notice of my intent to revoke this consent to Provider. This consent cannot be revoked to the extent that action has already been taken based on this consent.

This consent is valid for a period of two years from the date of the actual client signature below.

Provider will not use or disclose personal health information beyond the scope of this authorization without your written consent or authorization. Please note that, subject to applicable law, disclosed information may be subject to re-disclosure by the recipient, and may no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

_____
Signature of Client or Client's Legal Representative

_____
Print Name

_____
Date

_____
Relationship (if signed by person other than client)

Chicago Homeless Management Information System
Client Consent for Data Sharing

Agency Name: _____

This Agency is part of a group of stakeholders that coordinate their efforts to end homelessness in Chicago. This group is referred to in this document as the Chicago Homeless Management Information System (HMIS) Collaborative ("Collaborative", "we", or "us"). The Agency and members of the Collaborative collect your information and enter it into HMIS)*.

A representative of this Agency is going to ask you for information about you and your dependents. (The word "dependent" is used in this document to refer to any person under the age of 18 for whom you consider yourself to be responsible.) Once your information is entered into HMIS it will be shared as described below.

The purpose of this form is to allow you to decide how much of the information that you provide to this Agency can be shared with third parties and how it might be shared within the Collaborative. You may decline to allow this Agency to share any of your information other than to the system administrator of HMIS, which may disclose such information in accordance with the Standard Agency Privacy Practices Notice. If you decline, the ability of this Agency and the Collaborative to provide housing to you may be reduced, but this Agency will still provide emergency services to you.

PART I – BRIEF ANSWERS TO QUESTIONS YOU MAY HAVE

What Are the Reasons for Sharing Information about Me?

- Help service providers offer suitable housing and care options to you.
- Assist the Collaborative in documenting the need and obtaining funding for its housing and services.
- As described in the Standard Agency Privacy Practices Notice, as may be amended from time to time.

How Is My Data Protected?

- Every Agency is required to comply with the Standard Agency Privacy Practices Notice.
- Members of the Collaborative must sign an agreement to protect your privacy and comply with state and federal laws and policies before seeing any information.
- HMIS incorporates industry standard security requirements and is updated to stay current with these security requirements.

What Are My Rights?

- You can obtain an electronic version or paper copy of your information that has been entered HMIS upon request and obtain a list of partner agencies within the Collaborative,
- You can ask to amend or revoke the sharing of your information entered in HMIS at any time, by signing a new Consent form.

Are There Circumstances in Which My Information Might Be Disclosed Without My Consent?

- Yes, there are multiple reasons for which your information will be used or disclosed without your consent, which include but are not limited to for administrative functions, payment or reimbursement of services, when required by law, system maintenance and reporting, and academic research purposes described in the Standard Agency Privacy Practices Notice, as may be amended from time to time.

For more detailed information, ask to see a copy of our Standard Agency Privacy Practice Notice.

PART II – YOUR CONSENT

Basic Information:

This information will be shared through HMIS and with members of the Collaborative.

- Personal Identifying Information (Name, Social Security Number, Date of Birth, Gender, Veteran Status, photo)
- Personal identifying information about your dependents (if applicable) (*Note*: Anyone 18 years of age or older must sign a separate consent form.)
- Enrollment information (may include your past enrollment information)
- Recipient Identification Number (if you do not know the number we will try to look it up)
- Contact information

Coordination of Care and Housing Information:

This information, along with other information from the HMIS, will be used or disclosed for the purposes of matching you to the appropriate services and possible housing, to conduct referrals and assessments, to determine program eligibility, to otherwise collaborate to address specific needs and circumstances, and to share information in case conference meetings for the purposes of finding and/or coordinating services for you and your dependents.

Information about your military service (if applicable)

- Experience with homelessness and living situation (housing status)
- Household income and source(s)
- Presence of a current disabling condition
  - Illinois law requires us to obtain your explicit consent to share information with respect to mental health, substance use, and/or HIV/AIDS issues. ***A separate consent form will be offered to you before you are asked to share information about these conditions.***
- Services you receive, including your receipt of financial assistance
- Medical insurance/primary care provider information

For purposes of this consent, Basic Information and Coordination of Care and Housing Information shall be referred to herein collectively as the "information".

I,_____(Name) agree to share information as detailed below.

A. **Share my information** to provide housing and/or coordinate services to help me end my homelessness.

B. **Share my information as a locked file** to provide housing and/or coordinate services to help me end my homelessness.

Note: The locked file will be visible to the system administrators and be shared with the agencies overseeing/assigned to providing me with matching of housing and care, and agencies I am currently receiving or received services from. My information will not be used or disclosed at case conference meetings for finding and/or coordinating services for me. ***Information from Survivors of Domestic Violence and/or Human Trafficking will automatically be treated only as locked file.***

C. **Do not agree to share any information:** I do not want any of the information about me shared for the purposes of housing and /or coordination of care; I understand the system administrator will have access and my information may be shared in accordance with the Standard Agency Privacy Practices Notice. I acknowledge that if my information is shared as permitted or required, I may be contacted by agencies to which my information was disclosed.

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making homelessness history

When you sign this form, it shows that you:

- Acknowledge that certain information may be shared without your consent in accordance with the Standard Agency Privacy Practices Notice, as may be amended from time to time.
- Read this Client Consent or heard an explanation of its contents.
- Understand this consent does not expire unless you withdraw your consent to share at any time by signing a new copy of this Consent; however, any information already shared with another agency cannot be taken back or revoked.
- Understand that housing providers may record significant incidents in which you are involved in their programs, and that these incidents will be shared with the entities that provide emergency services, housing coordination and outreach services for matching individuals to appropriate programs.

Names of Dependents (please list ALL dependents):

Name 1: _____ **Name 2:** _____

Name 3: _____ **Name 4:** _____

Name 5: _____ **Name 6:** _____

Data Sharing Selection for Head of Household (check one):

A. Share my information

B. Share my information as a locked file

C. Do not agree to share any information.

Data sharing selection for all dependents, as listed (check one, if applicable):

A. Share my information

B. Share my information as a locked file.

C. Do not agree to share any information.

Client or Representative Signature: _____ **Date:** _____

Agency Witness Signature: _____ **Date:** _____

For Organization Use only: (Initial all that apply)

The Client above received a telephonic explanation of this form, as needed. On behalf of the Client, staff at this agency served as the representative. The Consent was read in its entirety. _____

An authorized representative completed this consent for the Client. A description of the representation as required by the agency is approved and included in the file.

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Homeless Management Information System (HMIS)

Supplemental Client Consent for Sharing of Certain Disability Data and Health Information

Agency Name: _____

This Supplemental Client Consent for Sharing of Certain Disability Data and Health Information should be completed at the time of initial assessment, in addition to the Client Consent for Data Sharing. This supplemental consent is consistent with the policies laid out in the All Chicago Making Homelessness History HMIS Standard Agency Privacy Practice Notice ("Privacy Notice"). The current version of the Privacy Notice and a list of partners in the Collaborative can be viewed at www.allchicago.org. Alternatively, the agency you are working with should also be able to provide you with these documents upon request.

We are required by law to obtain your explicit consent to share information with respect to your experience with mental health issues, HIV/AIDS, and substance abuse. Some agencies within the Collaborative have specific eligibility requirements. Sharing this information allows us to connect you with as many housing and care options as possible for which you might be eligible.

This information will be collected as part of your assessment and will be disclosed by the agency you are working with to the Collaborative to improve the ability of the Collaborative to make an appropriate housing match and coordinate care on your behalf. You may decline to share this information as noted below, but doing so may make it more difficult for the participating agencies in the Collaborative to qualify you for assistance suited to your needs.

Please check the appropriate box below:

_____ I consent to the use and disclosure of my mental health condition, HIV/AIDS status, alcohol and/or drug abuse history, as may be applicable, with the Collaborative. I authorize the agency providing me with services to enter my mental health condition, HIV/AIDS status, alcohol and/or drug abuse history, as may be applicable, into the HMIS and I authorize the Collaborative to use such information to make an appropriate housing match and coordinate care on my behalf. In addition, I authorize the use and disclosure of my mental health condition, HIV/AIDS status, alcohol and/or drug abuse history, as may be applicable, on an aggregate basis so long as my information is de-identified.

____I decline to share any information relating to my mental health condition, HIV/AIDS, alcohol and/or drug abuse for the purposes of matching or other specific services; provided that I understand that the foregoing information will be; (i) shared among a certain cohort of assessors within the Collaborative, only if this information is being collected as part of the Standardized Housing Assessment and (ii) used and disclosed on an aggregate basis so long as my information is de-identified and I expressly authorize the foregoing.

____I do not presently experience the above conditions or have any information to share.

This authorization shall be in force and effect for seven years from the date of signing, at which time this authorization to use or disclose this information expires.

I understand that I have the right to inspect and copy any mental health information included in or made part of the information disclosed in accordance with this consent.

I understand that the Collaborative will not disclose information about my experience with these conditions without my specific written authorization unless a disclosure is authorized by applicable law including Confidentiality of Alcohol & Drug Abuse Patient Records (42 CFR, Part 2). I also understand that I may revoke my authorization to disclose this information by signing a new copy of this Supplemental Client Consent in which I decline future sharing of the information. I understand that my revocation will not be effective to the extent that my information has been used or disclosed in reliance on this consent. I also understand that the Collaborative will not use or disclose personal health information beyond the scope of this authorization without my written authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act. However, except as provided herein, information regarding mental health, HIV/AIDS, substance abuse and alcoholism may not be disclosed by the person or entity authorized herein to receive said information without my express written consent.

If I am requesting disclosure of psychological test material, I understand that all records related to any psychological testing shall only be disclosed to a psychologist designated by me.

Client Name: _____

Client Signature: _____ Date: _____

Agency Witness: _____ Date: _____

V 2.1

Emergency Financial Assistance Policy and Procedures

Subject: **AFC Emergency Financial Assistance Application**
Date: **July 1, 2019**

I. PURPOSE

To set minimum eligibility criteria and standardize the process for distribution of multiple funding streams consistent with the guidelines established by those funding streams, which include Emergency Food and Shelter Program (EFSP), Housing Opportunities for People With AIDS (HOPWA STRMU), and Ryan White Part A. It is at the discretion of AFC staff along with the **guidelines established by the funding streams** to determine which funding source will be used in providing financial assistance to the client.

II. POLICY

The AIDS Foundation of Chicago receives funding from a variety of sources to assist low income residents who reside in the following counties: Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, McHenry and Will.

The principal purpose of this assistance is to stabilize individuals and families in their current home, to decrease the amount of time spent in shelters, and to help individuals and families secure and maintain affordable housing.

Additionally, these funds are not intended to provide continuous or long-term assistance. These funds are defined as being a "needs-based" assistance program – not an entitlement. Assistance from these funding streams is considered short-term help that is intended to promote long-term housing stability. AFC Emergency Financial Assistance is **based on funding availability** and is subject to the rules of the funding source. Additional forms may be required based on funding stream chosen. Those forms may be requested in the determination process.

III. ELIGIBILITY

AFC Emergency Financial Assistance offers **two options** to stabilize individuals and families in their current home, or to assist in moving to more affordable housing:

One-Time Emergency Assistance Payment	OR	Ryan White 90-Day EFA Program
For clients who have experiencing a temporary financial crisis to cover past due rent/mortgage, past due utilities, or first and last month's rent		For clients who have experienced a significant loss of income to cover past due rent and utilities for three months.

The application process is the same for either of these options. All applicants must meet certain eligibility criteria to be considered for assistance under either option. All approvals are at the discretion of AFC staff.

Eligibility Criteria:

1. Households in imminent danger of eviction;
   AND/OR
2. Households in imminent danger of homelessness;
   AND/OR
3. Households in imminent danger of foreclosure (Note: the household cannot already be in the foreclosure process);
   AND/OR
4. Households that are currently homeless. (Note: the household must provide documentation indicating their ability to afford rent and utilities in the future without this assistance.)

All households applying for assistance must be able to document a **temporary financial crisis** beyond their control. A crisis includes:

- → Loss of employment
- → Medical Disability or emergency
- → Loss or delay of a public benefit
- → Natural Disaster
- → Substantial change in household composition
- → Victimization by criminal activity (including Domestic Violence)
- → Illegal action by a landlord
- → Displacement by government or private action
- → Client is moving from homelessness into permanent housing
- → Obtain or maintain subsidized housing
- → Client is moving into more affordable housing that promotes long term stability

In addition, households must be able to document **the ability to sustain stable housing after receiving assistance**. This includes:

- → Proof of income or housing subsidy
- → Current lease or mortgage

Other Eligibility Requirements:

- → Households applying for emergency financial assistance through **HOPWA** or **Ryan White Part A** must also provide documentation indicating an HIV+ diagnosis.
- → Households applying for the **Ryan White Part A 90-Day EFA Program** must also provide documentation to demonstrate a significant loss of income (e.g., loss of employment, loss of benefits documentation, or other loss of income)

Emergency Financial Assistance Policy and Procedures

IV. FUNDING SOURCES

Emergency Financial Assistance payments will be drawn from one of three funding sources and are contingent on funds availability:

1. **Emergency Food and Shelter Program (EFSP)**
2. **Housing Opportunities for People with AIDS (HOPWA/STRMU)**
3. **Ryan White Part A** (Payer of last resort)

Any emergency financial assistance payment made cannot exceed a particular funding source's cap amount. Actual payment amounts will always be determined by the documentation submitted on the applicant's lease, eviction notice, utility bill or mortgage statement as provided in the application. The table below provides eligibility details for each of these three funding sources:

ELIGIBILITY DETAIL	FUNDING SOURCE		
	Emergency Food & Shelter Program (EFSP)	**Housing Opportunities for People with AIDS (HOPWA/STRMU)**	**Ryan White Part A** ***(Payer of last resort)***
Clients Living with HIV Only?	No - all households meeting eligibility criteria can apply	Yes – per funder requirements, households must have a documented HIV+ diagnosis and meet all eligibility criteria	Yes – per funder requirements, households must have a documented HIV+ diagnosis and meet all eligibility criteria
Capped Assistance Amount:	One month's rent ($1200 max)	Up to $1000 per payment	Up to $1000 per payment
Allowable Timeframe:	Clients may be eligible to receive assistance through EFSP once in a 12-month period. Crisis must be different from most recent crisis for which they received assistance.	Clients may be eligible to receive assistance through HOPWA/STRMU once in a 12-month period (see grant year cycle below). Crisis must be different from most recent crisis for which they received assistance.	Clients may be eligible to receive assistance through Ryan White Part A once in a 12-month period. Under the 90-Day EFA Program, clients may receive three consecutive monthly payments in a 12-month period (see grant year cycle below). Crisis must be different from most recent crisis for which they received assistance.
Grant Year Cycle:	Varies/based on fund availability	January 1 – December 31	March 1 – February 28

Eligible costs and expenses vary by funding sources. The table below indicates which costs and expenses are eligible for payment assistance under each funding source:

What Costs/Expenses are Eligible?	FUNDING SOURCE		
	Emergency Food & Shelter Program (EFSP)	**Housing Opportunities for People with AIDS (HOPWA/STRMU)**	**Ryan White Part A** ***(Payer of last resort)***
Past Due Rent	✓ Yes	✓ Yes (except for HUD subsidized programs)	✓ Yes
Past Due Mortgage	✓ Yes	✓ Yes	✗ No
First/Last Month's Rent	✓ Yes	✗ No	✓ Yes
Security Deposits	✗ No	✗ No	✗ No
Move-In Fees	✗ No	✗ No	✗ No
Utilities	✗ No	✓ Yes	✓ Yes

Additional Notes:

- Any payment made, regardless of how much it may be below the cap amount, will be counted as one payment.
- It is allowable for a client to obtain both a rent/mortgage assistance payment AND a utility assistance payment in the same month with one application IF the sum of both payments is still below the cap amount and they have submitted adequate supporting documentation.
- For one-time payment assistance: If a client requires assistance in an amount greater than a single source's cap in order to prevent homelessness, the use of two payments may be considered in the same application. The second payment MUST resolve the balance and MUST come from a different funding stream.

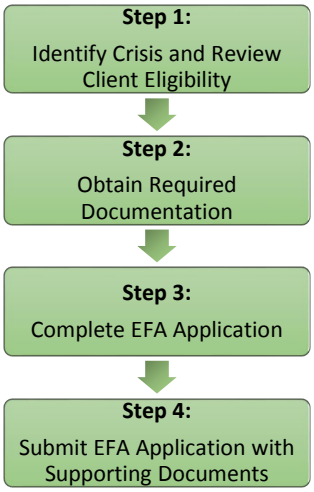
Determining Funding Source:

AFC staff will determine, based on the application provided by the Service Provider, which funding source will be used to assist the client. AFC will first determine if the client's application meets the requirements for EFSP in order to receive funds. If EFSP funds are determined to be an ineligible source or if EFSP funds have been exhausted for the given period, AFC staff will then review HOPWA/STRMU as an alternate funding option. If HOPWA/STRMU funds are determined to be an ineligible source or if HOPWA/STRMU funds have been exhausted for the given period, AFC staff will then review Ryan White Part A ***payer of last resort funding requirements in order to assist the client's application.***

Emergency Financial Assistance Policy and Procedures

V. PROCEDURE FOR OBTAINING ASSISTANCE

Clients must complete the **Step by Step** application process with their assigned Service Provider and submit to the AIDS Foundation of Chicago for review.



Step One: Prior to completing any application forms the Service Provider must review the client for eligibility. At this time, the Service Provider and client should agree upon which of the eligible temporary financial crisis they are striving to document. Use the attached guide **"Documenting the Crisis"** to help determine eligibility. If it appears that the client is experiencing one of the eligible temporary financial crisis and will be able to document it, they should move on to step two.

Step Two: The client must present the Service Provider with all of the documentation that supports the temporary financial crisis that is being experienced. The attached guide **"Documenting the Crisis"** will help the Service Provider inform the client what must be submitted.

Step Three: All application forms should be completed along with the Service Provider writing a narrative that describes the temporary financial crisis that is supported by the documentation.

Step Four: The completed application may be submitted to the AFC Housing staff for review. Submitting an application does not guarantee approval. Once an application is reviewed the Service Provider will be notified within 72 hours if it is approved, denied or incomplete with a confirmation letter. If the application is considered incomplete, the Service Provider and client must submit supplemental documentation to AFC Housing Staff within 14 business days to potentially move it forward for review.

VI. PROCEDURE FOR APPEALING A DENIAL

AFC's decisions for approval or denial are based on two factors:

1. The narrative provided in the application; and
2. The supporting documentation submitted.

Step One: If the client is unable to present supporting documentation of an eligible temporary financial crisis, or the narrative in the application does not sufficiently explain the financial crisis, the application will be denied, and AFC will provide an official denial letter.

Step Two: The denial letter from AFC will state all reasons for the application denial. The Service Provider should share the denial letter with the client and explain if necessary.

Step Three: If the client is dissatisfied with the Service Provider's explanation, they should be given the contact information of the Server Provider's supervisor. The supervisor should further explain how the denial decision was made based on the ineligibility of the application or the lack of supporting documentation**.**

Step Four: Clients who are dissatisfied with the process or results of their application for the AFC Housing and Utility Assistance Program will be provided the name and number of the AFC Director of Housing Stabilization, Alma Arroyo, and (312) 334-0966.

VII. RESPONSIBILITIES OF CLIENT, SERVICE PROVIDER, AND AFC

Responsibilities of Client/Applicant:

- All applicants for AFC Housing and Utility Assistance must be enrolled in the central client registry at AFC.
- Applicants must provide adequate documentation that they are experiencing a temporary financial crisis beyond their control.
- Applicants are not to engage in physically and/or verbally threatening behavior toward their Service Provider or AFC staff at any time. Physical or verbal threats will be cause for application denial.
- Discriminatory remarks and harassment in regard to, but not limited to, matters of race, color, national origin, creed, gender, sexual orientation or religion **will be considered verbal threats** and will be cause for application denial.

Responsibilities of Service Provider:

- The Service Provider will work with the client to submit all required forms and supporting documentation.
- The Service Provider will complete all pending incomplete applications within 14 business days of receiving the letter confirming an incomplete application from AFC Housing Staff.
- The Service Provider will offer comprehensive services regardless of race, color, creed, sex, ethnicity, national origin, marital status, sexual orientation, citizenship status, spoken language, physical/mental disability, age, economic status or religion.

Responsibilities of AFC:

- No payments will be made directly to the client; all payments will be made directly to a third party/vendor (property Management Company, utility company, building owner or mortgagor.
- AFC will make decisions on each application on a case-by-case basis, based on funding availability and prioritization of client needs.
- AFC will inform Service Provider of approval status, and for which assistance program the application was approved.
- AFC will inform the Service Provider where the payment will be made from along with the date the check will be issued. The issue date is determined by the AFC Finance Department.
- AFC will provide services regardless of race, color, creed, sex, ethnicity, national origin, marital status, sexual orientation, citizenship status, spoken language, physical/mental disability, age, economic status or religion

Emergency Financial Assistance Application

Service Provider: This document is designed to assist you in submitting a complete application with all necessary documentation. This sheet should be attached to the front of the completed EFA application and all supporting documents.

APPLICANT INFORMATION:

Complete the applicant information below. Including the AFC Client ID or Ryan White ID is not required, but will help expedite the application process and coordination of services.

First Name:	Last Name:	AFC Client ID:	Ryan White ID:

Birthdate:	Social Security Number:
__ __ / __ __ / __ __ __ __	__ __ __ - __ __ - __ __ __ __ ☐ Don't know/Don't Have

APPLYING FOR *(check only one)*:

☐	**One-Time Emergency Assistance Payment** For clients who have experiencing a temporary financial crisis to cover past due rent/mortgage, past due utilities, or first and last month's rent	**OR**	☐	**Ryan White 90-Day EFA Program** For clients who have experienced a significant loss of income to cover past due rent and utilities for three months.

DOCUMENTATION CHECKLIST

All relevant supporting documents must be included with the Emergency Financial Assistance application to be considered for approval. In the list below, please place a check mark in the box next to each item included with your application.

APPLICATION

☐ **Emergency Financial Assistance Application : Documentation Checklist (pg. 1)**

Client Demographics Form (pg. 2-3)
Client Household Info/Consent to Enroll in Client Database Form (pg. 4)
Client Budget Form (pg. 5)
Narrative and Temporary Financial Crisis (pg. 6)
AFC Client Rights/Responsibilities and Grievance Form (pg. 7)
AFC Consent to Release Information (pg. 8)

SUPPORTING DOCUMENTS

☐ **Temporary Financial Crisis <u>Supporting Documentation</u>** *(e.g. letter from unemployment, police report, letter of homelessness, proof of subsidy etc.)*

☐ **Current Lease or Current Rental Agreement Form or Mortgage Payment Statement** *(The rental agreement form included in this packet may be used in place of a formal lease agreement)*

☐ **Notice of Eviction <u>OR</u> Landlord Statement Form** *(The Landlord Statement form included in this packet may be used in place of a formal notice of eviction)*

☐ **Copies of Past Due Utility Bills/Shut-off Notices** *(Bills cannot exceed 30 days from issue date)*

☐ **Documentation of Household's Current Income** *(e.g., full month of paycheck stubs, current benefits statement, current unemployment assistance statement)*

☐ **Copy of the Client's State/Govt Issued ID**

☐ ***P*roof of HIV Status** *(If labs indicate an undectable viral load, additional proof may be requested)*

☐ **Proof of Ownership from Landlord** *(Only for Private Market Lanlords: e.g. property tax statement)*

☐ **Federal W9 and EIN Verification Letter** *(Please use attached Landlord Letter for guidance)*

RELEASES AND AUTHORIZATIONS

☐ **Signed Chicago Department of Public Health HOPWA Authorization to Use and Disclose Confidential Information**

☐ **Signed Illinois Department of Public Health Ryan White Part B Authorization for Release of Health Information**

SIGNATURE

Print Service Provider Name	Service Provider Signature	Service Provider Agency	Date

Emergency Financial Assistance Application

Application Date:	__ __/__ __/__ __	Application Completed by:	
Client First Name:		Client Last Name:	

1. Birthdate: __ __/__ __/__ __ __ __

2. Social Security Number: __ __ __- __ __-__ __ __ __ ☐ Don't know/Don't Have

CLIENT INFORMATION

3. Mailing Address:

4. Address Line 2:

5. City:

6. State:

7. Zip Code:

8. Okay to send mail? ☐ Yes ☐ No

9. Best Contact Number: (__ __ __) __ __ __- __ __ __ __ ext. _____

10. Contact Type: ☐ Home ☐ Work ☐ Mobile

11. Message Type: ☐ Any ☐ Discreet ☐ None

12. Alternate Contact Number: (__ __ __) __ __ __- __ __ __ __ ext. _____

13. Contact Type: ☐ Home ☐ Work ☐ Mobile

14. Message Type: ☐ Any ☐ Discreet ☐ None

15. Gender: Do you consider yourself to be:
- ☐ Male
- ☐ Female
- ☐ Genderqueer
- ☐ Non-binary/nonconforming/third gender
- ☐ Prefer to self-describe:_____
- ☐ Prefer not to say

16. Do you identify as transgender?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

17. Sexuality: Do you consider yourself to be:
- ☐ Straight/Heterosexual
- ☐ Gay or Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Asexual
- ☐ Prefer to self-describe _____
- ☐ Prefer not to say

18. Race (Check all that apply):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Don't know
- ☐ Refused

19. Ethnicity:
- ☐ Hispanic/Latinx/a/o
- ☐ Non-Hispanic/Latinx/a/o
- ☐ Don't know
- ☐ Refused

20. Are you a veteran?
- ☐ Yes ☐ Client doesn't know
- ☐ No ☐ Client refused

21. Are you pregnant?
- ☐ Yes ☐ Client doesn't know
- ☐ No ☐ Client refused

22. Country of Origin:

23. Primary or Preferred Language:

24. Do you need translation services? ☐ Yes ☐ No

25. Emergency Contact Name(s):	Relationship to Client:	Home phone number:	*IF LIVING WITH HIV*: Aware of client's diagnosis?
		(__ __ __) __ __ __- __ __ __ __	☐ Yes ☐ No
		(__ __ __) __ __ __- __ __ __ __	☐ Yes ☐ No
		(__ __ __) __ __ __- __ __ __ __	☐ Yes ☐ No

26. Have you ever experienced domestic violence?
- ☐ Yes ☐ Don't know
- ☐ No ☐ Refused

If Yes:

27. When did the experience occur?
- ☐ Currently experiencing
- ☐ Within the past 3 months
- ☐ Three to six months ago
- ☐ Six months to one year ago
- ☐ Over one year ago
- ☐ Don't know
- ☐ Refused

28. Are you CURRENTLY fleeing a domestic violence situation?
- ☐ Yes ☐ Don't know
- ☐ No ☐ Refused

Emergency Financial Assistance Application

UNIVERSAL DATA ASSESSMENT

1. Have you experienced homelessness before?

☐ Yes ☐ No

2. Current Residence: What is your current living situation?

Homeless Situations
- ☐ Place not meant for habitation
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Safe Haven
- ☐ Interim Housing

Institutional Situations
- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, prison or juvenile detention facility
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center

Transitional & Permanent Housing Situations
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with VASH subsidy
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Transitional housing for homeless persons (incl. homeless youth)

Other
- ☐ Don't know
- ☐ Refused

3. Current Residence: For how long have you stayed there?

☐ One night or less ☐ One week or less ☐ One month or more, but less than 90 days ☐ One year or longer
☐ Two to six nights ☐ More than one week, but less than one month ☐ 90 days or more, but less than one year ☐ Don't know
☐ Refused

4. What is the number of times you have been on the streets, in Emergency Shelter, or Safe Haven in the past three years, including today?

☐ One time ☐ Three times ☐ Don't know
☐ Two times ☐ Four or more times ☐ Refused

5. Total number of months homeless (on the street, in ES or SH) in the past three years:

_____ months ☐ Don't know ☐ Refused

HEALTH INSURANCE/PRIMARY CARE PROVIDER

1. Insurance Type:

☐ Medicare ☐ Indian Health Insurance ☐ Military Insurance ☐ Other Public
☐ Medicaid ☐ State Children's Health Insurance Program (S-CHIP) ☐ Private – Employer ☐ Other
☐ State-Funded ☐ Combined Children's Health Insurance/Medicaid Program ☐ Private – Individual ☐ No Insurance

2. Insurance Provider/Managed Care Organization (MCO) Name:

3. Policy Number:

4. Is this primary? ☐ Yes ☐ No

5. Are medications covered? ☐ Yes ☐ No

6. Policy Status: ☐ Active ☐ Pending/Applied

7. Date applied for: __ __/ __ __/ __ __ __ __

8. Policy Start Date: __ __/ __ __/ __ __ __ __

1. Do you have a Primary Care Physician (PCP)? ☐ Yes ☐ No

If No: **2.** Why do you not have a PCP?

If Yes:

3. What is your PCP's name?

4. With what institution is your PCP affiliated?

CLIENT HEALTH

1. Have you been diagnosed as HIV positive? ☐ Yes ☐ No

If Yes: **2.** Date of HIV Diagnosis: __ __/ __ __/ __ __ __ __

3. Have you been diagnosed as positive for AIDS? ☐ Yes ☐ No

If Yes: **4.** Date of AIDS Diagnosis: __ __/ __ __/ __ __ __ __

5. Do you have a Ryan White Case Manager? ☐ Yes ☐ No

If Yes: **6.** Have you seen your case manager in the last 6 months? ☐ Yes ☐ No

AIDS FOUNDATION CHICAGO

Emergency Financial Assistance Application

HOUSEHOLD INFO.

Name, DOB, SSN:	Relation to Head of Household:	Gender:	Race and Ethnicity:
First Name: Last Name: Birthdate: __ __/__ __/__ __ __ __ ☐ Full DOB ☐ Approx./Partial DOB Social Security Number: __ __ __-__ __-__ __ __ __ ☐ Full SSN ☐ Approx./Partial SSN	☐ Child ☐ Partner or Spouse ☐ Other Family ☐ Other Non-Family	☐ Male ☐ Female ☐ Genderqueer ☐ Non-binary/third gender ☐ Prefer to self-describe: ________ ☐ Prefer not to say Identify as Transgender? ☐ Yes ☐ No ☐ Prefer not to say	Race (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Doesn't Know ☐ Refused Ethnicity: ☐ Hispanic/Latinx/o/a ☐ Non-Hispanic/Latinx/o/a
First Name: Last Name: Birthdate: __ __/__ __/__ __ __ __ ☐ Full DOB ☐ Approx./Partial DOB Social Security Number: __ __ __-__ __-__ __ __ __ ☐ Full SSN ☐ Approx./Partial SSN	☐ Child ☐ Partner or Spouse ☐ Other Family ☐ Other Non-Family	☐ Male ☐ Female ☐ Genderqueer ☐ Non-binary/third gender ☐ Prefer to self-describe: ________ ☐ Prefer not to say Identify as Transgender? ☐ Yes ☐ No ☐ Prefer not to say	Race (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Doesn't Know ☐ Refused Ethnicity: ☐ Hispanic/Latinx/o/a ☐ Non-Hispanic/Latinx/o/a
First Name: Last Name: Birthdate: __ __/__ __/__ __ __ __ ☐ Full DOB ☐ Approx./Partial DOB Social Security Number: __ __ __-__ __-__ __ __ __ ☐ Full SSN ☐ Approx./Partial SSN	☐ Child ☐ Partner or Spouse ☐ Other Family ☐ Other Non-Family	☐ Male ☐ Female ☐ Genderqueer ☐ Non-binary/third gender ☐ Prefer to self-describe: ________ ☐ Prefer not to say Identify as Transgender? ☐ Yes ☐ No ☐ Prefer not to say	Race (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Doesn't Know ☐ Refused Ethnicity: ☐ Hispanic/Latinx/o/a ☐ Non-Hispanic/Latinx/o/a

CLIENT SIGNATURE, CONSENT TO ENROLL IN CENTRAL DATABASE, AND APPLICATION COORDINATION

☐ I certify that the information I have provided in this application is accurate to the best of my knowledge.

☐ I consent to enroll in the centralized client database established by the AIDS Foundation of Chicago (the "Database") to assist and monitor the enrollment of persons receiving financial assistance through the AFC Housing and Utility Assistance application.

In connection with my enrollment in the Database, I hereby allow the following information to be furnished to the AIDS Foundation of Chicago for entry into the Database: my name (where applicable), date of birth, any positive or negative HIV status and other demographic data. In addition, depending on funding source, services or financial assistance received may be reported. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, avoiding duplication of services and coordinating a system for service delivery to persons with or at risk of HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

☐ I give consent to my Provider to contact my landlord for the purpose of completing AFC Housing and Utility Assistance Application, following the same confidentiality requirements identified in this application. I can terminate this consent by submitting a written request to my housing navigation agency.

Client Signature	Print Client Name	Date
Service Provider Signature	Print Service Provider Name	Date

Emergency Financial Assistance Application

CLIENT INCOME

1. Do you receive cash income?	
☐ Yes *(complete table 3 below)*	☐ No

2. Do you receive non-cash benefits?	
☐ Yes *(complete table 4 below)*	☐ No

3. CASH INCOME
Please list all sources of client income, including monthly amounts, in the table below:

Income Source	Monthly Amount
Earned Income (Employment)	$
Unemployment Insurance	$
Supplemental Security Income	$
Social Security Disability Income	$
Veteran's Disability Payment	$
Private Disability Insurance	$
Worker's Compensation	$
TANF	$
General Assistance	$
Retirement (Social Security)	$
Veteran's Pension	$
Other Pension	$
Child Support	$
Alimony/spousal support	$
Family Support	$
AABD	$
Targeted Work Initiative	$
Other Household Income	$
Other Income	$
TOTAL:	**$**

4. Non-Cash Benefits
Please list all sources of non-cash benefits, including monthly amounts, in the table below:

Income Source	Monthly Amount
Food Stamps/SNAP	$
WIC (Supplemental Nutrition Program for Women, Infants, and Children)	$
Veteran's Administration Medical Services	$
TANF Child Care Services	$
TANF Transportation Services	$
Other TANF-Funded Services	$
Other Source	$
TOTAL:	**$**

CLIENT EXPENSES

1. Have you had any expenses in the past 30 days?	
☐ Yes (complete table 2 below)	☐ No

2. Monthly Expenses
Please list all expenses, including monthly amounts, in the table below:

Expense	Comments/Description	Monthly Amount
Car Payment		$
Electric		$
Rent/Mortgage		$
Car Insurance		$
Gas		$
Transportation		$
Water		$
Food & Personal		$
Sewer		$
Cleaning/Laundry		$
Phone		$
Legal Actions (Court)		$
Day Care		$
Medical/Insurance		$
Miscellaneous		$
	TOTAL:	$

AFC AIDS FOUNDATION CHICAGO

Emergency Financial Assistance Application

TEMPORARY FINANCIAL CRISIS AND PREVENTION SERVICES

1. Narrative *(To be completed by Service Provider)*: Please provide a brief narrative detailing the situation that caused the client's temporary crisis. Describe the impact the assistance will have moving forward:

2. Emergency/Crisis Situation: *(Check only one)*

☐ **Loss of Employment** (Termination letter from employer; unemployment application/ documentation that shows final date of employment)

☐ **Medical disability or emergency** (Bill from hospital or care provider; signed note from care provider)

☐ **Loss or delay of a public benefit** (PA, VA, or SS Letters)

☐ **Natural Disaster** (Fire or flood report or other similar documentation)

☐ **Substantial change in household composition** (Proof of death of household member or other similar documentation)

☐ **Victimization by criminal activity** (with police report)

☐ **Domestic violence situation** (with police report)

☐ **Illegal action by a landlord**

☐ **Displacement by government or private action** (Signed letter from landlord or other authority informing individual/household of need to move)

☐ **Client is moving from homelessness into permanent housing**

☐ **Obtain or maintain subsidized housing**

☐ **Client is moving into more affordable housing that promotes long-term stability**

3. Reason for Assistance: *(Check only one)*

☐ To maintain current residence ☐ To move from current residence to other permanent housing ☐ To move from homelessness to permanent housing

4. Assistance Requested: Enter the requested assistant amount(s) into the appropriate boxes below:

First and Last Month's Rent:	$ _____
Past Due Rent:	$ _____
Past Due Mortgage:	$ _____
Past Due Utility:	$ _____

Emergency Financial Assistance Application

Responsibilities of Client/Applicant:

- All applicants for AFC Housing and Utility Assistance must be enrolled in the central client registry at AFC.
- Applicants must provide adequate documentation that they are experiencing a temporary financial crisis beyond their control.
- Applicants are not to engage in physically and/or verbally threatening behavior toward their Service Provider or AFC staff at any time. Physical or verbal threats will be cause for application denial. Discriminatory remarks and harassment in regards to but not limited to matters of race, color, national origin, creed, gender, sexual orientation or religion **will be considered verbal threats** and will be cause for application denial.

The following **Step by Step** application process with my assigned Service Provider has been explained to me:

Step One: Prior to completing any application forms the Service Provider must review the client for eligibility. At this time, the Service Provider and client should agree upon which of the eligible temporary financial crisis they are striving to document. Use the attached guide **"Documenting the Crisis"** to help determine eligibility. If it appears that the client is experiencing one of the eligible temporary financial crisis and will be able to document it, they should move on to step two.

Step Two: The client must present the Service Provider with all of the documentation that supports the temporary financial crisis that is being experienced. The attached guide **"Documenting the Crisis"** will help the Service Provider inform the client what must be submitted.

Step Three: All of the application forms should be completed along with the Service Provider writing a narrative that describes the temporary financial crisis that is supported by the documentation.

Step Four: The completed application may be submitted to the AFC Housing staff for review. Submitting an application is not a guarantee of approval. Once an application is reviewed the Service Provider will be notified within 48 hours if it is approved, denied or incomplete with a confirmation letter. If the application is considered incomplete the Service Provider along with the client will have 14 business days to submit supplemental documentation to AFC Housing Staff to potentially move it forward for review.

Process for Grievance/Appeal of Decision

AFC's decisions for approval or denial are based on two factors:

1. The narrative provided in the application; and
2. The supporting documentation submitted.

Step One: If the client is unable to present supporting documentation of an eligible temporary financial crisis, or the narrative in the application does not sufficiently explain the financial crisis, the application will be denied, and AFC will provide an official denial letter.

Step Two: The denial letter from AFC will state all reasons for the application denial. The Service Provider should share the denial letter with the client and explain if necessary.

Step Three: If the client is dissatisfied with the Service Provider's explanation, they should be given the contact information of the Server Provider's supervisor. The supervisor should further explain how the denial decision was made based on the ineligibility of the application or the lack of supporting documentation**.**

Step Four: Clients who are dissatisfied with the process or results of their application for the AFC Housing and Utility Assistance Program will be provided the name and number of the AFC Director of Housing Stabilization, Alma Arroyo, and (312) 334-0966.

I understand my rights and responsibilities and the grievance procedure. I also understand that this policy is specifically related to the AFC Housing and Utility Assistance application and it is not intended the replace the Grievance Procedure at my Case Management agency.

Client Signature	Print Client Name	Date
Service Provider Signature	Print Service Provider Name	Date

Client: Please keep a copy of this form for your records.

Emergency Financial Assistance Application

Subject to the limitations and conditions set forth below, I, _____ hereby consent to _____("Service Provider"), acting through its employees or agents, to use and/or disclose my health information and medical records to the AIDS Foundation of Chicago (AFC), and/or any subcontracted agencies that provide services through them, as follows: (i) in connection with my participation in the centralized client database established by AFC (the "Client Track Database") and the operation of the client database; (ii) to allow sharing of my case management agency with my housing navigator. (iii) To allow sharing of my housing services/assistance with my case management agency. (iv) to enable AFC and the Ryan White Case Management Cooperative to conduct quality assurance programs for individuals receiving services through the Cooperative; (iiv) to avoid duplication of services by agencies; and (vi) in connection with the submission of reports and other data to funding sources.

In connection with my enrollment in the Database, I hereby give my consent for the following information to be furnished to AFC for entry into the Database: my name, date of birth, and other demographic data. In addition, verification of HIV positive status, viral load/CD4 counts, and dates of HIV medical services and case management services will be released to the AIDS Foundation. I understand that this information will be grouped together with that of other clients for the purpose of generating statistical reports, for development and monitoring of a housing and healthcare cascade, avoiding duplication of services and coordinating a system for service delivery to persons with HIV, their family members, and/or significant others and specifically authorize the use of such information for that purpose.

I further allow the program staff of AFC and its designated Oversight Committee and Ryan White Cooperative to review my individual service records as part of the funder's quality assurance program. For the purposes of this consent, I acknowledge and agree that my service records include any and all records generated by any of the Provider agencies that participate in the Ryan White Northeastern Illinois Cooperative, AFC Supportive Housing Programs or Financial Assistance Programs.

I further understand that any information I provide for the purposes of receiving services will be disclosed to the Illinois and/or Chicago Department of Public Health department for purposes of surveillance, or any purpose for continuity of obtaining health care, housing, financial assistance or social services, (1) with my consent, (2) as required by law, or (3) if necessary, to prevent a serious attempt to inflict harm on myself or others. Security precautions will be maintained to prevent unauthorized access to the Database by anyone other than the program staff of AFC.

I give further consent to allow AFC to report information that I provide in connection with my enrollment in the Database and in connection with my receipt of services to the federal grant programs that support AFC. I understand that such information may be provided either in the aggregate or on an individualized basis.

I further understand that should I receive service funded under Part A and B of the Ryan White CARE Act or IDPH HOPWA, certain information will be reported to the Direct Services Unit of the Illinois Department of Public Health and the Chicago Department of Public Health, including: Demographic information, including but not limited to name, gender, race, ethnicity, and birth date; service utilization information; HIV/AIDS diagnosis and treatment information, if any; and mental health and/or substance use diagnosis, treatment, and service information, if any.

I understand that this information will be shared for the purposes of evaluating Part A and B and HOPWA service utilization patterns, on-site service reviews, and when necessary to coordinate services.

I can terminate this consent by submitting a written request to my housing navigation agency indicating that I no longer desire to receive services through the Cooperative or AFC's housing programs, or my written revocation of this authorization, whichever occurs first.

I understand that I have the right to receive a copy of this consent. I further understand that I may revoke this consent at any time by providing written notice of my intent to revoke this consent to Provider. This consent cannot be revoked to the extent that action has already been taken based on this consent.

This consent is valid for a period of two years from the date of the actual client signature below.

Provider will not use or disclose personal health information beyond the scope of this authorization without your written consent or authorization. Please note that, subject to applicable law, disclosed information may be subject to re-disclosure by the recipient, and may no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

_____	_____	_____
Signature of Client or Client's Legal Representative	Print Name	Date

_____

Relationship (if signed by person other than client)

Chicago Department of Public Health
STI/HIV Division -- HIV Housing Programs
Housing Opportunities for Persons with AIDS (HOPWA) Program

Authorization to Use & Disclose Confidential Information

Client Name: _____

I, _____ (*Name*), hereby authorize

_____ (Provider) to disclose to AIDS Foundation of Chicago (*Delegate Agency*), to disclose my full name and date of birth (or, if I am signing below as a Personal Representative, the full name and date of birth of the above-named Client, whose Personal Representative I am) to the Chicago Department of Public Health (CDPH), for the following purposes:

- To enable the CDPH to collect names of individuals receiving HIV Housing services through the HOPWA program; and
- To enable CDPH to match names with CDPH HIV surveillance data in order to assess if HOPWA clients are linked to care, retained in care, and in Anti-Retroviral Therapy (ART) treatment in connection with the submission of reports and other data to funding sources.

This authorization is valid for one year from the date signed and witnessed.

I understand that: I may revoke this authorization at any time by providing written notice to the above-named Delegate Agency. Such revocation shall have no effect on uses or disclosures made prior to the revocation. The Delegate Agency may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations.

_____ _____
Client Signature / Date Witness Signature / Date

_____ _____
Print Client Name Print Witness Name

_____ _____
Personal Representative's Signature / Date Witness Signature / Date

_____
Personal Representative's relationship to Client
(i.e., authority to act on client's behalf)

_____
Print Personal Representative's Name

ILLINOIS Department of Public Health — **Authorization for Release of Health Information**

Ryan White Part B Program

First Name	Middle Initial	Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)
	/ /

Please read all statements and sign in the space provided to certify that you have read and understand this authorization. All references to "Program" or "Programs" refers to the Illinois Department of Public Health, Ryan White Part B Program and/or successor programs in which you participate or to which you apply for services.

1. I certify that the information in this application is true and accurate to the best of my knowledge. I understand that I may be disqualified from this program(s) and/or prosecuted for willfully providing false information.
2. I understand that the information requested on this application is for the purpose of determining my eligibility for a state and federally funded program. The funding is limited and may expire at any time without extended or alternate funds being available.
3. If I am considered eligible for services, my information will be utilized with our contractual partners for the reasons explained in this document. Eligibility approval does not mean I will receive or be enrolled in all services. I understand each service may require additional information, and that I must provide this information for verification before enrollment into said services.
4. Upon approval, my eligibility will expire after six months. Upon the conclusion of my six months, I will be required to reapply and provide updated eligibility information to continue accessing services. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my Recertification Application every (6 months) as per Federal Guidelines.
5. I agree to notify, or to have my Medical Case Manager notify the program(s) of any circumstances affecting my participation in, or eligibility for, the program(s). I agree to notify the program(s) within thirty (30) days of a change in address and understand that all program correspondence will be sent to the address I have on file with the program(s). I understand changes in my situation will be periodically evaluated to determine continued eligibility for the program(s).
6. I authorize the program to release my enrollment, eligibility and service utilization records and other information necessary to facilitate the provision of program services to my physicians, other providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, or entities that are under contract with the program with the understanding that my status will never be disclosed to entities not affiliated with the Ryan White Part B Program in the bullet point list below.
7. If I experience discrimination because of the release or disclosure of medical related information, I may contact the Illinois Department of Human Rights at (217) 785-5100 or (312) 814-6200. This agency is responsible for enforcing the Illinois Human Rights Act which provides certain protections for persons with disabilities.
8. If I request enrollment into Medical Case Management or request any service that requires coordination with a Medical Case Manager, my information will be shared with the Medical Case Management provider that the Care Connect Regional Lead Agent who is administering this program in my area assigns to me.
9. I acknowledge that my health insurance premiums (if applicable) are being paid by the program via a contractual third party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the IDPH for any unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.
10. I agree to indemnify and hold the Illinois Department of Public Health (IDPH) harmless from any and all claims for making premium reimbursement payments directly to the IDPH or any entity under contract with the IDPH in connection with Program Services. I agree to indemnify and hold the IDPH, or any entity under contract with the IDPH in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from IDPH or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program(s).
11. I agree to reimburse IDPH for any and all premium reimbursement payments that are paid to me in error during my enrollment.
12. I understand that my records are protected under the Health Insurance Portability and Accountability Act, Pub.L 104-491, 110 Stat. 1936, enacted August 21, 1996, and Illinois Statute 410 ILCS 305 relating to confidentiality of medical information, and cannot be disclosed to any other entity except those referenced herein without my written consent. I do not have to consent to the release of this information. However, if I refuse to sign this authorization, I will be ineligible to receive services through this program.
13. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of **24 months** from the date this form is signed, or until such time as I inform the administrator of the Program(s), in writing, of my wish to terminate services in the Program(s). I also understand that I will still be required to sign a new authorization form every 6 months to continue Ryan White Services. I also understand that each time I sign a new reauthorize on a 6 month basis for renewal purposes that any and all previous authorization(s)

PLEASE RETURN THIS PAGE

REQUIRED PAGE

ILLINOIS Department of Public Health **Authorization for Release of Health Information**

Ryan White Part B Program

become null and void.

a. This authorization refers to authorizing the release for a validity period spanning 24 month period from the date this form is signed for those instances when I may step away from care after a 6 month certification, which this authorization will provide permission for reengagement activities to take place by designee(s) of the Department not to exceed the 24 months from the date of signature.

The agencies listed below are utilized to coordinate and verify eligibility for all services, and for treatment and care coordination with other program(s) within IDPH, following the same confidentiality requirements identified above in statements 1-13:

- System Software Vendor *
- Premium Assistance Payment Vendor*
- Pharmacy Benefits Manager Vendor*
- Quality Assurance & Compliance Vendor*
- Centers for Medicare & Medicaid Services
- IL Department of Insurance
- DIS Outreach Specialists employed by IDPH and/or local Health Departments
- Chicago Department of Public Health
- IL Department of Employment Security (Income Verification Services)
- IL Department of Health and Family Services (Medicaid Verification Services)
- IL Department of Public Health programs per Illinois Statute 410 ILCS 305
- IL Department of Public Health's Office of Health Protection Sections/Programs
- All Ryan White funded Providers

* Specific vendor information can be requested at: https://www.wh1.ioc.state.il.us

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact listed below, and understand that I will be required to list this contact on each submission of this form.

_____

Alternate Contact Person Name **(You do not have to list your Case Manager)**

_____

Street Address

_____

City State Zip Code

(_____) _____ - _____ Is this person aware of your + status? ☐ Yes ☐ No

Telephone

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact listed below, and understand that I will be required to list this contact on each submission of this form.

_____

Alternate Contact Person Name **(You do not have to list your Case Manager)**

_____

Street Address

_____

City State Zip Code

(_____) _____ - _____ Is this person aware of your + status? ☐ Yes ☐ No

Telephone

_____ / /

Client Signature (age 12 and older) **Date**

_____ / /

Parent/Guardian (if under 12) or Legal Representative **Date**

PLEASE RETURN THIS PAGE

REQUIRED PAGE

EMERGENCY FINANCIAL ASSISTANCE
Rental Agreement Form

Date:	__ __/ __ __/ __ __ __ __

RENTAL AGREEMENT:

Agreement between _____, Owner(s),
Print Owner(s) Name(s)

and _____, Tenant(s)
Print Tenant(s) Name(s)

for a dwelling located at:

Address:	Address Line 2:

City:	State:	Zip Code:

Tenant(s) agree to rent this dwelling on a month-to-month basis for $_____ per month,
Monthly rent amount

Payable in advance on the _____ day of the calendar month,
Monthly due date

Beginning on __ __/ __ __/ __ __ __ __.
Start date of rental agreement

ADDITIONAL EXPENSES/FEES:

The first month's rent for this dwelling is: $_____

Tenant is responsible for making direct payments to utility companies for the following utilities:		
Electric:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent
Heating:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent
Cooking:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent
Water:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent
Garbage Removal:	☐ Yes, tenant is responsible for this utility	☐ No, this utility is included in the unit's rent

SIGNATURES:

_____
Print Tenant Name

_____
Print Landlord Name

_____
Tenant Signature

_____
Landlord Signature

_____
Date

_____
Date

EMERGENCY FINANCIAL ASSISTANCE
Landlord Statement Form

Date:	__ __/ __ __/ __ __ __ __

TENANT INFORMATION:

Tenant's First Name:	Tenant's Last Name:

Tenant's Address:	Address Line 2:

City:	State:	Zip Code:

Total Amount Due:	$

LANDLORD INFORMATION:

Owner's Name or Management Company Name:	

Mailing Address:	Mailing Address Line 2:

City:	State:	Zip Code:

Contact Person (Owner or legal representative of property):	

Contact Number:	(__ __ __) __ __ __ - __ __ __ __ ext. _____

LANDLORD SIGNATURE:

By signing below, I certify that I am the owner, or legal representative of the owner, of the property listed under "Tenant's Address" above, and that the information provided is true and accurate to the best of my knowledge.

_____ _____

Landlord Signature Print Landlord Name

AFC OFFICE USE ONLY:

SERVICE MONTH(S) APPROVED:

AMOUNT APPROVED: $

FOR:
☐ *PAST DUE RENT*
☐ *1ST & LAST MONTHS RENT*

NOTES:

AFC STAFF APPROVAL (INITIALS):

AFC HOUSING PROGRAM EMERGENCY FINANCIAL ASSISTANCE

Dear Landlord or Property Manager,

You are receiving this letter because a **current or potential tenant** has requested assistance from the AFC Housing Program which provides Emergency Financial Assistance. The purpose of the AFC Housing Program: Emergency Financial Assistance is to stabilize individuals and families in their current home, to decrease the amount of time spent in shelters, and to help individuals and families secure and maintain affordable housing.

In order to be in compliance with our state/federal funders and The Internal Revenue Service (IRS), we are required to collect the following documentation:

For Private Market Landlord:

If the landlord is a private market landlord, the Tax ID number will be a Social Security number or an Individual Tax Identification Number (ITIN). A Copy of your social security card or ITIN card/letter must be attached for verification.

If the landlord is a private market landlord, proof of property ownership must be submitted. A current copy of the property tax bill or copy of the property deed must be attached for verification.

For Property Management Company or Business:

If the landlord is a property management company, the Tax ID number will be the Employer Identification Number (EIN) for the business. A Copy of the EIN Verification letter or state business verification print out must be attached for verification.

Unable to locate?

If you are unable to locate your federal Tax ID forms, you can visit www.irs.gov or www.mytaxillinois.gov

If you are unable to locate property proof of ownership, you can visit www.cookcountytreasurer.com or www.cookrecorder.com

This information is gathered exclusively for the purpose of making payments to landlords so that the tenant can remain stably housed. Your information will never be used for any other purpose and your privacy will be respected at all times.

If you would like to fax these documents directly to AFC Housing Programs, please fax to: (312)-334-0977
ATTN: AFC Housing Program/EFA
Or mail to:
AFC Housing Program/EFA
PO BOX 1022
Chicago, IL 60690

For any additional questions or concerns that you may have please reach out to the Director of Housing Stabilization, Alma Arroyo at (312)-334-0966.

Thank you very much for your cooperation and for your commitment to providing safe and affordable housing for your tenants!

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ►

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

Fare Card Authorization and Reimbursement Request Form

All requests for client fare cards MUST BE pre-approved by AFC in order to be reimbursed. Agencies must scan and e-mail a copy of this signed authorization form, a copy of the agency check used to purchase the client fare cards, a copy of the shipping form, a copy of the fare card receipt for purchase and the sales order form provided by Ventra or Pace to Alex Rhodes, AFC's Linkage to Care and Retention Associate at Arhodes@aidschicago.org within 15 business days of purchase.

This Authorization Form is valid for only 20 business days from date of AFC authorization below and will be considered VOID after that time.

Date of Request:	
Agency Name:	
Name of Person Making Request:	
Requestor's Phone Number:	
Agency Authorized Signature:	

Client Fare Cards:	$
Client Metra Cards:	$
Client Gas Cards: (Agencies are not allowed to purchase gas cards, please request them from AFC as part of your quarterly allocation).	$
Total Authorization Amount:	$

_____ _____

Case Manager Signature **Date**

_____ _____

Client Signature **Date**

Medicare Complaint Form

Date:	
Agency Name:	
Staff Member:	
Date of Incident:	
Date/Time of Car Order:	
Car Company:	
Car Number:	
Pick-Up Address:	
Destination:	

	Other
	No Show
	Round Trip
	One Way

Comments/Explanation:

NOTIFICATION OF CHANGE IN AGENCY PERSONNEL AND TRAINING REQUEST

AGENCY NAME _____

AGENCY ADDRESS (service site) _____

POSITION SUPERVISOR: _____

Funding Source:

Part A: _____ (% FTE) Medical _____ (% FTE) Non-Medical
Part B: _____ (% FTE) Medical _____ (% FTE) Non-Medical
Corrections: _____ (% FTE) PACPI: _____ (%FTE)
DRS: _____ (estimated % FTE) Retention Specialist: _____ (%FTE)

Will this staff person be a Provide user? ☐ **YES** ☐ **NO**

New Hire:

Start Date: _____ Name: _____

Phone #: _____ Fax #:_____ E-Mail: _____

Does this position/staff member replace staff: ☐ YES ☐ NO Name: _____

Last degree earned: _____ Other training/certificates:_____

Previous employment experience in social services:

Skills and experience that qualify individual for case management:

Change in Employment:
Effective date: _____
Reason: _____

This form should be completed for any personnel changes for AFC-funded positions, and attached to staff resumes for all new hires. Personnel include case managers, and supervisors. ***email to AFC, Mara Williamson at support@aidschicago.jitbit.com***

OR

Click the button below to automatically submit to Jitbit

Submit

JOB SUMMARY

This position is responsible for performing duties associated with conducting intakes and referrals for people living with HIV/AIDS who are seeking case management services. The Medical Case Manager will determine client eligibility for services, conduct an initial assessment of client needs, record basic demographic information in AFC's client-level database, and coordinate care with HIV primary care providers.

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

DUTIES:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan jointly with the client that includes short and long term goals focused on attaining, maintaining and achieving positive health outcomes
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services
- Coordination of the care plan with client's primary care provider
- Work in conjunction with medical care providers (e.g. case conferencing, attending rounds); ensuring all clients are case conference at least twice per year
- Implement the medical treatment plan by providing counseling on medication, appointment and other treatment adherence issues
- Verify enrollment in medical care, and support enrollment of the uninsured in health care services
- Refer and link clients to appropriate services within the system of care that promote positive health outcomes, treatment adherence, and greater self-sufficiency. Monitor the client's follow-through with these services
- Provide access to Emergency Financial Assistance (EFA), (e.g. food vouchers, utility payment assistance, and transportation vouchers) as needed to promote and maintain positive health outcomes
- Evaluate effectiveness of services based upon client outcomes in the scope of work
- Enter and utilize the client level database for the tracking and reporting of all services provided
- Follow the Standard Operating Procedures of the AIDS Foundation of Chicago's Northeastern Illinois HIV/AIDS Case Management Collaborative

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

JOB SUMMARY

This position is responsible for performing duties associated with conducting intakes and referrals for people living with HIV/AIDS who are seeking case management services. The Non-Medical Case Manager will determine client eligibility for services, conduct an initial assessment of client needs, record basic demographic information in AFC's client-level database, and work with client to ensure retention in HIV primary care.

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

Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas *Medical Case Management services have as their objective improving health care outcomes.*

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan jointly with the client that includes short and long term goals focused on attaining, maintaining and achieving positive health outcomes.
- Timely and coordinated access to appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Client-specific advocacy and/or review of utilization of services
- Coordination of the care plan with client's various service providers
- Implement the treatment plan by providing counseling, support and referrals on medication, appointment and other treatment adherence issues
- Verify enrollment in medical care, and support enrollment of the uninsured in health care services
- Refer and link clients to appropriate services within the system of care that promote positive health outcomes, treatment adherence, and greater self-sufficiency. Monitor the client's follow-through with these services
- Provide access to Emergency Financial Assistance (EFA), (e.g. food vouchers, utility payment assistance, and transportation vouchers) as needed to promote and maintain positive health outcomes
- Evaluate effectiveness of services based upon client outcomes in the scope of work
- Enter and utilize the client level database for the tracking and reporting of all services provided
- Follow the Standard Operating Procedures of the AIDS Foundation of Chicago's Northeastern Illinois HIV/AIDS Case Management Collaborative

AIDS FOUNDATION OF CHICAGO
QUARTERLY PROGRESS REPORT NARRATIVE

Time Frame: _____

Agency Name: _____

Address: _____

Phone: _____

Project Administrator: _____

Author of Report: _____

Author's phone # and email: _____

Purpose: Quarterly reports serve as an important tool in analyzing progress, needs, successes and barriers to programming. These reports serve as a tool when reporting back to funders, inform funding decisions based on agency needs, and provide AFC with information to be able to provide the appropriate technical assistance. Additionally, these reports aid in tracking progress on your programs quality improvement initiatives. Please be as detailed as possible when you are submitting your quarterly reports.

Part A & B funded agencies will electronically submit reports by 4:00 pm on the 10th of the month after the end of the quarter to Lpatterson@aidschicago.org. The schedules are outlined below.

Part A: 10th of June, September, December and March.
Part B: 10th of July, October, January and April

I. Scope of Services

List the scope of services that your agency is funded to provide in ***each*** applicable category (**Medical case management, Supportive case management, Outpatient Ambulatory Services, Early intervention Services, Mental Health, Substance Abuse (outpatient), Oral Health, Legal Services, Food Bank/Home delivered meals, Transitional Housing,**

Emergency Financial Assistance, Transportation) and describe your progress. Indicate the payer of the aforementioned services, Part A or Part B. If your agency receives both Part A & Part B funding through AFC, you will submit reports to the Part A ***and*** Part B Program Coordinators.

II. Program Progress

a) Describe activities to provide clients with harm reduction and risk reduction information for the prevention of secondary transmission.

b) Describe how clients are screened for insurance coverage and third party funding sources at minimum every six months to ensure the program only serves eligible clients and that the Ryan White HIV/AIDS Program is the payer of last resort.

c) Provide a description of activities conducted during the reporting period to pursue third-party payments for services subject to this agreement, including Medicaid, Medicare, and private insurance. If third-party payment was retroactively received, describe how the recovered funds were redirected for use in the Ryan White program.

d) Provide any additional narrative to describe successes not already discussed in Section II. Above, and their potential impact in HIV/AIDS direct services

III. Barriers or Trends

a) Describe program and/or administrative including fiscal challenges that have occurred during this reporting period and their potential impact on your ability to provide HIV/AIDS direct services. Also, detail your plan to address those challenges including TA requests by AFC.

Action Item: **Target Completion Date:**
Expected Outcome: **Completion Date:**

Key Steps	Timeframe	Responsible Party	Status	TA Needed/Requested

b) Describe trends that have emerged within your program and their potential impact on your ability to provide HIV/AIDS direct services.

IV. Staffing Changes

(a.) Describe any personnel changes in this section and an action plan as to how your agency will resolve the issue, including trainings and certification process for new employees(s) using the template below.

Action Item: **Target Completion Date:**

Expected Outcome: **Completion Date:**

Key Steps	Timeframe	Responsible Party	Status

V. Quality Management

(a.) Describe quality assurance/improvement activities related to your funded Part A/B direct services that occurred during this reporting period. Quality assurance/improvement

activities should be linked to your organization's QM plan. QM indicators can measure accessibility, appropriateness, continuity, demographic characteristics, effectiveness, efficacy, patient satisfaction, safety of the environment and timeliness of care.

(b.) Describe the methods your agency employs to actively solicit consumer feedback and indicate how consumer feedback is incorporated within your agency. List specific areas of concern expressed by consumers and how the agency plans to address them.

(c.) Describe case management supervisory activities conducted this quarter. (**case management providers only)**

(d.) Please attach below progress reports related to quality management activities

VI. Program Income and Client Charge

(a.) In the following table, please report any program income that was generated by the Ryan White grant or earned as a result of the grant, including funds collected or recouped due to client's insurance or Medicaid eligibility identified after initial payment with Ryan White funds.

	Amount
Medicaid back billing for any core services rendered through Ryan White	$0
Cost sharing from Ryan White and the client	$0

(b.) Describe how the program income generated was used during this reporting period.

Action Plan

Grantee Name:
Grantee Mailing Address:
Principal Grantee Contact:
Date:

Action Item: **Target Completion Date:**
Expected Outcome: **Completion Date:**

Key Steps	Timeframe	Responsible Party	Status	TA Needed/Requested

Fiscal Supporting Audit Document
Required Supporting Audit Documentation

PERSONNEL:

- Copy of the agency's personnel policies and procedures with required sections being Confidentiality Policy, Disclosure of Information, Background Check Policy, and Non-discrimination section that includes language regarding Discrimination, Civil Rights and Human Rights.
- Personnel files for each employee funded through this grant. Files should have the following sections: Date of Hire, Job Description, Current Salary, Application/Resume, Staff evaluations, Background Checks, Current Contact/Emergency information and Annual Review of Personnel Policies and Procedures. (Will only need to review files to check off required sections)

ORGANIZATION AND ADMINISTRATION:

- Copy of agency written accounting policies and procedures on file and internal controls have been established.
- Agency has following documents on file: Current Agreement and Budget, current Scopes of Services, copies of submitted vouchers or financial reports.
- Any subcontractor/consultant agreements funded thru this grant (i.e., physicians, therapists, etc.)
- Copy of agency's most recent bank reconciliation to tie out with accounting system in place.
- Staff allocation and payroll records of employees that are paid under this grant.
- Copy of Board of Directors' meetings and by-laws and Code of Ethics.

AUDIT INFORMATION:

- Copy of the most recent audited financial statements and **OMB Circular A-133 single audit**, if applicable.

GOVERNMENT FILING REQUIREMENTS:

- Copy of agency's Annual Report to Illinois Secretary of State and proof of payment.
- Copy of federal payroll (941) reports and proof of payment.
- Copy of state payroll tax (IL 941) reports and proof of payment.
- Copy of IL unemployment UI-3/40 forms and proof of payment.
- Copy of form 1096, Annual Summary and Transmittal of U.S. Information Returns if paying any consultants requiring forms 1099-Misc.
- Copy of agency's IRS 501 (c)(3) determination letter.
- Copy of agency's annual federal IRS Form 990.
- Certificate of Liability malpractice insurance.

REIMBURSEMENT REQUIREMENTS:

- Copy of the submitted monthly reimbursement voucher with supporting documentation to confirm 100% of the amount requested.
- For all shared costs, documented expense and cost allocation methodology.

Please see Universal tool for additional requirements/documentation that will be reviewed at site visit.

AIDS Foundation of Chicago
FISCAL SITE VISIT MONITORING TOOL

CONTRACT INFORMATION

Name of Agency		**Agency Staff Present**
Agency Address		
Site Visit Location		
Date of Site Visit		
Program Name		
Site Visit Conducted By:		

AGENCY STATUS

ADMINISTRATIVE/FISCAL:

Compliance		**COMMENTS:**
Conditional Compliance		
Non-compliance		

CORRECTIVE ACTION (if needed)

ISSUES/ACTIONS	AGENCY STAFF LEAD	TIMELINE FOR RESOLUTION

Agency Authorized Signature _____ Date _____

AFC Monitor Signature _____ Date _____

SITE VISIT COMPONENTS

	SITE VISIT COMPONENTS	TOTAL POINTS POSSIBLE	ACTUAL POINTS EARNED	SCORE
ADMINISTRATIVE AND FISCAL				
I.	Personnel*			
II.	Organization and Administration			
III.	Audit Information			
IV.	Government Filing Requirements			
V.	Reimbursement Requirements			
	TOTAL			%

***Total points possible is determined by the number of staff funded through this grant.**

KEY:

100%-85%	Compliance
84%-70%	Conditional Compliance
69%-0%	Non-compliance

I.	PERSONNEL	Points possible: Points earned:
1	Agency has a timekeeping system in place	C-2 NC-0 NA-0
2	If staff vacancies exist, agency is conducting a search for replacement	C-2 NC-0 NA-0
Key	C = Compliant NC = Non-Compliant NA = Not Applicable	

PERSONNEL
Personnel files should contain:

Employee Name & Title	FTE % on AFC grant	Date of Hire (1)	Job Description (1)	Current Salary (1)	Applicatio n/ Resume (1)	Staff Evaluations (1)	Background Check (0)	Annual Review of Personnel Policies (0)	Total Points (5 points possible)
1									
2									
3									
4									
5									
TOTAL									

Agency should complete shaded section and provide personnel files

***Fee for service agencies must provide up to 5 files of personnel working on the grant**

****Points are given for every item in each personnel file reviewed. Total possible points per each personnel file are five points. If more than five employees are paid under this grant, a random sample will be chosen by the AFC monitor.**

****Points for employee background checks and Annual Review of Personnel Policies are accounted for on the accompanying Site Visit Review tool.**

II.	**ORGANIZATION AND ADMINISTRATION**	**Points possible:** **Points earned:**
1	Agency has the following documents on file: Current Agreement and Budget; current Scopes of Services; copies of submitted vouchers or financial reports.	C-2 NC-0 NA-0
2	Agency maintains copies of all subcontractor and consultant agreements funded through this grant. Provide copies.	C-2 NC-0 NA-0
3	Agency has written accounting policies and procedures on file and internal controls have been established.	C-2 NC-0 NA-0
4	Accounting system can trace all charges back to paid invoices, receipts, canceled checks or other proof that the expense was incurred and paid.	C-2 NC-0 NA-0
5	Agency performs monthly bank account reconciliation. (with signature of approval from VP of Finance and/or Director of Finance)	C-2 NC-0 NA-0
6	Agency maintains an updated and accurate property control/inventory log for equipment purchases charged to AFC, including documentation that the purchase was pre-approved by AFC.	C-2 NC-0 NA-0
7	Payroll records are maintained for all employees paid under this grant and a staff allocation plan exists for employees.	C-4 NC-0 NA-0
8	Boards of Directors Minutes / reports indicate that the Board meets regularly in compliance with its by-laws and the board exercises its oversight responsibilities. ❑ How frequently does the board meet:_____ ❑ Date of last Board Meeting: _____ ❑ Board President's Name: _____	C-2 NC-0 NA-0
III.	**AUDIT INFORMATION**	**Points possible:** **Points earned:**
1	A certified independent public accountant examines agency fiscal records periodically. Name of Audit Firm: _____ Address: _____ Phone: _____ Date of last audit _____ (More than 3 years prior to end of last fiscal year = non-compliant)	C-2 NC-0 NA-0
2	Copy of most recent audited financial statements and OMB Circular A-133 single audit, where applicable*, have been sent to the AIDS Foundation of Chicago. *Entities expending $500,000 or more in federal funds are subject to single audit requirements of OMB Circular A-133. Findings Reported: _____ _____ _____	C-2 NC-0 NA-0

IV.	**GOVERNMENT FILING REQUIREMENTS**	**Points possible:** **Points earned:**
1	Pursuant to the Illinois General Not For Profit Corporation Act, Agency's Annual Report to the Illinois Secretary of State has been filed and to Corporation File Detail Report screenshot is attached. DATE FILED: _____ (Report is due each year on the first day of the month the agency was originally incorporated. The fee on this report is $5 if timely filed. This is a one-page report.)	C-2 NC-0 NA-0
2	All federal payroll taxes have been paid to date. (Verified by reviewing IRS Form 941, Employers' Quarterly Federal Tax Return.) Most recent quarter paid:_____+ Amount: _____ Date:_____	C-2 NC-0 NA-0
3	Agency is in compliance with Illinois Unemployment Insured coverage requirements Most recent quarter paid: _____ Amount: _____ Date:_____	C-2 NC-0 NA-0
4	Agency has provided a copy of IRS 501(c)(3) determination letter.	C-2 NC-0 NA-0
5	Agency has filed an annual Federal IRS Form 990 with a Schedule A, 990 EZ or Form 2758 (extension) for previous year. (Document due by 15th day of the 5th month following the close of the agency's fiscal year)	C-2 NC-0 NA-0
V.	**REIMBURSEMENT REQUIREMENTS**	**Points possible:** **Points earned:**
1	Agency has submitted for reimbursement vouchers on a monthly basis. Most recent month submitted _____	C-4 NC-0 NA-0
2	Agency has maintained copies of all reimbursement vouchers with supporting documentation to substantiate 100% of the amount submitted.**(See attached list for types of substantiating documents.) List voucher numbers verified. **Vouchers to be reviewed will be specified prior to the site visit.** Voucher #_____ Voucher # _____	C-10 C-5 NC-0 NA-0
3	For all shared costs, there is a documented allocation methodology which is applied to actual expenses to determine the charges on monthly vouchers for allocated costs such as telephones, equipment lease/maintenance, supplies, etc.	C-2 NC-0 N/A-0
4	If agency pays rent or a portion of rent out of this grant, **a copy of lease/rental agreement is available.**	C-2 NC-0 N/A-0
VI.	**OTHER (points accounted for on accompanying Site Visit Review tool)**	**Points possible:** **Points earned:**
1	No cash payments directly to service recipients (written policy and procedure)	C-0 NC-0 NA-0

Illinois Ryan White
Subcontract Site Visit Review

Date of Review:_____

SERVICE PROVIDER INFORMATION	
Agency Name:	
Address:	
Agency Participants:	

LEAD AGENCY MONITORS		
Name	Title	Email

GRANT INFORMATION	
Funded Service Categories:	

2.0	AGENCY POLICIES AND PROCEDURES					0/0
	Standard		**Measure**	**Yes**	**No**	**N/A**
2.1	Agency has a written Health Insurance Portability and Accountability Act (HIPAA) policy and procedure which includes a mechanism for assessment.		• Written policy on file at provider agency.			
2.2	Release of Information policy exists.		• Written policy on file at provider agency			
2.3	Grievance procedure exists.		• Written procedure on file at provider agency. • The grievance procedure policy is visible posted.			
2.4	Client Rights and Responsibilities policy exists.		• Written policy on file at provider agency. • Policy includes language regarding clients observing confidentiality.			
2.5	Agency complies with federal Occupational Safety and Health Administration (OSHA), Centers for Disease Control and Prevention (CDC), Environmental Protection Agency (EPA), and Americans with Disabilities Act (ADA)		• Policy and procedures on file • Site walk through to ensure ADA compliance.			
2.6	Agency has a drug-free workplace policy.		• Written policy and procedure on file at provider agency.			
2.7	Agency has a harassment free workplace policy.		• Written policy and procedure on file at provider agency.			
2.8	Agency has a process for the early detection and mitigation of irregularities and illegal acts by employees, members, and providers.		• Written policy and procedure on file at provider agency. • Personnel Policies • Anti-kickback			

			• Code of Ethics or Standards of Conduct			
2.9	Agency has a policy and procedure to report to the project director of the occurrence of falsified and/or fraudulent information/activity, or any misuse of resources or services		• Written policy and procedure on file at provider agency.			
2.10	Agency prohibits employees (as individuals or entities) from soliciting or receiving payment in kind or case for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, or any goods, facility services, or items for any federally funded program		Documentation of: • Key employee background checks • Recruitment practices Written policy and procedure on file to discourage soliciting cash or in-kind payments for: • Awarding contracts • Referring clients • Purchasing goods or services • Submitting fraudulent billings Employee policies that discourage: • Hiring of persons with a criminal record related to or are currently being investigated by Medicare or Medicaid			

2.11	Agency policy manual is reviewed annually for updates and written evidence is documented in regards to being reviewed during this period.		• Documentation of annual review of the organization policy and procedures with personnel is in file			
3.0	**CLIENT RECORDS AND DOCUMENTATION**					**0/0**
	Standard					
3.1	Agency has a policy client record storage, transportation and access policy. If client files are not transported offsite, a policy stating this must be present		• Written policy on file at provider agency.			
3.2	A complete file for each client is stored in a secure and confidential location and electronic client files are protected from unauthorized use.		• Files are stored in a locked file or cabinet with access limited to appropriate personnel.			
4.0	**PERSONNEL**					**0/0**
	Standard					
4.1	Agency staff has the minimum qualifications for their job position, as well as other experience related to the position, services provided, and communities served.		• Case managers have an annual in-service on physical and emotional self-care. • Case managers have completed 12 trainings annually. • Annual staff performance evaluations are on file.			
4.2	Agency staff is licensed as necessary to provide services.		• Copy of license is in agency personnel file including those of interpreters (Copy provided to AFC)			
5.0	**CULTURAL AND LINGUISTIC COMPETENCE**					**0/0**
	Standard					
5.1	Agency has a policy and procedure to ensure that all providers receive cultural competency training and/or materials that incorporates race/ethnicity and cultural characteristics of individuals receiving their services, as well as, to ensure services and written materials are culturally sensitive and competent.		• Written policy and procedure on file at provider agency. • Documentation is on file showing training or review of cultural competency materials.			
5.2	Providers ensure access to services, when necessary, with bilingual staff, licensed or qualified interpreters, and/or TDD services.		• Written policy and procedure is on file at provider agency			

5.3	Agency has a policy and procedure regarding the use of family and/or friends as interpreters to address privacy, confidentiality, and other issues. If a client chooses to have family and/or friends as interpreters, a written, signed consent is obtained from the client. Family and/or friends must be over the age of 18.		• Written policy and procedure on file at provider agency. • Family/friend interpretation consent form signed by client is on file and updated annually.			
6.0	**ACCESS TO CARE**					**0/0**
	Standard					
6.1	Provision of services is available to eligible clients, regardless of the individual's ability to pay or the current or past health condition.		• Written policy on file at provider agency. • Documentation is on file of client's refused services with the reason for refusal, complaints from clients, with documentation of complaint review and decision reached.			
6.2	Provider billing and collection policies and procedures (All program income has been billed, collected and reported to lead agency).		• Have billing collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the client's ability to pay • Utilization of program income is in place			
6.3	Payer of last resort policies do not deem a veteran living with HIV ineligible for Ryan White services due to eligibility for Department of Veterans Affairs (VA) health care benefits		• Written policy and procedure on file at provider agency exempt veterans from the payer of last resort requirement.			
6.4	Services are accessible, offered in a safe and secure environment, and in such a way as to overcome barriers to access and utilization.		• Alternate services sites or referral sources are maintained that are geographically sensitive to clients. • Procedures are in place to ensure clients have access to information regarding services in case of emergency 24-hours a day • Agency is easily accessible via public transportation.			
6.5	When applicable, providers make reasonable efforts to pursue third-party payments for services, including Medicaid, Medicare, and private insurance, to ensure Ryan White funds are the payer of last resort.		• Written policy and procedure on file to identify clients who do not have insurance and ensure "Aggressive Pursuit" in enrolling clients in insurance • Written policy and procedure that program can clearly			

			demonstrate how it accesses community services and other payers prior to utilizing Ryan White funds for services. (i.e. disability bus passes, Medicaid transport, utility assistance, etc.)			
6.6	Providers are able to coordinate services and cooperate with other agencies providing HIV/AIDS services and entities that constitute key points of access to the health care system.		• Documentation, such as memorandum of understanding or letter of agreement, is on file supporting relationships.			
6.8	Efforts to inform low income individuals of the availability of HIV related services and how to access them.		• Maintain file documentation provider activities for the promotion of HIV services to low income individuals, including copies of HIV program materials promoting services and explaining eligibility.			
6.9	Structure and ongoing efforts to obtain input from clients in the design and delivery of services in the form of one of the following:		• Maintain file of materials documenting Consumer Advisory Board (CAB) membership and meetings, including minutes • Regularly implement client satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented • Documentation of existence and appropriateness of a suggestion box or other client input mechanism			
7.0	**DATA MANAGEMENT**					**0/0**
	Standard					
7.1	Agency shall comply with reporting requirements http://hab.hrsa.gov/deliverhivaidscare/coremeasures.pdf		• Provide timely, properly documented reports that are consistent with eligibility requirements specified by the funder, which demonstrates eligible clients are receiving eligible services • Agency has a QM plan and the QM plan includes QI activities related to the Core Performance Measures. The performance measures are available online at			
8.0	**ADMINISTRATIVE & FACILITY**					**0/0**
	Standard					
8.1	Agency shall comply with reporting requirements		• Agency representatives regularly attend contract Admin Meetings			
9.0	**FISCAL**					**0/0**

Standard						
9.1	No cash payments directly to service recipients		• Written policy and procedure on file at provider agency.			
9.2	For Medicaid covered services, provider participates in Medicaid and certified to receive Medicaid payments required.		• Documentation on file of provider Medicaid status. If not currently Medicaid certified, documentation showing current efforts to obtain certification.			
			Total Possible Score:			
			Total Scored Points:			
			Final Overall Percent:			

AGENCY:
DATE OF REVIEW:

RECOMMENDATIONS-UNIVERSAL STANDARDS

Areas where the agency did not meet standards

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

OTHER RECOMMENDATIONS

Areas where the agency did not meet standards

1.	
2.	
3.	
4.	
5.	

Programmatic Administrative Procedures

1) **Describe how the agency responded to the recommendations identified in last year's site visit report**
   - **Recommendations that were completed**

   - **Recommendations that were not completed**

2) **What technical assistance/support could AFC provide to your organization?**

Comments:

Site Visit Corrective Action Plan (CAP)			
Agency:		Submission Date:	##/##/####
Submitted By:			

Recommendation Number: *##*
Area of Improvement: *The area of improvement listed on the agency site visit report*
How the Grantee Will Improve: *This should outline what will be done to address and correct the finding/recommendation that is being listed.*
Responsible Party: *This should identify the person(s), or job title(s), that will be responsible for correcting the issue.*
Date Completed, or Anticipated Completion Date: *This should contain either the date that the correction was made, or the date the correction will be completed by to bring the item into compliance*
Progress to Date: *This should contain any work that has been made to bring the finding/recommendation into compliance.*

Recommendation Number	Area of Improvement	How Grantee Will Improve	Responsible Party	Date Completed/ Anticipated Completion Date	Progress to Date

Appendix 48. Sliding Fee Scale Collection Call Script

Sliding Fee Scale Collection Script

Hello [client name], my name is [your name] calling from AFC. I work with your case manager, [CM name] at [agency name].

I am calling to discuss the fees you owe for services you have received in the past 3 months. Beginning April 2020, the Illinois Department of Public Health implemented a fee for recipients of certain Ryan White services, including: outpatient ambulatory, oral health, mental health, and outpatient substance use services. With this new change, staff from AFC are reaching out to clients on a quarterly basis to inquire about collecting these fees. The fees you have accrued for this quarter are [amount owed] for [service category].

Before I continue, I just want to ensure you that non-payment of these fees will NOT affect your ability to receive Ryan White services. Fees collected by AFC will be utilized to continue to provide Ryan White services for clients to help improve health outcomes. We currently are accepting cash or check payments, but can arrange for automated payments to be made as well. Are you able to pay this fee today?

Guion de colección de escala de tarifa variable

Hola [nombre del cliente], mi nombre es [nombre de agente llamando] llamando de AFC. Yo trabajo con su administrador(a) de casos, [nombre de administrador(a) de casos] de [nombre de agencia].

Estoy llamando para hablar sobre las tarifas que debe por los servicios que ha recibido en los últimos 3 meses. A partir de abril de 2020, el Departamento de Salud Pública de Illinois implementó una tarifa para los recipientes de ciertos servicios de Ryan White, que incluyen: servicios ambulatorios externos, de salud oral, de salud mental y de uso de sustancias para pacientes ambulatorios. Con este nuevo cambio, el personal de AFC se está comunicando con los clientes trimestralmente para solicitar información sobre el cobro de estas tarifas. Las tarifas que ha acumulado para este trimestre son [monto adeudado] para [categoría de servicio].

Antes de continuar, solo quiero asegurarle que la falta de pago de estas tarifas NO afectará su capacidad de recibir los servicios de Ryan White. Las tarifas recaudadas por AFC se utilizarán para continuar brindando servicios de Ryan White a los clientes para ayudar a mejorar el bienestar de la salud. Actualmente estamos aceptando pagos en efectivo o con cheque, pero también podemos organizar pagos automáticos. ¿Puede pagar esta tarifa hoy?

Appendix 49. Sample Receipt for Payment

CarePLUS

RECEIPT FOR SERVICES

Client name: _____

Service	Date	Amount
		$
		$
		$
	Total	$

Date paid: _____ Received by: _____

Format received: _____