AIDS Foundation of Chicago

Ryan White Treatment Modernization ACT
Standard Operating Procedures
Revised: January 31, 2020
Effective: March 1, 2020

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INTRODUCTION

These standard operating procedures were developed in collaboration with select subcontractor agencies to ensure the highest quality of service delivery. These standards should be used as a guide to understand the definitions of Ryan White care services as well as the program requirements and deliverables.

How to Use this Manual

Each policy is sequentially numbered and organized by Universal, Case Management, Other Core, Quality Assurance procedural categories. Included as part of each policy section are standard headers as defined below.

POLICY – Guiding purpose and intent of the policy section.

PROCEDURES – Lists systematic procedures required to execute the stated policy.

REQUIRED FORMS – Lists the required forms to be distributed, signed/dated by the case manager or client.

REQUIRED DOCUMENTATION – Lists documentation that the client must submit to the case management team.

PROVIDE SYSTEM – Identifies if the stated policy section requires reference in the Provide system.

UNIVERSAL POLICIES

01. Ryan White Treatment Modernization ACT Authority

PROCEDURE:	01	EFFECTIVE DATE:	March 1st, 2020

AUTHORITY

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is a federal law enacted to address the unmet health needs of persons living with HIV and AIDS (PLWHA). The program serves PLWHA who have no health insurance, have insufficient health care coverage, or lack financial means to get the care they need. Federal Ryan White funding is provided to cities, states and territories, providers, and other organizations. The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS) administer the program. AFC is the recipient of Ryan White Part A funds from the Chicago Department of Public Health and Part B funds from the Illinois Department of Public Health.

Services funded through the Ryan White Program are “payer of last resort”. In accordance with HRSA, Ryan White funds may not be used for any item or service to the extent that payment had been or can reasonably be made by another source. This means that funded providers must make reasonable efforts to secure non-Ryan White funds for services whenever possible.

With the implementation of the Affordable Care Act (ACA), PLWHA have more options for public and private health insurance made available through Illinois Medicaid program expansion and the Health Insurance Marketplace. Significantly, more clients are enrolled in public or private health insurance plans, resulting in increased access to quality health care services.

In an effort to deliver the highest quality services, these Standard Operating Procedures were revised and/or updated based on the changing landscape of case management services across the nation.

02. Ryan White Request for Proposals (RFP)

PROCEDURE:	02	EFFECTIVE DATE:	November 1st, 2016

AUTHORITY

The AFC Ryan White Request for Proposal project marks a progressive step forward in the delivery of case management services across the Chicago EMA.

In 2019, the AIDS Foundation of Chicago (AFC) issued its competitive Request for Proposal for Ryan White Part A and B services from community-based organizations, HIV service organizations and other eligible health and social service providers to deliver high quality, cost-effective Ryan White HIV/AIDS Program services. Funding for this RFP is made available from the Chicago Department of Public Health (CDPH), which administers the Ryan White Part A program and the Illinois Department of Public Health (IDPH), which administers the Ryan White Part B program. AFC was awarded to administer the 11 service categories highlighted in this Standard Operation Procedures (SOP) document. The competitive bid process yielded a wide array of service providers funded to deliver RW Part A and B services across the EMA. AFC is committed to a full transparent competitive review process for its public services on a no less than every three-year cycle.

Request for Proposal (RFP) Process

The following are required elements for issuing a competitive RFP for Ryan White services.

- Services being competitively bid
- Agency eligibility criteria
- Intent to Apply instructions for interested agencies
- AFC Bidder's Conference
- Scope of work and other program requirements
- RFP submission requirements and dates
- AFC proposal scoring and evaluation explanation
- Required tools and forms
- Award notification information

Refer to the previously issued 2019 Ryan White Part A Request for Proposal document.

AFC RFP Proposal Selection Process

AFC prioritizes services and activities that are aligned with the Getting to Zero Illinois plan. AFC is committed to ensuring resources are appropriately allocated to geographic areas that are most impacted by the HIV epidemic, and funding is based on needs and gaps and serves communities that have historically had limited or no access to HIV services.

03. Payer of Last Resort

PROCEDURE:	03	EFFECTIVE DATE:	November 1st, 2016

POLICY
By statute, Ryan White HIV/AIDS Program (RWHAP) funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payment source. This means grantees must assure that funded providers make reasonable efforts to secure non-RWPB funds whenever possible for services to clients. This includes, but is not limited to, other options for housing assistance, meal/food assistance, transportation, health care, etc.

Agencies funded to provide Ryan White (RW) services are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer sponsored health insurance coverage, and/or other private insurance) to ensure Ryan White funds are the payer of last resort. RW funds are intended to support only the HIV-related needs of eligible individuals. Case managers must be able to make an explicit connection between any service supported by RW funds and the intended client's HIV or care-giving relationship to a person living with HIV.

Health Insurance Premiums, Cost Sharing, Deductibles
Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RW funds for health insurance premium and cost sharing assistance, the case manager and medical benefits staff must ensure that clients are buying health insurance that includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines, along with appropriate HIV out/patient ambulatory health services. IDPH reviews all plans on an annual basis to ensure that a list of approved and compatible plans is distributed to all case managers.

Payment Requests and Cost-Sharing Options

- Paying for out of pocket costs related to comprehensive HIV outpatient/ambulatory health, oral health, mental health and substance abuse services and pharmacy benefits for eligible clients.

Ryan White Billing
All agencies funded for non-case management services funded by the Ryan White Part B program are required to document all services provision in the Provide database, as well as scan an invoice per client per service unit. When an agency can bill for Medicaid, they should monitor their ability to bill Medicaid before billing AFC. If a client becomes retroactively eligible for Medicaid for services provided within the last 90 days, agencies must bill Medicaid for those services and documentation for these services is to be reported in the agency's quarterly report. All program income must be reported via quarterly reports.

Verification/Documentation for Billed Services
All billed services must have clinical justification that it is included and documented in Provide.

PROCEDURES

1. All subcontractors must create a written policy and procedure to retroactively bill other payer sources for covered services. If a client becomes eligible for other payment sources, the provider must retroactively bill for services within 90 days of service date. Documentation of retroactive billing must be included in quarterly reports

2. Collect income, health insurance, and other public benefits information during client intake and every reassessment to determine eligibility for services, as well as payer status.
3. Assist clients in applying for health insurance and other public benefits.
4. Insurance coverage must be verified at minimum every 6 months as required under this SOP.
5. Veterans living with HIV receiving Veterans Affairs health care benefits are eligible for RW services.
6. Clients who refuse to apply for Medicaid or private insurance in the health coverage marketplace may be deemed ineligible in the near future to receive RW services per funder policies and procedures.
7. Clients who falsify income, insurance coverage, or public benefits information will lose their eligibility status.
8. Documentation of retroactive billing must be included in quarterly reports.
9. Use the Provide database to submit all client level data and documented interactions.

REQUIRED FORMS

Appendix 1. Affidavit of No Insurance Coverage

REQUIRED DOCUMENTATION

Providers must scan in all insurance cards as proof of insurance and complete the Benefits tab in the Eligibility Screening.

04. Payment for Billable Services

PROCEDURE:	04	EFFECTIVE DATE:	March 1st, 2020

POLICY
AFC has established payment schedules for case management and other core and supportive services. Based on the contract negotiated with subcontractors at the beginning of each program year, AFC or Pool Administrators, a third-party billing agent, will reimburse agencies/vendors accordingly.

BILLING REQUIREMENTS
The case management contracts distributed to agencies contains all documentation needs for the processing of billing for case management services. The below instructions are to be followed for billing processing of all other core and supportive services.

1. All billing for services rendered must be submitted to the client database by the 10th of the following month for services rendered in the prior month.
2. An itemized invoice indicating specific services received must be uploaded in the client database.
3. An itemized bill detailing services must accompany all collection notices and service costs make up the collections bill.
4. Any bills submitted erroneously and paid for by AFC or Pool Administrators are the responsibility of the submitting agency and must be paid back to the payer within five business days.
5. For all changes required after a bill has been submitted and paid by AFC or Pool, contact AFC prior to making any changes in the database.

PROCEDURES

1. Use the client database to submit all billing except for case management services.
2. AFC will review subcontractor/vendor invoices after the 10th of every month for services provided in the previous month. The payment request may be marked approved or rejected based on the quality of the invoice.
3. By the end of the month, AFC will submit all vouchers to IDPH for payment. Once approved, checks will be sent directly to each subcontractor agency/vendor.
4. All agencies must monitor their pending and rejected bills on a regular basis to ensure pending bills are submitted if possible, and rejected bills are remedied if possible.

REQUIRED FORMS
Appendix 2. Invoice Template

REQUIRED DOCUMENTATION
Bills/Invoices must be generated

05. Unallowable Costs

PROCEDURE:	05	EFFECTIVE DATE:	March 1st, 2020

POLICY
Certain costs are unallowable/are not reimbursable through AFC Ryan White funding. AFC will review expenditure documentation to ensure that costs are allowable. Agencies are required to create policies to ensure that Ryan White funds are not used for unallowable services.

Allowable costs must be related to HIV diagnosis, care, and support services. All RW providers must be appropriately licensed and in compliance with state and local regulations.

PROCEDURES
The following activities are unallowable and cannot be supported using Ryan White funding:

1. To make cash payments to intended clients of RW funded services (i.e., cash incentives, payment for core/supportive services, gift cards, vouchers, coupons, tickets that can be exchanged like cash for a specific service or commodity). Vouchers are only allowable if they are affiliated with a specific store/vendor (e.g., AmEx, Target, etc.). General gift cards that can be "converted" to cash or other gift cards are not allowed.
2. Purchase of clothing, employment placement/training services, funeral/burial services, and property taxes.
3. To purchase or improve land, or to purchase, construct, or permanently improve any building or other facility (other than minor remodeling).
4. To develop materials designed to promote or encourage intravenous drug use or sexual activity.
5. To purchase vehicles without written approval of the lead agency, Illinois Department of Public Health, and Grants Management Officer (GMO).
6. Non-targeted marketing promotions or advertising about HIV services that target the public (poster campaigns for display on public transit, TV or radio public service announcements, etc.)
7. Broad-scope awareness activities about HIV services that target the public.
8. Outreach activities that have HIV prevention education as their exclusive purpose.
9. Lobbying activities to influence or attempt to influence members of Congress and other Federal personnel.
10. Foreign travel.
11. To pay any costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools), or to pay any amount expended by the State under Title XIX of the Social Security Act.
12. To pay salaries and fringes for staff who have been federally debarred/suspended/excluded from use of federal dollars. All staff or sub-recipients that meet this disqualification need to be reported to IDPH.

REQUIRED FORMS – N/A

REQUIRED DOCUMENTATION – N/A

06. Subcontractor Policy & Procedural Manual

PROCEDURE:	06	EFFECTIVE DATE:	March 1st, 2020

POLICY
Subcontractors must create/adopt/modify the following policies outlined in this section. Subcontractors must perform an annual review of these polices with their employees to ensure ongoing compliance.

NOTE: AFC will maintain a website to store the AFC Ryan White Standard Operating Procedures document and forms. AFC will provide an email link to this drive upon request from an agency. The site may be accessed by following this address: http://www.aidschicago.org/page/our-work/case-management/case-managers.

PROCEDURE
AFC will provide agencies with templates of the following policies through google drive and procedures for inclusion in their internal policy manuals:

1. Drug-free workplace policy
2. Equal employment opportunity policy
3. Statement of values and code of ethics
4. Employee performance evaluation policy
5. Confidentiality policy
6. Anti-harassment policy
7. Conflict of interest policy
8. Anti-kickback policy
9. Whistleblower protection policy
10. Record retention, storage, and access policy
11. Staff/clients grievance procedure policy
12. Discipline and termination policy
13. Client's rights and responsibilities
14. Release of information policy
15. Accommodation of staff/clients with physical disabilities, including hearing impaired and linguistic concerns
16. Service to veterans policy
17. RW Payer of last resort policy
18. Health Insurance Portability and Accountability Act (HIPAA) policy

REQUIRED FORMS – N/A

REQUIRED DOCUMENTATION – N/A

07. Health Care Access & Navigation

PROCEDURE:	07	EFFECTIVE DATE:	March 1st, 2020

POLICY

Case management and medical benefit teams are expected to engage in high quality efforts to assess, link, and ensure benefits acquisition for their clients. Clients are required to have stable access to health insurance, clinical care, medications, and basic health literacy. The role of the case manager is to ensure that the client does not experience significant disruptions in coverage that could result in disruption of care services. As part of the Intake and Eligibility Assessment process, case managers must assess basic health literacy.

All case managers must vigorously pursue eligibility for other funding sources to extend finite RWHAP (Ryan White HIV/AIDS Program) grant resources to new clients. Policies must be maintained regarding the required process for the pursuit of enrollment for all clients and the documentation of the steps taken during pursuit of enrollment for all clients. Vigorous pursuit is a process ensuring that Persons Living with HIV/AIDS (PLWA) continue to receive care and treatment services while being informed, educated, and enrolled into coverage systems.

Illinois has traditionally provided individuals Medicaid benefits using a fee-for-service system. However, in the past few years, Illinois has begun implementing a managed care delivery system for Medicaid benefits. In a managed care delivery system, people get most or all of their Medicaid services from an organization under contract with the state, including Managed Care Organizations (MCOs), Coordinated Care Entities (CCEs), and Accountable Care Organizations (ACOs). Ryan White case managers are not required to recommend a provider. At a minimum, case managers must discuss enrollment and coverage options with clients to ensure that insurance needs are met.

PROCEDURES

1. Ensure that clients are educated regarding accessing the appropriate medical care, including utilization of clinics and urgent care facilities in lieu of emergency rooms for non-emergency related issues (i.e., prescription refills, minor injuries or illnesses).
2. Establish client access to and effective utilization of eligible services, including benefits counseling and referral activities to increase access to alternate programs/services.
3. Ensure that all clients have health insurance coverage, a medication payer source, primary care provider, a managed care organization (where applicable), and basic health literacy.
4. For clients with no insurance coverage, the agency must assess the highest quality plan for which the client will qualify (i.e., Medicaid, the marketplace and the Medication Assistance Program). The case manager will coordinate a streamlined benefit eligibility screening and enrollment process using a Benefits/Enrollment Counselor or the Affordable Care Act Passport Reporting Software.
5. The case manager will facilitate the enrollment process and prepare a list of documents the client will need to apply.
6. Provide follow-up services to ensure that insurance benefits are secured.
7. Medicaid eligible clients can voluntarily enroll in a MCO, CCE or ACO within 60 days of notification or be automatically enrolled by the State.
8. Conduct periodic reassessment benefits coverage. Ensure the ongoing affordability of coverage.
9. Track any changes in insurance coverage and eligibility to ensure continuity of care.

REQUIRED FORMS
Appendix 1. Affidavit of No Insurance Coverage

REQUIRED DOCUMENTATION
Providers must scan in all insurance cards as proof of insurance and complete the Benefits tab in the Eligibility Screening.

08. Memorandums of Agreements

PROCEDURE:	08	EFFECTIVE DATE:	March 1st, 2020

POLICY
All Ryan White service activities are guided using Memorandums of Agreements. As a best practice, all agencies should obtain signed and dated Memorandums of Agreements.

PROCEDURES

1. Agencies independently pursue and acquire executed memorandums of agreement supporting case management service delivery. This establishes referral relationships and allows for the development of regular communication with key service staff.
2. Authorization to Release Information forms must be completed for each client referral. Memorandums of Agreements do not supersede signed Releases of Information.

REQUIRED FORMS
Appendix 3. Sample Inter-Agency Memorandums of Agreement

REQUIRED DOCUMENTATION – N/A

09. Confidentiality & Releases of Information

PROCEDURE:	09	EFFECTIVE DATE:	March 1st, 2020

POLICY
All client information is confidential. Agencies must ensure that client health information is protected and is only accessed for care purposes. This policy provides guidelines for protecting and securing confidential health records. Confidentiality measures ensure that protected health information, including but not limited to, a client's HIV status, behavioral risk factors, or use of services cannot be released without his or her documented consent. Subcontracted agencies are required to take the necessary steps to ensure that their practice conforms to these policies and procedures.

Authorization to Release Information
Client information can only be released to third-party entities upon client consent using an Authorization to Release Information. Adolescents aged 12-17 can legally sign their own Authorization to Release for Health Services for Ryan White services without requiring a parent or guardian signature.

Case managers must inform clients of confidentiality protocols and have clients sign all requisite confidentiality policies and releases at intake and annually thereafter (when appropriate). Confidentiality procedures comply with the Illinois AIDS Confidentiality Act and the Health Insurance Portability and Accountability Act (HIPAA). Information related to the client record is deemed confidential and will be made available to the appropriate funders, AIDS Foundation of Chicago, and Groupware Technologies for technical support. This information will be documented in the AFC, CDPH and IDPH client database systems.

The Collaborative and case managers may only release information without client approval under the following circumstances:

1. When records are subpoenaed, and legal counsel confirms that information must be shared. In such cases, the client will be informed of the information shared, if legally possible, before AFC does so; or
2. In the event of a medical emergency when the client, guardian, or caretaker is unable to provide consent.

Revocation of Authorization to Release Information
Clients may choose to revoke their consent to release at any time. A revocation form should be provided to the client to sign off on and date.

PROCEDURES – Authorization to Release Information

1. During the brief Intake and Eligibility Assessment process, the case manager should obtain signatures on both the requisite AFC, funder Authorization to Release Information forms, as well as the agency's own Authorization to Release Information form. The release form must minimally include the following information: the receiving entity, the receiving individual (when appropriate and necessary), the nature of information to be shared, the duration of the consent agreed upon by the client, the client and case manager's signatures, and the identifying information of the client.
2. Authorization to Release Information forms must be signed and can be submitted to only the third-party agencies for which the form has been signed. Forms can be faxed, sent via secure email, mailed, or physically distributed to the entity.

3. If a client refuses to sign the Authorization to Release Information form, the case manager must indicate so on the signature line and place the form in the client chart. The case manager must make every effort to inform the client of the purpose of the form, as well as the ramifications for not signing the form but must not be coercive in forcing the client to sign. No information is to be submitted to AFC for reporting purposes and the client must be informed that he or she is ineligible for services that require verification of diagnosis or identity.
4. Annually obtain new Authorizations to Release Information.
5. Include all signed authorization release forms in the client database system as part of the client record.

Accessing and Sharing Protected Health Information

Protected Health information should never be accessed unless it is necessary to perform one's case management duties. The following provides guidelines to protect confidentiality while conducting verbal communications with clients, accessing data and technology systems used to host data, and ensuring basic physical security of information.

PROCEDURES – Accessing and Sharing Protected Health Information

Protecting Routine Communications

Be very careful to not disclose Protected Health Information (PHI) through routine conversation. This could be easily done by mentioning to a third party something as seemingly insignificant as saying, "John Doe had an office visit today," or making a similar remark.

1. Discuss client record information when in a secure setting like an office or meeting room with a closed door. Be mindful not to discuss client progress and records in unsecure areas like hallways and breakrooms, or while using cell phones in public places.
2. Ensure that verbal or written communications are being presented only to those personnel or partners who are part of the case management team.
3. Do not include client names in GroupWise/Outlook calendars. Only reference the client RWID number.

Physical Document Maintenance and Storage

Discard documents containing Protected Health Information (PHI) ONLY in a locked shredding container. If you notice the container is nearly full (6" from the top), please notify a Supervisor so the container can be emptied. Do not discard PHI or other confidential information in recycling bins.

Computer Hardware Security

Ensure that desktop, laptop, and office copy machines are updated to provide the highest security available. Update existing IT and hardware policies to include the following suggested procedures:

1. Have users read and sign an acceptable use policy describing precisely what is and is not acceptable on the company machine.
2. Lock down laptops with a cable lock wherever you are, including an office, home, airport, conference, or hotel room. If an immovable anchor is not available, loop the security cable around a chair, or other hard to move object. Keep a spare key apart from the one on your keychain.
3. Apply a tamper resistant asset tag or engrave the machine to aid authorities in recovery.
4. Keep an inventory of computer serial no., asset tag no., and computer model no.
5. If leaving a machine unattended, log out or turn machine off. Configure a policy to auto-lock machine after 10 minutes of idle time.
6. While traveling, never leave a laptop unattended in a public place.
7. When leaving a laptop in the car, lock the computer in the trunk.
8. Consider Recovery software that allows computer to "phone home" in case of loss or theft.

9. If a laptop is lost or stolen, report it immediately. Time is of the essence to keep thieves from intruding on the company network.

Personal Accounts and Client Management

Do NOT use personal accounts for work, or work accounts for personal use. This includes email, instant messaging, drop boxes, social media, document sharing, and other similar types of accounts. Personal accounts can be hacked more easily than work accounts, which then poses a security threat to AFC's information since hacked accounts often spread viruses and malware.

1. Store passwords securely. Do not store them underneath your keyboard, in your unlocked desk drawer, somewhere visible near your computer, or in any other unlocked area.

Operating Systems and Network Security

Update existing IT, software, and hardware policies to include the following suggested procedures:

1. Use a current and actively supported operating system (OS).
2. Apply updates and patches to the OS on a regular basis.
3. Do not let users download third-party software and applications, or enable unauthorized protocols or services.
4. Do not disable OS firewall.
5. Install an antivirus product that auto-updates. Enable real time protection by default.
6. Use an anti-malware client or web filtering service.

Protecting Electronic Data

Update existing IT, software, and hardware policies to include the following suggested procedures:

1. Laptop hard drives MUST be fully encrypted using encryption software in conjunction with a TPM (Trusted Platform Module) chip.
2. If using a USB drive, make sure it is encrypted.
3. Back up and synchronize your files on a regular basis.
4. Secure VPN technologies should be used to access the organization LAN from offsite.
5. Make sure secure (https) connections are in use for all web applications.
6. Do NOT use email to transfer PHI (protected health information), unless a HIPAA compliant encrypted email solution is in place.
7. Use privacy screens when using your laptop in semi-open or public places.
8. Have in place a password policy that requires passwords between 8-14 characters. Passwords should use at least three of the four complexity requirements: uppercase letters, lowercase letters, numbers, and non-alphanumeric characters. Do not write passwords down, and do not share them with others.

Security Awareness Training

AFC recommends that case managers participate in security awareness trainings to increase capacity to secure confidential health information. Topics such as usage of email, web surfing, physical security, travel procedures, password protection and any other measures should be discussed.

Additional non-mandatory measures include:

1. Bolster existing internet and intranet usage policies. Establish regular communications in company newsletters and emails about the latest threats and incidents that could affect your end user community.
2. Review your policies at new employee orientations.

3. Keep employees alert by doing occasional compliance checks. Do not rely solely on your automated systems.

REQUIRED FORMS
Appendix 4. Authorization to Release Information Script
Appendix 5. Authorization to Release Information (AFC)
Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)

REQUIRED DOCUMENTATION – N/A

10. Language Translation

PROCEDURE:	10	EFFECTIVE DATE:	March 1st, 2020

POLICY
Case managers must determine if the client requires professional foreign or sign language services during case management visits.

PROCEDURES

1. Identify foreign or sign language translation needs (where appropriate).
2. If a client prefers to use a "private" sign language or foreign language resource, including family or a friend, the translator must be over the age of 18 and an Authorization to Release Information must be obtained for said resource, as well as documented in Provide. If the client chooses an alternate translation provider beyond that which AFC provides, the case manager must inform the client that AFC assumes no liability for the quality of those translation services.
3. If the client chooses to utilize AFC translation services, the case manager completes the Sign Language Interpretation Request Form or Foreign Language Translation Request Form where appropriate and emails it to support@aidschicago.jitbit.com 48 hours prior to client contact with each interaction.
    a. To access foreign language interpretation services, call 844-723-6288 and enter PIN# 8418839. ACUTRANS is AFCs translation services provider.
    b. During the call, you will be asked for a username and password. This information is agency specific and has been provided to case managers supervisors.

REQUIRED FORMS
Appendix 7. Foreign Language Translation Request Form
Appendix 8. Sign Language Interpretation Request Form

REQUIRED DOCUMENTATION – N/A

11. Field Visits & Safety

PROCEDURE:	11	EFFECTIVE DATE:	March 1st, 2020

POLICY

Funded Collaborative case management subcontractors may assess clients in various locations, including but not limited to, a client home, public library, or public park. Case managers must assess each client's needs and offer field visits as needed. Field visits are considered best practices, especially for clients at risk of being lost to care and clients that struggle to make case management appointments. Case managers and supervisors must ensure that all necessary safety precautions are taken during case management visits with clients, whether they take place at the case management agency, in the client home, or in the community across Collaborative subcontractors.

PROCEDURES

When completing field visits, case managers need to be aware of safety issues. Some tips for safe field visits include:

1. When possible, avoid making unannounced visits. A letter or call prior to the visit may avoid a surprised client/household.
2. Call the client in advance of the visit to inform the clients/household members that you are on your way.
3. Let a co-worker or supervisor know where you are going and when you plan to be back and log it into your work calendar
4. If you need to make a field visit to a household you do not know well, take a co-worker with you.
5. Have directions and/or a map to the location.
6. Once at the location, notice your surroundings. Does anything seem unsafe? Unsecured dogs? Large groups of people? If you can, call the client to inquire.
7. Once inside the location, introduce yourself (unless you have already done so) and explain the purpose for your visit.
8. Notice the location of the exit.
9. If you notice illegal substances, weapons, or the client or a household member seems impaired by drugs or alcohol, you need to leave the home.
10. Follow your instincts; if you feel unsafe, you need to leave immediately.
11. Report any safety concerns or incidents using the Incident Reporting procedure in Section 11.

REQUIRED FORMS – N/A

REQUIRED DOCUMENTATION – N/A

12. Incident Reporting

PROCEDURE:	12	EFFECTIVE DATE:	March 1st, 2020

POLICY
Funded subcontractors will complete an incident report when organizations' staff first becomes aware that an incident has occurred. Incident, as described in this policy, is defined as an occurrence involving the individual using the service that:

- Results in a physical injury to or by the individual that requires a physician's treatment or admission to a hospital.
- Result in the death of any person.
- Requires emergency mental health treatment for the individual.
- Requires the intervention of law enforcement.
- Results in a breach of confidentiality.
- Requires a report of child abuse pursuant to Illinois Statutes 325 ILCS 5 Abused and Neglected Child Reporting Act or report of dependent adult abuse pursuant to (#@) ILCS 20/) Elder Abuse and Neglect Act.
- Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in the first, second, or third scenarios stated above.
- Involves a member's location being unknown by provider staff who are actively working with that individual and are expected to be aware of the member's location.

ELIGIBILITY – N/A

PROCEDURES
The organization may use its internal incident-reporting tool, which must include at least the following information:

1. Name of the individual(s), staff, and others who were present, witnessed, responded to and/or were directly involved in the incident. (To maintain confidentiality, any RW clients involved in the incident should be referred to using initials or other acceptable means.)
2. Date and time of the incident.
3. A description of the incident.
4. The action the organization took to handle the situation.
5. The resolution or follow-up actions to the incident.
6. Staff who were directly involved or served as the first respondent to the incident must prepare and sign the incident report and submit to the Case Management Supervisor.
7. File a copy of the signed incident report in the client file and client-level database system.
8. Notify AFC staff immediately and as part of quarterly reporting requirements.
9. Supervisor will maintain a central file of all incident reports and review these to identify patterns or trends and corrective action planning.

REQUIRED FORMS
Appendix 9. Incident Reporting Form

REQUIRED DOCUMENTATION – N/A

13. Grievance Reporting

PROCEDURE:	13	EFFECTIVE DATE:	March 1st, 2020

POLICY
AFC requires all subcontractor agencies to have an internal grievance policy in place. The case manager must discuss the policy with each client and provide a written copy to the client upon intake. The policy must be posted in an area where it is visible to clients for review. Clients receiving DRS HSP case management services can also submit grievances under the following scenarios:

Clients may contact the Center for Conflict Resolution at (312) 922-6464 at any point in the grievance process.

Clients may grieve the following actions/inactions, including but not limited to:

- Failure of a case manager to act in a timely manner.
- Failure of a case manager to provide the client with adequate service referrals.
- Case manager verbally, in writing, or other means offends the client.

Clients may not grieve the following:

- Policies of the Collaborative that are based on financial constraints.
- Reductions in service hours for the DRS program or termination of services due to financial constraints.
- Policies of the Collaborative that are based on HRSA guidelines.
- Behaviors of the client that are grounds for dismissal from case management based on the agency's Rights and Responsibilities guidance. This includes, but is not limited to, dismissal due to use of alcohol or drugs that create an unsafe or hostile environment for the case manager or make the client incoherent.

NOTE: DRS clients cannot access CCR's mediation program unless the grievance is regarding a Part A service (i.e., transportation, emergency financial assistance, emergency food vouchers, and emergency housing assistance).

ELIGIBILITY – N/A

PROCEDURES

1. The client must follow the agency's signed grievance policy.
2. Any grievance that has not been resolved by the agency or the client is not satisfied with the outcome must be reported to AFC's Grievance Officer (312-784-9089) and the client must complete the AFC Service Complaint/Inquiry form. The Grievance Officer will consult with the Director of Care to ensure a proper resolution has been attempted.
3. The AFC Grievance Officer will coordinate with the client to document the reason for grievance.
4. The AFC Grievance Officer will contact the agency Supervisor within 48 hours (business days) of the filed grievance to discuss policies, procedures, follow-up, and corrective actions.
5. Agency appeal of the grievance decision made by AFC must be processed through the Chicago Department of Public Health.

REQUIRED FORMS
Appendix 11. Sample Agency Grievance Rights and Responsibilities
Appendix 12. Grievance Tracking Form

Appendix 13. Service Complaint Inquiry Form AFC

REQUIRED DOCUMENTATION – N/A

14. Documentation & Progress Notes

PROCEDURE:	14	EFFECTIVE DATE:	March 1st, 2020

POLICY
The client database system is used to document case manager actions, including care plans, client actions/follow-up, Case Management and file notes, and any other information necessary to track the client's progress. The client database is also used to submit payment requests for agencies funded for core and supportive services. Documentation must include the following elements:

Case management

- Describes the substance of the meeting with the client.
- Describes the type of contact made with the client.
- Describes the level of need of client.
- Discusses the status of the client's progress toward the care plan goals.
- Describes any services that the client was provided during the visit, as well as the need for the service and how the service assists the client with their care plan goals.
- Describes any changes in eligibility, benefits, service needs, or treatment adherence, as well as retention/engagement in primary care.

Other staff

- An invoice detailing service provided.

A service provided record or payment request

NOTE: Ensure that no communications or referrals occurred without the appropriate signed Authorization to Release Information.

ELIGIBILITY – N/A

PROCEDURES

1. Notes should be specific and contain enough information for the reader to understand the client's specific situation, needs, and services. Documentation should be objective, include observations, and avoid subjective opinions. Documentation should respect the client and staff privacy, and not include names or identifying information that is not essential to the note. Documentation should have proper grammar and spelling, should include full sentences, and should avoid uncommon abbreviations, text language, and slang.
2. Notes should follow the DAP (Data, Assessment, Plan) or SOAP (Subjective, Objective, Assessment, Plan) formats.
3. Must reflect the contact method, actual time, and duration of the meeting with the client.
4. Each progress note should have one or more activity labels that appropriately identify the information contained in the note.
5. Case notes should indicate a plan for future or action of future client encounter.
6. Notes should remain objective, factual, and free of the case manager's opinion.
    a. Case managers must refrain from using diagnostic information unless they are certified/licensed in the area noted.

7. Staff documenting agency information or processes that do not belong or should not be part of the case management file should use file notes. These are usually notes that pertain to actions performed that do not include a substantial conversation with a client.
8. Under the service definition, all interactions with the client, the client's care team, or the client's support system are considered case management activities.
9. Progress notes must be entered in the client database within 5 days of client interaction.

NOTE: If notes are not documented in the database system, the interaction cannot be considered to have occurred.

REQUIRED FORMS – N/A

REQUIRED DOCUMENTATION – N/A

15. Document Retention

PROCEDURE:	15	EFFECTIVE DATE:	March 1st, 2020

POLICY
Agencies will maintain electronic charts with all required forms and documents used to determine eligibility and service utilization. Documents must be retained in a manner that protects the confidential Personal Health Information (PHI) of the client. Breaches in confidentiality of PHI, including the accidental or purposeful dissemination or retention of information in the wrong client file can result in contract termination and/or civil liability. All breeches that occur in Provide must be reported to the AIDS Foundation of Chicago immediately.

Provide Enterprise functions as an Electronic Health Record (EHR) that contains Federal and State mandated documentation and information required in AFC program operations.

Records
The following client information and signed forms are considered Electronic Health Records (EHR) regardless of when/by whom the information is collected at intake or reassessment. All documents must be entered/scanned into the Provide system.

Form or Document Requirement	Frequency
Initial Eligibility Assessment and reassessment	Every 6 months
Care plan and signature page	Every 6 months
Signed Ryan White Authorization to Release Information	Every 6 months
Completed Medical Update form if needed	Every 6 months
Proof of Residency	Every 6 months
Proof of Income	Every 6 months
Proof of documented HIV infection including CD4 (recommended) and Viral Loads (mandatory)	Every 6 months
Signed Notice of Privacy Practice form	Every 6 months
Signed Client Rights and Responsibilities and Grievance	Annually
Partner services acknowledgement	Every 6 months
Affidavit of no insurance	As needed
Photo ID	One time only
Payment requests and invoices	As needed

Record Retention

- Client information, benefits, and service information are considered Electronic Health Records (EHR) and must be kept confidential and maintained in the database system.
- Physical client record and charts must be maintained for 5 years for all closed/inactive clients from the date of closure.

Paper Document Retention
Agencies can maintain paper records for categories other than case management. It should be noted that all paper documents containing Personal Identifying Information and medical content must be kept in a locked/secured manner. Agencies are required to have a document retention and destruction policy. Any forms that have been

scanned and entered into the client level database need not be retained in hard copy format if they are safe and secured.

ELIGIBILITY – N/A

PROCEDURES

1. Violations of confidentiality in client Electronic Health Records must be reported to AFC immediately. The report must include the incident, parties involved, corrective actions taken, and future process improvement plans.
2. AFC will send a warning email to an agency for a first or second violation of client confidentiality. A third violation will result in the case manager losing Provide system access and status as a Ryan White Case Manager. The case manager supervisor will be responsible for submitting all client documentation into the Provide system until AFC sees evidence of the case manager's competence in keeping client confidentiality.

REQUIRED FORMS
Appendix 14: Confidentiality Violation Report Form (can be completed electronically in Provide)

REQUIRED DOCUMENTATION – N/A

16. Client Satisfaction Survey/Need

PROCEDURE:	16	EFFECTIVE DATE:	March 1st, 2020

POLICY
As required by the Illinois Department of Public Health (IDPH) and Chicago Department of Public Health (CDPH), AFC will coordinate an annual distribution of a client satisfaction survey to clients receiving any Ryan White funded service. A sample of clients will be surveyed confidentially in English or Spanish. Agencies must utilize internal client feedback mechanisms in conjunction with AFC's surveying practices to gather information regarding quality of and access to service. AFC will utilize survey data to identify quality improvement opportunities, evaluate client needs, and adjust budgets based on identified needs within respective agencies.

ELIGIBILITY – N/A

PROCEDURES
AFC is committed to ensuring that all clients have an opportunity to provide feedback on the quality of services they receive, as well as additional needs they may have. To that end, AFC will execute various methods to obtain client feedback, including surveys, focus groups, and key informant interviews from individuals and Community Advisory Boards. AFC will compile, analyze, and report on survey findings. In addition, AFC will consider findings when completing quarterly budget meetings. This will allow adjustments to be made in allocations per service category.

REQUIRED FORMS
Appendix 15. Client Satisfaction Survey Template

REQUIRED DOCUMENTATION – N/A

17. Health Literacy

PROCEDURE:	17	EFFECTIVE DATE:	March 1st, 2020

POLICY
The health literacy and risk assessment counseling sessions are designed to be conducted by medical and non-medical case managers with clients enrolled in the Northeastern Illinois HIV/AIDS Case Management Collaborative.

Health literacy is the degree to which an individual has the capacity to obtain, process, and understand basic health information and services required to make appropriate health decisions. Health literacy involves understanding instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Basic components of health literacy screening include, but are not limited to, the ability to read and comprehend health-related information.

The standardized risk assessment is intended to help case managers assess an individual's risk for sexually transmitting HIV-1 or contracting other sexually transmitted infections via an open and direct conversation. If a patient is found to be high-risk, the discussion should also include an assessment of an individual's readiness to comply with daily adherence and comprehensive prevention strategies.

Case management-funded agencies agree to implement health literacy and risk reduction assessment, screening, and counseling procedures for all clients receiving case management services. The formal assessment of health literacy counseling must take place at least once annually, although it is recommended that case managers routinely screen clients during case management encounters to ensure health understanding and comprehension. All health literacy activities that occur in case management sessions must be documented in the client chart in the client-level database.

ELIGIBILITY – N/A

PROCEDURES

1. At intake and periods of reassessment, screen and assess level of knowledge of HIV disease, medication adherence, other medical issues, and behaviors that affect health outcomes. This may be done via administration of health literacy tools adopted and utilized by the organization.
2. Distribute health education materials to client through direct and simple methods.
3. Include the literacy assessment information in the client care plan.
4. Include the literacy assessment information in the client database.

PROCESSING TIMEFRAME – N/A

REQUIRED FORMS
Appendix 16. Health Literacy Assessment
Appendix 17. Risk Assessment Tool

REQUIRED DOCUMENTATION – N/A

PROVIDE SYSTEM – N/A

HAB / OTHER PERFORMANCE MEASUREMENT – N/A

UNIVERSAL CASE MANAGEMENT PROGRAM POLICIES

18. Screening & Referral for Case Management Services

PROCEDURE:	18	EFFECTIVE DATE:	March 1st, 2020

POLICY
Clients newly entering the Ryan White Case Management system are required to be screened for eligibility and case management agency referral. AFC and AFC-funded agencies are required to assess the level of medical and social service needs, medical home status, client site location preferences, language barriers, as well as agency capacity.

At AFC, Intake and Referral staff must make a referral for case management services within 48 hours from the time of screening individuals. AFC funded agencies must contact AFC within 24 hours of screening a potential new client received outside of an AFC referral to verify that the client is not receiving service elsewhere.

Screening for case management through a specific population-based program (e.g. Corrections, MACA, or DRS) must be done by the program specific staff and coordinated with AFC Intake and Referral staff.

CASE MANAGEMENT LEVELS

The following levels of need are updated to reflect changes in the Ryan White case management system. The new system requires case management needs to be scored on two levels for medical and non-medical service needs. Scores on either level indicate client eligibility and case management assignment.

Level of Need	
Medical Case Management If a client scores 1 or more points in Section 1, the client is eligible for medical case management services. (Total 21 Points)	Client needs help being 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 a client scores 0 points in Section 1 but scores at least one (1) point in Section 2, the client is eligible for non-medical case management services. (Total 14 points)	Client needs services to aid in obtaining medical, social, community, legal, financial and other needed services. Additional services include benefit/entitlement counseling and referral activities to help clients obtain access to programs they may be eligible for.

Level of Need Analysis Questions

Section 1 Assessment	Yes	No
1. Does the client need reminders and assistance to remain adherent to HIV medication? (2 points)		
2. Does the client need frequent medical care for HIV and/or co-morbid conditions requiring him/her to need frequent contact for medical and social service appointments? (2 points)		

3. Does the client have physical or mental disabilities (does not qualify for DRS) and need special care and assistance? (3 Points)		
4. Does the client need health education and social support to remain adherent to care plan goals? (1 point)		
5. Does the client have an unstable housing situation directly linked to non-adherence to medication and/or appointments? (3 points)		
6. Does the client experience mental health challenges that affect his/her ability to complete activities of daily living? (2 points)		
7. Does the client experience substance abuse challenges that affects his/her ability to complete activities of daily living? (2 points)		
8. Is the client pregnant and need support for medical visits? (3 points)		
9. Is the client experiencing medical complications that creates a need for assistance with referrals to specialty care or durable medical equipment? (2 points)		
10. Is the client in need of assistance with end of life plans and/or coordination of services for palliative/hospice care? (1 point)		
Grand Total Section One Score (21 Possible Points)		

Section 2 Assessment	**Yes**	**No**
1. Does the client need assistance enrolling into ADAP? (1 point)		
2. Does the client need assistance enrolling into insurance programs? (2 points)		
3. Does the client need assistance with public benefits such as: Link, Medicaid, etc.? (2 points)		
4. Does the client need Emergency Financial Assistance to maintain secure housing? (3 point)		
5. Is the client aging and in good health but needs referrals to supportive services? (2 points)		
6. Has the client been treated for mental health and/or substance abuse issues but needs supportive services such as medical transportation? (1 point)		
7. Does the 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)		
8. Is the client pregnant and needs supportive services related to HIV such as: transportation, food, referrals, etc.? (2points)		
Grand Total Section One Score (14 Possible Points)		

Refer to Appendix 19 for the RW Case Management Level of Need Analysis tool.

Intensive DRS Case Management Eligibility

Category	Criteria
Residency	US Citizen and resident of Illinois.
HIV Status	Diagnosed HIV positive in the last 18 months; (HIV positive pregnant woman).
Disability Status	Severe disability lasting at least the last 12 months.
Long-Term Care	Must have a need for long-term care based on Determination of Need.
Assets	Assets cannot exceed $17,500 for an individual and $35.00 for a family (if client is under 18).
Medical Insurance	Must apply for or is receiving Medicaid.

Intensive Corrections Case Management

Category	Criteria
HIV Status	Diagnosed HIV positive in the last 18 months; (HIV positive pregnant woman).
Incarceration Status	Must be recently released from prison/jail within the last 12 months.
Ryan White Services	Not currently receiving Ryan White case management services.

Intensive Supportive Housing Program (SHP) Case Management

Category	Criteria
Housing Status	Is homeless or chronically homeless. Cannot retain stable housing without coordinated care and intensive supportive services.
Income	Must be earning 30-50% of the area median income (AMI) or less.
Other Chronic Conditions	Episodically disabling mental illness, substance use, or other barriers to stability (e.g., domestic violence, homelessness, incarceration, etc.); experience with high-risk pregnancy affected by mental health, substance abuse, lack of access to prenatal care, etc.

Intensive Perinatal Case Management

Category	Criteria
Pregnancy Status	Must be an HIV positive pregnant woman.
Risk	Must be experiencing high-risk pregnancies affected by substance use, mental health, lack of access to prenatal care and/or other complicating medical or social factors.

Medical Case Management Services

Category	Criteria
Residency	Resident in Chicago EMA.
Income	Income is equal to or less than 800% FPL.
HIV Status	Diagnosed HIV positive in the last 18 months; (HIV positive pregnant woman). Can be HIV negative if service needs affect that of the HIV positive individual in case management services.

Non-Medical Case Management Services

Category	Criteria
Residency	Resident in Chicago EMA.
Income	Income is equal to or less than 800% FPL.
HIV Status	Diagnosed HIV positive; (HIV positive pregnant woman).

Exclusions to Eligibility

- Service referrals will be facilitated even when the client is not eligible for RW or DRS services.

Conflicts of Interest

To avoid conflicts of interest, when two or more people requesting case management services are romantically involved and/or closely related (e.g., civil union, sexually involved, siblings, parent/child), they will be assigned to different case management agencies whenever possible.

PROCEDURES

AFC Intake and Referral staff or AFC-funded agency staff will:

Link clients to case management services within 48 hours of initial contact from client, prevention staff, Medication Assistance Program or Illinois CareConnect.

1. If the client made direct contact to a case management agency, that agency must contact AFC to determine if the client is actively receiving case management services elsewhere to prevent duplication of services. If the client is not currently case managed, agency may refer client to a case manager within the agency.
2. Screener may use the Client Screening Tool to collect various demographic and needs assessment information to determine eligibility and fit for their organization.
3. If the agency accepts the client they will contact the client within 72 hours to schedule an intake interview. If the agency is unable to accept the referral they will contact AFC staff to reassign the client to another case management agency; the case management agency will contact the client within 72 hours to schedule an intake interview and inform the client of the required documentation.

AFC Case Management Performance measures

The following chart outlines the performance measures for both medical and non-medical case management:

Contact Type	Medical Case Management	Non-Medical Case Management	Corrections Case Management	Perinatal Case Management (MACA)	Housing Case Management
Eligibility Assessment	Every 6 months	Every 6 months	Every 6 months	Every 6 months	At intake: Every 6 months
Care Plan	Every 6 months	Every 6 months	Every 6 months	Every 6 months	Every 6 months
Face-to-Face	Every 3 months	Every 6 months	Every month	Every 2 weeks	Once a month
Other contact (phone, email, text)	No less than once per month	Every 3 months	No less than once per month	Every week	At least once a month
Home Visits	As needed	As needed	As needed	Once a month	Once a month
PCP communication	Every 6 months	N/A	Every 6 months	Every 3 months or as needed	Every 6 months
Treatment Adherence Counseling	Every 6 months	N/A	Every 3 months	Every month or more often	Every 6 months in conjunction w/PCP communication
Case Conferencing	Every 6 months	N/A	Every 6 months	Every 3 months or as needed	As needed at monthly Systems Integration Meetings (SIT) w/case managers

Caseload Size	25-45	25-100	25-30	12-15	15-17
Referrals	Every 6 months	As needed	As needed	As needed	Every 6 months & annual reassessments

PROCESSING TIMEFRAME
For AFC referrals sent to agencies, case managers must contact the client within three business days of initial referral from AFC, Prevention agency, Medication Assistance Program, Illinois CareConnect, or care agency.

REQUIRED FORMS
Appendix 18. AFC RW Case Management Level of Need Analysis
Appendix 19. Client Screening and Placement Form (for AFC staff only)
Appendix 20. Affordable Health Care Act Passport

REQUIRED DOCUMENTATION – N/A

PROVIDE SYSTEM – N/A

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Referral to CM Services	% of clients with a referral to CM services within 72 hours of intake.	AFC CM Performance Measures

19. Intake & Eligibility Assessment

PROCEDURE	19	EFFECTIVE DATE:	March 1st, 2020

POLICY

When requesting Ryan White funded services, all new and returning clients who have not been active in the system for more than six months must have an intake to determine eligibility and need for case management services; obtain a list of current service providers; and identify prospective referral types. The Intake and Eligibility Assessment session is the initial meeting between the client and the case manager. A qualified case manager or non-medical case manager will perform eligibility determination. The information collected and needs identified during the intake process will be used to initiate a client care plan. The intake session may involve executing an acuity scale assessment to determine level of need. The intake interview must be conducted in person. Agencies are required to schedule the intake interview within 72 hours of assignment by AFC. A client is officially enrolled into the case management system after the Intake and Eligibility Assessment processes are complete.

Dimensions of Client Need/Current Circumstances

The following are dimensions of need assessed during the Intake and Eligibility Assessment interview. Interviewers are required to collect information to evidence these needs, where available.

Food /Transportation	Access to/engagement in other health services
Finances / Access to Benefits	Prevention of HIV transmission
Housing	Prevention of HIV progression
Legal Services	Substance Use
Domestic Violence	Support Systems
HIV Disease and Other Medical/Health Concerns	Transportation
Oral Health Services	Copay/Out of pocket cost assistance
Partner Services	

ELIGIBILITY

The following is a list of documentation or criteria required to conduct an eligibility assessment. The participant must immediately report any changes in income, residency, and health coverage to the program directly or through a case manager. Case managers must update the program participant's information in the data system within seven to ten business days after receiving the new information.

Category	Criteria
Demographic/Contact	Basic identifying, demographic, personal and emergency contact information; Household size/members.
Residency	Resident in Chicago EMA; if the applicant is "homeless," indicate on the Verification of Residency form. State ID is no longer proof of residency. Mail showing the clients name and address is an acceptable form of proof.
Income	Income at or below 500% Federal Poverty Level. For more information on City of Chicago AMI limits, refer to this link. Note: limits are updated by the City annually. https://www.cityofchicago.org/city/en/depts/dcd/supp_info/area_median_incomeamichart.html
HIV Status / Lab Results	CD4 (recommended) and viral load within the past six months. Proof of HIV is required one time only and needs to be certified by IDPH to be considered valid proof.

Provider information	Clients currently without a stable medical provider or who have not seen their existing provider in the last 6 months.
Benefits	Must apply for or is receiving Medicaid; or premium/deductible/co-pay information.

Program participants may submit an Eligibility Assessment within 60 days prior to their current eligibility expiration date. Information submitted more than 60 days prior will be treated as an update and will not change the program participant's current eligibility period.

Conditional Approval / Immediate Referrals

Conditional approval for Ryan White services will be granted for 90 days while missing eligibility documentation is being collected. Immediate referrals to services needed should be made under the following circumstances:

1. Client is not engaged in medical/psychiatric care and demonstrates symptoms of active medical/mental illness.
2. Client states that he/she is in danger or are a danger to themselves or others.
3. Client indicates that he/she is homeless.
4. Client indicates that he/she is facing eminent eviction or his/her utilities have been discontinued.
5. Client states that he/she has no food.

Missing Documentation

If a completed assessment is not fully approved prior to the expiration of the current enrollment, any service the client receives after the expiration will be considered unallowable. This will result in your agency or the client paying for the service without being reimbursed by IDPH. These documents include labs, proof of HIV, and proof of residency.

Exclusions to Eligibility (services may be provided on a limited basis to ineligible individuals)

- Limited information and service referrals will be facilitated even when the client is not eligible for Collaborative services. These are to be reported to AFC via the agency narrative report.
- If a client is not deemed eligible for case management services, only referrals outside of the RW system are allowed.
- A client with an urgent need and who doesn't have the required documentation of HIV status or residency may have conditional eligibility for 90 days. RW services referred to can include all Core and supportive services and/or pharmaceutical assistance programs.

Affected Individuals

Affected individuals (people not infected with HIV) may be eligible for RW services in limited situations, but these services for affected individuals must always benefit people living with HIV. Funds awarded under RW may be used for affected individuals in the following circumstances:

1. The service's primary purpose is to enable the affected individual to participate in the care of someone with HIV/AIDS (e.g., caregiver training for in-home medical/support services; psychosocial support services like caregiver support groups; respite care that assist affected individuals with the stresses of providing daily care for someone living with HIV).
2. The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care (e.g., payment of RW client's portion of a family health insurance policy premium to ensure continuity of insurance coverage for a low-income HIV-infected family member; child care for children while an infected parent secures medical care/support services).

3. The service promotes family stability for coping with the unique challenges posed by HIV (e.g., psychosocial support services including mental health services funded by RW Part D only, that focus on equipping affected family members and caregivers to manage the stress and loss associated with HIV).
4. Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV-infected family member.

PROCEDURES

1. The intake interview must be in-person/face-to-face.
2. Staff conducting the intake interview must make three outreach attempts over 30 days to schedule the interview session. Documented outreach attempts must yield a scheduled/completed interview within 30 days.
3. Enter eligibility assessment information into the Provide system within five business days of initial contact.
4. If no client contact is made within 30 days of screening referral, the request is "withdrawn" by the agency, and the file is closed out.
5. Verify eligibility assessment information and confirm/prioritize needs assessment and service requirements.
6. Collect missing documentation. Client must provide all required documentation within 90 days of initial assessment. Outreach attempts must be documented.
7. Develop preliminary care plan within 30 days of initial contact.
8. Inform client of other required documentation and obtain Authorization to Release Information form(s) for all existing providers.
9. Forward Medical Update Form to the client's physician or designated clinical staff (via fax, mail, or client) after the sections "CM" page 1; and "Top Three Case Management Goals" page 2 have been completed. If case manager has access to EMR, the information present on this form can be entered directly into Provide.

EXCLUSIONS

Agencies may deny case management referrals for the following reasons:

- Vacancies in case management staff within the agency based on the number of agency funded FTE's.
- Extended agency closure prohibiting client intake.
- Lack of quality of the case manager's work as evidenced by agency performance measurement.

PROCESSING TIMEFRAME

- First Contact - Agency must contact client within 72 hours of initial referral from AFC, CM agency, Prevention agency, Medication Assistance Program or Illinois CareConnect.
- Second and third outreach attempts to schedule intake interview.
    - Second contact – 10 business days from date of first contact attempt.
    - Third contact – 10 business days from date of second contact attempt.
- Finalize preliminary assessment and care plan within 30 days of initial contact.
- Client must provide all required documentation and sign program required forms within 90 days of initial assessment. If the client cannot provide these forms, close the case.

REQUIRED FORMS

If client cannot provide the required documents within 90 days of intake, withdraw/close the file.

Appendix 1. Affidavit of No insurance Coverage
Appendix 5. Authorization to Release Information (AFC)
Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
Appendix 10. Partner Services Acknowledgement
Appendix 22. Household Income Statement
Appendix 23. RW Initial Assessment/Reassessment Checklist (Not Required)
Appendix 24. Client Intake and Reassessment Form (Not Required)
Appendix 25. Client Screening and Feedback Form (Not Required)
Appendix 26. Medical Update Form (Recommended. Not Required)
Appendix 33. Rights, Responsibilities, and Grievance Procedures (IDPH)
Appendix 36. Employee Oath of Confidentiality

REQUIRED DOCUMENTATION

Valid photo ID	
Proof of Residency	Utility bill with current address, lease/mortgage documentation, non-RW mail, Benefits letter, pay stub/most recent signed tax return, bank statement) Use the Verification of Residency form if no other documentation is available. State ID is not an acceptable proof of residency.
Proof of HIV Diagnosis	Acceptable documentation includes 1) Preliminary positive rapid with confirmatory 4thgen or Western Blot test result; 2) Positive HIV RNA PCR test; 3) Positive DNA PCR assay test; 4) Detectable HIV Viral Load test; or 5) Physician affidavit that certifies the confirmation of HIV diagnosis (which can be on official letterhead of provider (preferred), a printout from the provider's EMR system, or a copy of a medical record note/printout). If using a printout, the printout must contain the name of facility/system, medical provider name, and program participant name. The documentation must clearly identify the person being verified; and must have the name of the physician or their designee and be dated. 6) AFC signed medical update form
Proof of Income	(Dated within 90 days of intake)– current pay stub, most recent W2, unemployment benefits, unearned income benefit statement or award letter, alimony received, IRA distributions, Jury Duty pay, Pension award/most recent, SSI, SSDI, most recent signed tax returns, Monthly Household Income Statement, etc.
Proof of Insurance	Unearned income benefits (statements, award letter, etc.) If enrolled in Market Place Insurance, submit the most recently filed Federal Tax form either IRS-1095 or the IRS-8962. Acceptable documentation includes: •Copies of insurance cards for **any** plan including: •Medicaid, Medicare, Employer Based Insurance, Marketplace Insurance (including premiums, deductibles, copay amounts), Private Insurance, COBRA, Dental, Vision, Secondary, etc. •The client must complete the **Affidavit of No Insurance** if they: •Do not have insurance coverage. •Have insurance but the plan does not have prescription drug coverage •Have insurance but the plan does not consider the IDPH's dispensing pharmacy to be in network

	**** Insurance cards that do not have a RX Bin or Bin number may indicate that the insurance plan has separate prescription cards. In this case, the prescription cards must also be provided.***

PROVIDE SYSTEM

Note, enrollment begins when the Intake and Eligibility Assessment processes are completed.

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Intake Appointment	% of clients who have a scheduled intake appointment within 3 days of request from AFC or internal agency.	AFC CM Performance Measures
Eligibility Screening	% of CM clients who were initially screened or re-screened (reassessment) in the measurement year.	AFC CM Performance Measures
Third-Party Payer Eligibility	% of CM clients where third-party payer sources / benefits were assessed / re-assessed during the measurement year.	AFC CM Performance Measures
Consent for CM Services	% of clients who consent to enroll in CM services.	AFC CM Performance Measures
Ambulatory Medical Care Access	% of clients with a confirmed medical appointment in an HIV setting within 30 days of CM enrollment.	AFC CM Performance Measures

20. Comprehensive Reassessment

PROCEDURE:	20	EFFECTIVE DATE:	March 1st, 2020

POLICY
The Comprehensive Reassessment is required for all clients enrolled in non-medical case management services. Case managers review client progress toward goals outlined in the initial care plan. Goals outlined in the care plan will be assessed at least every six (6) months for individuals receiving case management services.

ELIGIBILITY
Refer to section *Intake and Eligibility* for eligibility criteria.

PROCEDURES

1. Collect necessary eligibility documentation required during reassessment.
    a. If the client documentation is not received during the reassessment period, the client may receive a conditional approval
2. Ensure that Releases of Information are obtained for new and existing service providers as needed.
3. Update the client care plan with client signature and date authorizing agreement with the plan.
4. Enter into client database system.
5. Document issues outlined in the care plan in client database. Notes should match client needs and document progress towards meeting identified goals.
6. Execute continuing or new referrals.

PROCESSING TIMEFRAME

- Generate an updated signed care plan within six months of the original care plan.
- Enter client data into database within five days.

REQUIRED FORMS
Appendix 27. Care Plan Template

REQUIRED DOCUMENTATION
Refer to section 19 *Intake and Eligibility Assessment* for eligibility criteria.

PROVIDE SYSTEM
Document elements of the care plan in the appropriate areas within the Provide system.

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Reassessment	% of NMCM clients with two eligibility assessments and care plans in the measurement year.	AFC CM Performance Measurement.
Medical Appointment	% of NMCM clients with a medical appointment in every six-month period for a period of 24 months.	AFC CM Performance Measurement.

Medication History Documentation	% of NMCM clients whose chart includes documented current/changes in medications at initial / reassessment during the measurement year.	AFC CM Performance Measurement
Mental Health Assessment	% of NMCM clients who receive mental health screening twice during the measurement year.	AFC CM Performance Measurement
Substance Abuse Assessment	% of NMCM clients who receive substance abuse screening twice during the measurement year.	AFC CM Performance Measurement

21. Mandatory Reporting for Case Management

PROCEDURE:	21	EFFECTIVE DATE:	March 1st, 2020

POLICY
All case management teams are required to immediately report any incidences of physical, sexual, psychological violence, neglect and/or abuse to AFC on the following scenarios:

- Abused and Neglected Child Reporting Act (ANCRA)
  - http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1460&ChapterID=32
- Adult Protective Services Act
  - http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1452&ChapterID=31
- Health Insurance Portability and Accountability Act
  - https://www.gpo.gov/fdsys/pkg/PLAW-104publ191/html/PLAW-104publ191.htm
- AIDS Confidentiality Act
  - http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1550&ChapterID=35
- Duty to Report/Warn
  - http://www.naswma.org/?116
- Intimate Partner Violence
  - http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf

<u>Abused and Neglected Child Reporting Act (ANCRA)</u>
Clients must be made fully aware that RW staff will and must report any suspicions of abuse and/or neglect of a child related to this Act. RW program staff must review and follow their mandatory reporting requirements under ANCRA and not rely solely on this SOP for all requirements under law (*must also complete an "Acknowledgement of Mandated Reporter Status" form prior to employment).* All RW staff must complete the Illinois Mandated Reporter online training (staff includes all MCM's).

<u>Adult Protective Services Act</u>
Suspected abuse and/or neglect occurring to an "eligible adult" must immediately be reported. Eligible adults are those that meet any of the following criteria:

- Mental Health difficulties, Low Functioning, Physical Limitations, reside in Nursing Homes, have Personal Care Assistant or Care Givers.
- Clients can also be victim of Financial Abuse or Neglect.

<u>Health Insurance Portability and Accountability (HIPPA) Act</u>
RW staff who become aware that there has been a breach of HIPAA rules as it relates to a client must immediately report these concerns to their supervisor and there must then be a written notification made to the AFC Lead Agency within five business days.

<u>AIDS Confidentiality Act</u>
RW staff who become aware there has been a breach of HIPAA rules as it relates to a client must immediately report these concerns to their supervisor and there must then be a written notification made to the IDPH RW Administrator within five business days.

Duty to Report/Warn

Any RW staff who learns of a client's valid plan that may result in harm to themselves or other persons must report this information to their supervisor immediately. To protect clients who desire to harm themselves, RW staff must immediately contact the appropriate entity in their area to assess for in-patient treatment. Law enforcement must be notified of any valid desire to harm others or self.

Intimate Partner Violence

When the client reveals the abusive scenario to the case management team member, the case manager must build a rapport, create a safe environment to discuss the scenario, gather incident information, and make the appropriate referrals. Connecting the client with an IPV resource immediately while they are currently with you in a safe environment is preferable.

ELIGIBILITY - N/A

PROCEDURES

1. Clients must be fully aware RW staff must report any suspicions of abuse and/or neglect of a client under this Act and is specifically mentioned during the creation of the client Care Plan.
2. RW program staff must review and follow their mandatory reporting requirements and not rely solely on this SOP for all requirements under law (Case Managers *must also complete the "Acknowledgement of Mandated Reporter Status" during completion of the Case Management Competencies Training.).*
3. It is required that the RW staff member reporting abuse and/or neglect will provide any pertinent information to an investigator who contacts them regarding suspicions of abuse and/or neglect and will testify fully in any administrative hearing resulting from their report.
4. Any reference to a client in relation to their HIV disease must be termed "communicable disease". Program enrollment information is only shared if required.
5. No RW staff member is to attempt to investigate an incident himself or herself or inquire more than necessary to determine if an incident of abuse/neglect may have occurred.

PROCESSING TIMEFRAME

Abused and Neglected Child Reporting Act (ANCRA) - Immediate
Adult Protective Services Act – Immediate
Health Insurance Portability and Accountability Act -5 Business Days of Initial Report
AIDS Confidentiality Act - 5 Business Days of Initial Report
Duty to Report/Warn - Immediate
Intimate Partner Violence – Immediate

REQUIRED FORMS

Appendix 14. Confidentiality Violation Report Form (can be completed electronically in Provide)
Appendix 21. Acknowledgement of Mandated Reporter Status

REQUIRED DOCUMENTATION

All documentation of reports and incident leading up to the reports must be included in ongoing client documentation.

PROVIDE SYSTEM - N/A

HAB / OTHER PERFORMANCE MEASUREMENT - N/A

22. Partner Services for Case Management

PROCEDURE:	22	EFFECTIVE DATE:	March 1st, 2020

POLICY

Partner Services is defined as services offered that assist program participants with identifying sexual and needle-sharing partners so that they can be notified of their possible exposure to HIV and are tested.

It is a requirement of all IL Ryan White Part B Case Managers to regularly engage in discussions with program participants to elicit previously unidentified partners. These discussions must occur at minimum during the creation or modification of the program participant's Care Plan. It is the expectation of the program that these discussions be documented in the associated Progress Logs.

If partners are identified, case managers must document the partner's information in Provide Enterprise within the Risk Assessment section of the Care Plan. For more information on how to create Partner Notification records, see the Provide Enterprise© User Manual.

When documenting partners, program participants have three options to initiate the notification:

Provider Notification – this option means that the partner record will be assigned to the appropriate authorized provider to locate and notify the partner.

Contract Notification – means that the program participant and Case Manager agree that the program participant will notify the partner by a certain date. If the date agreed upon passes without confirmation from the program participant, the Case Manager will refer the record to IDPH for assignment to a local provider to locate the partner and conduct the notification.

Dual Notification – this option means that the program participant will bring the partner into a session with the Case Manager and the notification will be conducted in partnership.

Prior to conducting notification, Case Managers must have completed the Program-approved HIV Testing training. Case Managers who have not completed this training **CANNOT** conduct partner notifications.

Case Managers must ensure that program participants are informed about the activities of Partner Services, what options they have to ensure any partners elicited are notified, and the consequences of a failure to comply with the agreed upon activities and dates. To document this, the ***Partner Services Acknowledgement*** must be signed, dated, and uploaded to the Care Plan prior to partners being elicited.

When conducting the notification, partners must be offered testing by the provider, if the provider is authorized to conduct HIV testing, or the partner must be provided with information on where they can be tested and where they can get treatment if they need it.

REQUIRED FORMS

Appendix 10. Partner Services Acknowledgement

23. Client Transfer, Discharge/Closure

PROCEDURE:	23	EFFECTIVE DATE:	March 1st, 20120

POLICY
Case managers, upon assessment, may identify the client's need for transfer between case management entities; in this case, they are expected to complete an electronic transfer and close the client case file while ensuring that services are not disrupted. Case managers are not permitted to indiscriminately transfer, close, discharge or terminate a client without cause.

PROCEDURES
Transfer of Clients
Clients may request a transfer from one case management agency to another within the Collaborative and must do so via their currently assigned case manager. A Release of Information is not necessary to confirm a client's case management services at another agency; nor is a release required for transferring a client to another agency. All client transfers must be facilitated electronically through the Provide database.

NOTE: An agency must first attempt to transfer a client internally, exhausting all transfer options prior to transferring the client to an external agency.

1. The current case manager must get approval from their case management supervisor to make the transfer. Documentation of this approval must be kept in the Provide database.
2. The case manager must prioritize transfer within the current case management agency.
3. The current case manager must contact the new case manager who must then agree to accept the client.
4. Once the new case manager has been identified, the current case manager will complete a discharge note and close the client's chart.
5. The new case manager will call the client and make an appointment, treating the client as brand-new client.

Situational Closure

1. A client does not have to agree to administrative discharge.
2. A letter must be generated on agency letterhead and given/mailed to the client.
3. The letter must include the grievance procedure, the phone number for AFC, and the client's right to request services from another agency if applicable.
4. A client must be informed that in order to re-engage in services, the new agency will require a behavioral contract.
5. A copy of this letter must be kept in Provide Database and must be submitted to AFC.

Reasons for Situational Closure

- The client moves out of EMA.
- The client is deceased.
- The client is incarcerated for more than six months.
- The client no longer wants/ has a need for case management services.

Administrative Discharge (Closure)
Administrative Discharge occurs because of client behavioral problems. Behavioral problems that cannot be resolved can result in transfer or termination from case management services.

1. The case manager must generate a Behavioral Contract with an agreed upon action plan to correct the behavior exhibited, including referrals to services like substance abuse and/or mental health.
2. If discharge is required, the contract must detail expectations for the client related to the reason for discharge from case management.
3. If transfer is required, the Behavioral Contract must be provided to the new case management agency.
4. In all cases, the client must be notified of the behavioral issue, contract and any subsequent transfer or termination.

Reasons for Administrative Discharge (Closure)

- Belligerent language or attitude toward CM or other agency staff.
- Threat or use of violence.
- Illegal substance use on the agency premises.
- Proven theft of agency or other client property.
- Actions violating confidentiality of other clients at the agency.
- Willful refusal to follow through with agreed upon service plan.
- Proven dishonesty and/or falsification of documents.
- Violation of any other aspects of the agency policies.

Automatic or Permanent Termination
In serious circumstances, clients may be automatically or permanently terminated from case management services.

Reasons for Termination

- Threatening a case manager, other agency staff, AFC staff or another client with a weapon or physical force, documented with a police report.
- Two consecutive violations of an established behavioral contract.
- Actions violating the confidentiality of other agency clients.

NOTE: AFC will make the final determination for termination.

Duration of Discharge
Regional grantees should only terminate services completely in the most severe of cases. If complete termination of services is necessary, a general guideline for the duration of the termination should be a period of six (6) months. There may be more egregious violations that warrant a 12-month or even a permanent discharge from services.

ELIGIBILITY – N/A

REQUIRED FORMS
Appendix 28. Case Management Discharge Summary

REQUIRED DOCUMENTATION
Discharge note, including date/reason, client notification/method of notification, HIV diagnosis documentation, most current enrollment form, up to date assessment/re-assessment, eligibility documentation, benefits information, full contact information, authorization to release, care plan with an overview of current case notes/open issues, etc. that is required for the newly assigned case management team.

Letter notifying the client; detailed reason/scenario of incident.

PROVIDE SYSTEM – N/A

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Discharge/Closure	% of CM clients discharged/terminated from CM services whose chart documents a discharge summary during the measurement year.	
Transfer	% of CM clients transferred to another case management agency/manager whose chart documents a transfer summary during the measurement year.	
Lost to Follow Up/MCM	% of MCM clients whose case manager documents attempts to contact a client who has been lost to follow-up during the measurement year.	
Lost to Follow Up/NMCM	% of NMCM clients whose case manager documents attempts to contact a client who has been lost to follow-up during the measurement year.	

MEDICAL CASE MANAGEMENT POLICIES

Medical Case Management Service Category Requirements

Medical Case Management
Medical Case Management (MCM) services are a range of client-centered services that link clients with health care, psychosocial, and other services. This may include benefits counseling and referral activities to assist clients with access to other public and private programs for which they may be eligible (e.g., Medicaid, Marketplace/Exchanges, Medicare Part D, State Pharmacy Assistance Programs and other State and local health care and supportive services). MCM services are designed to improve health care outcomes. Services, including treatment adherence, ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team through all types of encounters including face-to-face, phone contact and any other type of communication.
Service Activities:
• Initial assessment, • Development of a comprehensive individualized care plan. • Coordination of services required to implement the plan. • Continuous client monitoring to assess the efficacy of the plan. • Periodic re-evaluation and adaptation of the plan at least every six months or more frequently as necessary.
One (1) Unit of Service: An individual service plan, a client-centered assessment, face-to-face visits, phone contact, care conference meetings and timely reassessment using any of these service modalities.
Total Clients Per FTE: 25-45

24. Comprehensive Care Planning

PROCEDURE:	24	EFFECTIVE DATE:	March 1st, 2020

POLICY
Agencies providing Medical Case Management services must conduct a comprehensive assessment that expands upon the information obtained in the Brief Intake and Eligibility Assessment interview. The Client Care Plan is developed during the Intake and Eligibility Assessment process. The comprehensive assessment facilitates a broader client-level knowledge to address complex, long-standing medical and/or psychosocial needs.

The comprehensive assessment is designed to yield a formal Client Care Plan. The care plan is a critical component that guides case management activities with a proactive, concrete, and step-by-step approach to assessing needs. The care plan is designed to assist the client and case manager in identifying priorities and broad goals, and teach clients how to navigate any service delivery system.

The Care Plan must be finalized within 30 days of initial contact with client. The planning process may be conducted over the 30-day period. Reminder: ensure that Releases of Information are obtained for existing service providers.

The care plan will be revised every six (6) months for individuals receiving medical case management services (MCM).

NOTE: The care plan is required to be able to bill for other core and supportive services. No Ryan White services can be provided without a finalized care plan, except for case management.

The Care Plan at a minimum must include:

- Problem statement / need.
- Client SMART goals (specific, measurable, attainable, realistic and time focused). At least one goal is required for all active cases, and for all medical case management cases one goal at minimum should be medically related.
- Measurable Service Referral(s) or Activities.
- Individuals responsible for activities (e.g., case manager, client, clinician, etc.).
- Anticipated timeframe for each referral or activity.
- Client signature and date, signifying agreement with the plan.

ELIGIBILITY
Refer to section 19 *Intake & Eligibility Assessment* - Procedure 3 and required forms listed.

PROCEDURES
1. Clients must be notified at Intake and Eligibility that agencies providing case management services are a mandated reporting entity.
2. Using the suggested Care Plan form or similar format and with participation from the client, identify and prioritize medical and social service needs, including:
    a. Document the problem statement; goals; necessary actions/interventions

   b. Identify the role that the client and case manager will assume to ensure referrals are actualized.
   c. Identify and document the client's strengths and barriers to accomplishing goals.
3. Ensure that Releases of Information are obtained for existing service providers.
4. Document the plan in the Provide System.
5. Review and obtain the client's approval of the preliminary care plan.
6. Obtain both the case manager and client's signatures.
7. Revisions must be documented and agreed upon by the client. Revisions are required when the client's needs/circumstances change. Revisions to the care plan must be documented in Provide.

PROCESSING TIMEFRAME

- A final signed care plan must be completed within 30 days of initial contact with client.
- At 6-month reassessment.

REQUIRED FORMS

Appendix 21. Acknowledgement of Mandated Reporter Status
Appendix 26. Medical Update Form (Recommended. Not Required)
Appendix 27. Care Plan Template *

* The Care Plan Form template is to be used as a structured guide to the completion of the Provide Care Plan section. Agencies do not need to scan/upload the Care Plan Form into Provide. Instead, all the information in the template must be entered into Provide.

REQUIRED DOCUMENTATION

Refer to section *Intake & Eligibility Assessment* procedure 3.

PROVIDE SYSTEM

Document all elements of the care plan in the appropriate areas within the Provide system.

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Assessment	% of MCM clients with an initial assessment or reassessment within 6 months of the initial assessment in the measurement year.	AFC CM Performance Measurement
Primary Care Provider Identification	% of enrolled MCM clients assigned to a PCP within 30 days of Comprehensive Assessment and Care Planning in the measurement year.	AFC CM Performance Measurement
Medication History Documentation	% of MCM clients whose chart includes documented current/changes in medications at initial / reassessment during the measurement year.	AFC CM Performance Measurement
Mental Health Assessment	% of CM clients who receive mental health screening via the care plan during the measurement year.	AFC CM Performance Measurement
Substance Abuse Assessment	% of CM clients who receive substance abuse screening via the care plan during the measurement year.	AFC CM Performance Measurement
Care Plan	% of MCM clients with a care plan tied to the most recent assessment or reassessment; or quarterly update when changes in client circumstances occur within the measurement year.	AFC CM Performance Measurement

Care Plan Goals for Medical / Treatment or Adherence	% of MCM clients whose care plan includes at least one goal related to medical or treatment adherence during the measurement year.	AFC CM Performance Measurement
Care Plan Consent	% of MCM clients with a signed care plan (initial / reassessment) during the measurement year.	AFC CM Performance Measurement

25. Determining Level of Need

PROCEDURE:	25	EFFECTIVE DATE:	March 1st, 2020

POLICY

The AFC supported case management system is a needs-based program that strives to provide the appropriate level of services to clients in maintaining high quality medical care and managing their diagnosis effectively. The acuity scale score, in conjunction with information from the brief Intake or Care Plan, must be used to determine the client's level of need, dictate the frequency of case manager contact, and assign relevant services for referral. Each interaction with the client, after the Care Plan is executed, may change the original acuity score. Any changes in a client's acuity should be documented. As part of the re-assessment of needs outlined in the Care Plan, the acuity score is re-assessed every six months.

As of May 1, 2016, AFC requires all funded agencies use the Karnofsky Scale* to assess acuity. The contact and outreach expectations are to follow AFC's standard operating procedure guidelines.

NOTE: Each interaction with a client has the potential to change acuity scores in specific categories. Any changes in client acuity should be documented.

HIV Continuity of Care Dimensions

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

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 seek 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.

ELIGIBILITY – N/A

PROCEDURES

1. Complete the Karnofsky Scale Score at the same time as the Care Plan (Comprehensive Care Planning). The scale must align with the Care Plan recommendations.
2. Score the assessment tool generating a baseline acuity score for the client.
3. Reassess acuity every six months to assess current needs.

PROCESSING TIMEFRAME

- Generate an acuity score as part of the final signed care plan completed within 30 days of the brief Intake and Eligibility Assessment interview.
- At 6-month reassessment.

REQUIRED FORMS
Appendix 29. Karnofsky Acuity Assessment Scale Tool

REQUIRED DOCUMENTATION – N/A

PROVIDE SYSTEM
Document the score in the client database.

HAB / OTHER PERFORMANCE MEASUREMENT

26. Eligibility Reassessment

PROCEDURE:	26	EFFECTIVE DATE:	March 1st, 2020

POLICY
The Eligibility reassessment is required for all clients enrolled in case managements services. Case managers review client progress toward goals outlined in the initial care plan and changes in acuity. Care plan and a new acuity score will be assessed at least every six (6) months for individuals receiving case management services. Refer to the Care Planning and Determining Level of Need sections.

Case managers use the Medical Update Form to facilitate care plan management and coordination with medical and support services providers, including 1) means to request care conferencing; 2) communicating goals and progress with providers; and 3) receiving feedback from providers on treatment efforts.

ELIGIBILITY
Refer to section *Intake and Eligibility Assessment* for eligibility criteria.

PROCEDURES

2. Collect necessary eligibility documentation required during reassessment.
    a. If the client documentation is not received during the reassessment period, the client may receive a conditional approval.
3. Send Medical Update Form to the client's physician or designated clinical staff (via fax, mail, or client).
4. Reassess level of need / acuity using the Karnofsky Acuity Scale Tool.
5. Ensure that Releases of Information are obtained for new and existing service providers.
6. Update the client Care Plan with client signature and date, authorizing agreement with the plan. For more detail in the updating of a care plan, please see the Provide data entry manual from AFC.
7. Enter into client database system.
8. Document issues outlined in the care plan in client database. Notes should match client needs and document progress towards meeting identified goals.
9. Execute continuing or new referrals.

PROCESSING TIMEFRAME

- Generate an updated signed care plan within six months of the original care plan.

REQUIRED FORMS
Appendix 26. Medical Update Form (Recommended. Not Required)
Appendix 27. Care Plan Template
Appendix 29. Karnofsky Acuity Assessment Scale Tool

REQUIRED DOCUMENTATION
Refer to section 19 *Intake and Eligibility Assessment* for eligibility criteria.

PROVIDE SYSTEM
Document elements of the care plan in the appropriate areas within the Provide system.

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Reassessment	% of clients with two eligibility assessments and care plans in the measurement year.	AFC CM Performance Measurement.
Medical Appointment	% of clients with a medical appointment in every six-month period for a period of 24 months.	AFC CM Performance Measurement.
Medication History Documentation	% of MCM clients whose chart includes documented current/changes in medications at initial / reassessment during the measurement year.	AFC CM Performance Measurement
Mental Health Assessment	% of CM clients who receive mental health screening twice during the measurement year.	AFC CM Performance Measurement
Substance Abuse Assessment	% of CM clients who receive substance abuse screening twice during the measurement year.	AFC CM Performance Measurement

27. Referral Coordination & Follow-Up

PROCEDURE:	27	EFFECTIVE DATE:	March 1st, 2020

POLICY

Case management is effective when it uses clinical or social services to meet client needs. Referrals to outside services are needed to meet care plan objectives and to ensure that RW funding is used as the payer of last resort. Case managers will make appropriate referrals based on the agreed upon client care plan document. Each client will receive referral to medical and/or support services critical to achieving optimal health and well-being. Referrals must appropriately respond to the client's unique circumstances and health status.

When coordinating referrals, medical needs must be prioritized over supportive service needs. Therefore, referrals for medical services must be prioritized unless meeting the supportive need facilitates linkages to medical services (e.g., housing, food services, transportation, etc.). Follow up is a systematic process to determine if the client is accessing services. The case manager will ensure that clients are accessing needed referrals and services, identifying and resolving barriers clients may have in following through with the Care Plan.

The agency is required to have an established referral tracking mechanism to ensure referrals are executed and achieved. Agencies must have established Memorandums of Agreement with other agencies serving as referral resource agencies.

PROCEDURES

1. Case manager will execute referrals based on the timeframe agreed upon in the finalized care plan; or issue immediate referrals upon a need being identified.
2. Complete referrals via phone or using formal referral documents. Refer to sample referral forms.
3. Proper releases of authorization forms will be utilized where appropriate to release client information to the referral provider source.
4. Case manager will utilize a tracking mechanism to monitor the completion of case management referrals documented in the care plan.
    a. Referrals in the "Pending" or "Open" status for more than six (6) months will be reviewed upon reassessment of the care plan.
5. Referrals, follow-up activities and referral appointment outcomes (completed and/or missed) must be documented in the Provide system.
6. Follow up on referrals is required and must be aligned with acuity score frequency of case management contact requirements. Refer to SOP Determining Level of Need.

PROCESSING TIMEFRAME

- Referrals must be initiated within two weeks of the finalized care plan.

REQUIRED FORMS

Appendix 5. Authorization to Release Information (AFC)
Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
Appendix 30. Sample Referral Letter and Verification Form

REQUIRED DOCUMENTATION - N/A

PROVIDE SYSTEM

Referrals, follow-up activities, and referral appointment outcomes will be documented in the Provide system

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Adherence Counseling	% of CM clients whose chart documents a progress note and activity of adherence counseling and/or support for medication and appointment adherence at least two or more times during the measurement year.	AFC CM Performance Measurement.

28. Care Coordination & Care Conferencing

PROCEDURE:	28	EFFECTIVE DATE:	March 1st, 2020

POLICY
Case management providers serving people with HIV/AIDS across all levels and funding streams are required to participate in ongoing and open dialogue with the client and clinical providers to advance the established care plan. The following models promote treatment coordination:

Care Coordination
Day-to-day communication, information sharing and collaboration occurring on an as-needed basis between medical case managers and clinical and/or supportive teams. Care coordination activities include:

- Referrals for behavioral health, chemical dependence, and primary care.
- Reducing barriers to obtaining services
- Establishing linkages
- Informal communications
- Other activities as documented in the care plan and monitoring notes

Case Conferencing
The overarching goal of each case conferencing session is to coordinate all service provider efforts to maximize, stabilize or increase the client's overall health outcomes. Formally scheduled and/or informal meetings, video conference or phone conference calls in which interdisciplinary teams (internal/external providers), case manager, client and where applicable family or support resources. At a minimum, case conferencing meetings must include the case manager and primary HIV/AIDS medical care provider or another licensed clinician. All participants will engage in discussing areas of concern and progress, as well as develop time-specified goals/interventions designed help the client reach stability. Case conferencing should occur at least every six months with every client.

Activities include:

- Identify or clarify issues regarding client's status, needs and/or goals
- Define roles and responsibilities for the case manager, client and provider resources
- Resolve conflicts and strategize solutions
- Revise or update the existing care plan

ELIGIBILITY - N/A

PROCEDURES
The medical case management team will schedule, coordinate and host client case conferences adhering to the listed procedures. If multiple clients are being discussed during the case conferencing session, case managers must ensure that only relevant service providers are present for the respective client on the case list.

1. Review the established care plan, notes, updates, or goals outlined in the plan for any client that will be discussed during the conferencing session.
2. Identify and request conferencing meetings with any providers to be included in the scheduled care conference, including primary care, HIV care, mental health, substance abuse, oral health, nutritionist, emergency food service, housing and/or social service providers when applicable.

3. Obtain the relevant Authorization to Release Information from the client if the release is not on file or is expired.
4. Use the Medical Update Form to initiate the exchange of client information between providers.
5. Provide all relevant information to the care conference participants including the Medical Update Form, meeting schedule information, case conferencing agenda and case list (if multiple clients are being discussed).
6. All participants will engage in discussing areas of concern and progress, as well as develop time-specified goals/interventions designed help the client reach stability.
7. All participants will determine roles/responsibilities towards executing newly established goals and interventions.
8. Outcomes from case conferencing activities must be documented in the Provide system in progress notes within five business days after completion of the care coordination interaction.

PROCESSING TIMEFRAME
Outcomes from case conferencing activities must be documented in the Provide system in progress notes within five business days after completion of the care coordination interaction.

Case Conferencing – Every six months

REQUIRED FORMS
Not included. Agency must have its own release of information form for review at AFC site visit.
Appendix 5. Authorization to Release Information (AFC)
Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
Appendix 26. Medical Update Form (Recommended. Not Required)
Appendix 31. Medical Case Management Case Conferencing Agenda
Appendix 32. Case Conferencing Staffing Form

REQUIRED DOCUMENTATION - N/A

PROVIDE SYSTEM
Case conferencing outcomes, interventions, goals and parties responsible must be documented in the Provide system, including areas of concern, clinical and social factors, service provider with whom exchange of communication occurred, date/time of communication; agreed upon goals, interventions and next steps; and persons responsible for implementation.

Signed and updated forms including the Medical Update form, Case Conferencing Individual Client Form must be uploaded into the system.

Case conferencing attempts must be documented as part of client progress notes in Provide.

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Interagency / multi-disciplinary case conferencing	% of MCM clients who had a case conference including at least one member of the client's care team, twice during the measurement year.	

29. Retention Specialist & Medical Benefits Counseling

PROCEDURE:	29	EFFECTIVE DATE:	March 1st, 2020

Retention specialist
Retention Specialists are staff funded under the medical case management grant. The main role of retention specialists is to provide targeted intensive services to clients at risk of being lost to care or clients lost to care with the ultimate goal of linkage to case management, care and viral suppression. Services provided by retention staff include outreach, home/field visits, face-to-face visits, telephone contacts and the provision of transportation and food voucher services.

Medical Benefits Coordinators (MBC)
Medical benefits staff are staff funded under the medical case management grant. The main role of medical benefit counselors is to assist clients in navigating through health insurance, including Illinois marketplace, Medicaid, Medicare, as well as other benefit programs that the client may be eligible for. MBCs assist RW case managers in ensuring their clients have access to insurance and ensure payer of last resort policies are met.

Policies

- Retention staff as well as MBCs must go through the case management competencies trainings and must abide by all medical case management policies as well
- MBC must be certified application counselors through the Illinois Department of Public Health by taking a 40-60 hour course and passing an exam. This certification must be renewed annually
- AFC has MBCs on staff, who can be reached via the Insurance hotline 312-784-9060. AFCs MBCs can answer case manager's insurance questions, enroll clients over the phone (Medicare enrollments Only), in person at AFC, and outside the office as needed. AFC MBCs offer trainings related to insurance on an ongoing basis.

NON-MEDICAL CASE MANAGEMENT POLICIES

Non-Medical Case Management Service Category Requirements

Non-Medical Case Management
Non-Medical Case Management includes the provision of services that provide advice and assistance to program participants in obtaining medical, social, community, legal, financial, and other needed services.
Service Activities:
• Assist program participants in submitting all required documentation in order to determine eligibility for the program • Conduct outreach to program participants who have fallen out of care or whose eligibility has terminated due to a failure to reapply • Provide benefits/entitlement counseling and referral activities to assist eligible program participants to obtain access to public and private programs for which they may be eligible • Provide case management for incarcerated persons as they prepare to exit the correctional system Non-Medical Case Management does not involve coordination and follow-up on medical treatments or access to medical coverage. Those services are conducted under Medical Case Management.
One (1) Unit of Service: A face-to-face or telephone contact to complete the following: an individual service plan, a client-centered assessment, and a timely reassessment
Total Clients Per FTE: 25-100

30. Care Planning for Non-Medical Case Management

PROCEDURE:	30	EFFECTIVE DATE:	March 1st, 2020

POLICY

Agencies providing Non-Medical Case Management services must conduct a comprehensive assessment that focuses on the need for supportive services. It expands upon the information obtained in the Brief Intake and Eligibility Assessment interview. The Client Care Plan is developed during the Intake and Eligibility Assessment process.

The comprehensive assessment is designed to yield a formal Client Care Plan. The care plan is a critical component that guides case management activities with proactive, concrete, step-by-step approach to assessing needs. The care plan is designed to assist the client and case manager will identify priorities, broad goals and teach clients how to navigate any service delivery system.

The Care Plan must be finalized within 30 days of client referral. The planning process may be conducted over the 30-day period. Reminder: Ensure that Releases of Information are obtained for existing service providers.

The care plan will be revised every six (6) months for individuals receiving medical case management services (MCM) and non-medical case management services (NMCM).

NOTE: The care plan is required to be able to bill for other core and supportive services. No Ryan White services can be provided without a finalized care plan, except for case management.

The care plan at a minimum must include:

- Problem statement / Need
- Client SMART goals (specific, measurable, attainable, realistic and time focused)
- Measurable Service Referral(s) or Activities
- Individuals responsible for activities (e.g., case manager, client, clinician, etc.)
- Anticipated timeframe for each referral or activity
- Client signature and date signifying agreement with the plan

PROCEDURES

1. Clients must be notified at Intake and Eligibility that agencies providing case management services are a mandatory reporting entity.
2. Using the suggested Care Plan form or similar format and with participation from the client, identify and prioritize medical and social service needs including:
    a. Document the problem statement; long and short-term goals; necessary actions/interventions
    b. Identify the role that the client and case manager will assume to ensure referrals are actualized.
    c. Identify and document all service providers involved in client's care including full contact information and hours of operation.
    d. Identify and document the client's strengths and barriers to the accomplishment of goals.
3. Ensure that Releases of Information are obtained for existing service providers.

4. Ensure that all missing eligibility documentation is requested. Make at least two outreach attempts (written and verbal) to obtain missing documentation. Discharge the client if missing documentation is not collected within the 30-day planning period.
5. Document the plan in the Provide System.
6. Review and obtain the client's approval of the preliminary care plan.
7. Obtain both the case manager and client's signatures.
8. Revisions must be documented and agreed upon by the client. Revisions are required when the client's needs/circumstances change. Revisions to the care plan must be documented in Provide.

PROCESSING TIMEFRAME
A final signed care plan must be completed within 30 days of referral from AFC.
At 6-month reassessment

REQUIRED FORMS
Appendix 27. Care Plan Template

REQUIRED DOCUMENTATION
Refer to section *Intake & Eligibility Assessment* procedure 3.

PROVIDE SYSTEM
Document elements of the care plan in the appropriate areas within the Provide system.

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Assessment	% of NMCM clients with an initial assessment or reassessment within 6 months of the initial assessment in the measurement year.	AFC CM Performance Measurement
Care Plan	% of NMCM clients with a care plan tied to the most recent assessment or reassessment; within a 6-month period	AFC CM Performance Measurement
Referrals	% of NMCM clients with a referral within a 6-month period	AFC CM Performance Measurement
Referral outcomes	% of NMCM clients with a documented referral outcome within a 6-month period	AFC CM Performance Measurement

31. Referral Coordination & Follow-Up for Non-Medical Case Management

PROCEDURE:	31	EFFECTIVE DATE:	November 1st, 2016

POLICY
Case management is effective when it uses clinical or social services to meet client needs. Referrals to outside services are needed to meet care plan objectives and to ensure that RW funding is used as the payer of last resort. Case managers will make appropriate referrals based on the agreed upon Client Care plan document. Each client will receive referral to support services critical to achieving optimal health and well-being. Referrals must appropriately respond to the client's unique circumstances and health status.

When coordinating referrals, medical needs must be prioritized over supportive service needs. Therefore, referrals for medical services must be prioritized unless meeting the supportive need facilitates linkages to medical services (e.g., housing, food services, transportation, etc.). Follow up is a systematic process to determine if the client is accessing services. The case manager will ensure that clients are accessing needed referrals and services identifying and resolving barriers client may have in following through with the Care Plan.

The agency is required to have an established referral tracking mechanism to ensure referrals are executed and achieved. Agencies must have established Memorandums of Agreement with other agencies serving as referral resource agencies.

ELIGIBILITY - N/A

PROCEDURES

1. Case manager will execute referrals on a timeline consistent with the agreed upon finalized care plan; or issue immediate referrals upon a need being identified. Crisis referrals psychiatric/domestic violence DCFS must be prioritized.
2. Complete referrals via phone or using formal referral documents. Refer to sample referral forms.
3. Proper releases of authorization forms will be utilized where appropriate to release client information to the referral provider source.
4. Case manager will utilize a tracking mechanism to monitor the completion of case management referrals documented in the care plan.
    a. Referrals in the "Pending" or "Open" status for more than six (6) months will be reviewed upon reassessment of the care plan.
5. Referrals, follow-up activities and referral appointment outcomes (completed and/or missed) will be documented in the Provide system.
6. Follow up on referrals is required.

PROCESSING TIMEFRAME

- Referrals must be initiated within 2 weeks of the finalized care plan.

REQUIRED FORMS
Appendix 5. Authorization to Release Information (AFC)
Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
Appendix 30. Sample Referral Letter and Verification Form

REQUIRED DOCUMENTATION - N/A

PROVIDE SYSTEM
Referrals, follow-up activities and referral appointment outcomes will be documented in the Provide system

HAB / OTHER PERFORMANCE MEASUREMENT

Standard	Indicator	Source
Referrals	% of NMCM clients whose chart documents the outcomes of all referrals within 14 days of making the referral.	AFC CM Performance Measurement.

32. Care Coordination for Non-Medical Case Management

PROCEDURE:	32	EFFECTIVE DATE:	March 1st, 2020

POLICY
Non-Medical case management providers serving people with HIV/AIDS across all levels and funding streams are required to participate in ongoing and open dialogue with the client and clinical providers to advance the established care plan.

NOTE: Care Conferencing is not a requirement for non-medical case management providers.

Care Coordination
Day-to-day communication, information sharing and collaboration occurring on an as-needed basis between medical case managers and clinical and/or supportive teams. Care coordination should occur at least once per year with every client. Care coordination activities include:

- Referral
- Reducing barriers to obtaining services
- Establishing linkages
- Informal communications
- Other activities as documented in the care plan and monitoring notes or releases of information

ELIGIBILITY - N/A

PROCEDURES
The non-medical case management team will schedule, coordinate and execute activities designed to coordinate care efforts.

1. Obtain the relevant Authorization to release information from the client if the release is not on file or is expired.
2. Provide all relevant information to referral providers.
3. All participants will determine roles/responsibilities towards executing newly established goals and interventions.

PROCESSING TIMEFRAME – N/A

REQUIRED FORMS
Appendices 5. Authorization to Release Information (AFC)
Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)

OTHER CASE MANAGEMENT PROGRAMS POLICIES

Corrections Case Management
Corrections Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the participant's health and human service needs.
Service Activities:
• Prepares program participants to maximize chances for successful community reintegration • Improve access to primary medical services • Eliminate the structural and medical barriers to reintegration • Work with program participants on parole and probation mandates and connect to essential services to keep individuals in care • In coordination with Ryan White Part B Case Management is to ensure the program participant's Healthcare needs and Legal mandates/requirements are addressed.
One (1) Unit of Service: A face-to-face or telephone contact to complete the following: an individual service plan, a client-centered assessment, and timely reassessment
Total Clients Per FTE: 25 - 30

Eligibility Requirements

Individuals will be required to meet the same eligibility requirements to enroll in Ryan White Part B. A condensed eligibility assessment is available for completion for Correctional Facility Inmates. All individuals who meet the following criteria will receive expedited processing of the eligibility assessment.

- Inmate of a County Jail.
- Inmate of a Prison that has begun discharge process (for parole or work release).
- Inmate of a Prison that has been moved to Work Release/Transitional.
- Inmate of a prison that has been recently released.

Housing Case Management
Intensive Housing Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the participant's health and human service needs. Establishing safe, affordable housing and providing wraparound services through intensive case management is a proven model of service delivery in helping homeless individuals and families improve their health and social functioning.
Service Activities:

• Assess needs, develop service planning and goal setting
  ○ Advocate on the client's behalf when necessary all in the effort to help clients reach their individualized goals and remain stably housed.
• Identify community resources and make appropriate referrals
  ○ Link clients into primary care
  ○ Accompany client to medical appointments as frequently as possible
• Establish safe, affordable housing and provide wrap around services through intensive case management

Perinatal Case Management
Mother and Child Alliance Case Management (MACA) is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the health and human service needs of pregnant HIV+ participants and their unborn children. MACA supports mothers in their efforts to have healthy pregnancies and babies born free of HIV to eliminate deaths from pediatric AIDS.
Service Activities:
• Provides enhanced case management linking pregnant women who are HIV positive to care • Assists in addressing complex cases involving child welfare, chemical dependency, mental health, homelessness, and being undocumented. • 24/7 IL Perinatal HIV Hotline: Helps link hard-to-reach women to care and to provide real-time medical consultation on HIV-related obstetric and pediatric issues. • Prenatal Classes: HIV-specific community-based classes providing women with information regarding their own health, their pregnancy, and their baby's health. • New Moms Support Group: Offers a safe place for HIV+ mothers to talk to their peers about issues that impact their lives such as disclosure, supportive relationships, parenting, and family issues.

OTHER CORE SERVICE CATEGORY POLICIES

Core Services

Core Services

Core Services are a set of direct health care services provided to HIV positive and HIV indeterminate clients awaiting a confirmatory test result. HIV negative individuals or individuals at-risk of HIV infection cannot receive services under this category.

- Ambulatory/Outpatient Medical Care (AOMC)
- Mental Health
- Oral Health Care
- Substance Abuse Outpatient Services

33. Ambulatory / Outpatient Medical Care

PROCEDURE:	33	EFFECTIVE DATE:	March 1st, 2020

POLICY

Ambulatory/Outpatient Medical Care (AMOC) is a Core Medical Service and is part of a set of direct health care services provided to HIV positive and HIV indeterminate clients awaiting a confirmatory test result. HIV negative individuals or individuals at-risk of HIV infection cannot receive services under this category. AFC will assist with client copay and deductible costs for any HIV related ambulatory service with a documented need.

ELIGIBILITY

Ambulatory/Outpatient Medical Care (AOMC)	
Ambulatory/Outpatient Medical Care (AOMC) includes the provision of professional diagnostic and therapeutic services directly to a client by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional licensed in the Chicago EMA jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings.	
Service Activities:	
• Diagnostic testing	• Education and counseling on health issues
• Early intervention and risk assessment	• Well-baby care
• Preventative care and screening	• Continuing care and management of chronic conditions
• Practitioner examination, medical history evaluation, diagnosis and treatment of physical or mental conditions	• Referral to and provision of specialty care (including all medical sub-specialties)
• Prescribing and managing medical therapy	• Provision of laboratory tests integral to treatment of HIV infection and related conditions
Other Requirements:	
Treatment Adherence - Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with guidelines of the US Department of Health and Human Services (HHS). Such care must include access to combination antiretroviral (ARV) and other drug therapies, including prophylaxis and treatment of opportunistic infections and other comorbidities and health conditions.	
One (1) Unit of Service: A single 20-minute face-to-face encounter or a single lab test visit	

PROCEDURES

Invoices must be created by client and uploaded in the client database monthly for billing purposes.

PROCESSING TIMEFRAME

All invoices must be submitted by the 10th of the month for the previous month's services. Invoices submitted for a given month are paid before the end of the following month.

REQUIRED FORMS

Appendix 2. Invoice Template

34. Mental Health Services

PROCEDURE:	34	EFFECTIVE DATE:	March 1st, 2020

POLICY

Mental health services are considered essential non-medical services needed to ensure that clients remain in primary care and achieve improved health outcomes, namely viral load suppression. These services are directed to HIV-positive clients; however, they can also be delivered to HIV-affected individuals, including partners or family members of HIV-positive persons when the service supports a health outcome for the HIV-infected client.

ELIGIBLITY

Mental Health Services
Mental Health Services are psychological and psychiatric treatment and counseling services offered to individuals with diagnosed mental illness conducted in a group or individual setting. Services are provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists and licensed social workers.
Service Activities:
• Psychological and psychiatric treatment and counseling
One (1) Unit of Service: a single individual or group session

PROCEDURES

Invoices must be created by client and uploaded in the client database monthly for billing purposes.

PROCESSING TIMEFRAME

All invoices must be submitted by the 10th of the month for the previous month's services. Invoices submitted for a given month are paid before the end of the following month.

REQUIRED FORMS

Appendix 2. Invoice Template

35. Oral Health Care

PROCEDURE:	35	EFFECTIVE DATE:	March 1st, 2020

POLICY

Oral health care is a core medical service and is part of a set of direct health care services provided to HIV positive and HIV indeterminate clients awaiting a confirmatory test result. HIV negative individuals or individuals at-risk of HIV infection cannot receive services under this category.

ELIGIBILITY

Oral Health Care
Oral Health Care includes diagnostic, preventative and therapeutic dental services that comply with state dental practice laws and include evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters. Services are based on an oral health treatment plan and adhere to specified service caps. Oral Health Care services must be provided by a dental health care professional licensed and certified to provide health care in the state of Illinois and Chicago EMA, including general dental practitioners, dental specialists, and dental hygienists and licensed and trained dental assistants.
One (1) Unit of Service: A single diagnostic, preventative or therapeutic visit

PROCEDURES

Invoices must be created by client and uploaded in the client database monthly for billing purposes.

PROCESSING TIMEFRAME

All invoices must be submitted by the 10th of the month for the previous month's services. Invoices submitted for a given month are paid before the end of the following month

REQUIRED FORMS

Appendix 2. Invoice Template

36. Substance Abuse Outpatient Services

PROCEDURE:	36	EFFECTIVE DATE:	March 1st, 2020

POLICY

Substance abuse outpatient services are core medical services and are part of a set of direct health care services provided to HIV positive and HIV indeterminate clients awaiting a confirmatory test result. HIV negative individuals or individuals at-risk of HIV infection cannot receive services under this category.

ELIGIBILITY

Substance Abuse Outpatient Services	
Substance Abuse Outpatient Services includes medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician or by other qualified/licensed personnel.	
Service Activities:	
• Pre-treatment/recovery readiness programs	• Neuropsychiatric pharmaceuticals
• Harm reduction counseling	• Relapse prevention
• Outpatient drug-free treatment and counseling	• Opiate-assisted Therapy
• Mental health counseling to reduce depression, anxiety or other disorders associated with substance abuse	
Other Requirements: Services provided must include a treatment plan that calls for allowable activities and includes:	
• Document quantity, frequency and modality of treatment provided	• Regularly monitoring and assessment of client progress
• Document the date treatment begins and ends	• Document the signature of the practitioner providing service or supervisor
One (1) Unit of Service: An outpatient visit or a single methadone treatment session lasting at least 30 minutes	

PROCEDURES

Invoices must be created by client and uploaded in the client database monthly for billing purposes.

PROCESSING TIMEFRAME

All invoices must be submitted by the 10th of the month for the previous month's services. Invoices submitted for a given month are paid before the end of the following month

REQUIRED FORMS

Appendix 2. Invoice Template

Supportive Services

Supportive Services
Supportive Services are a set of non-medical services needed to ensure that clients remain in primary care and achieve improved health outcomes, namely viral load suppression. These services are directed to HIV-positive clients; however, they can also be delivered to HIV-affected individuals, including partners or family members of HIV-positive persons when the service supports a health outcome for the HIV-infected client.

- AIDS Medicaid Waiver Case Management Services / Department of Rehabilitation Services
- Emergency Financial Assistance
- Emergency Food Services
- Emergency Housing
- Food Bank Home Delivered Meals
- Legal Assistance
- Psychosocial Services
- Transitional Housing Services
- Transportation Services

37. AIDS Medicaid Waiver Case Management Services/DRS

PROCEDURE:	37	EFFECTIVE DATE:	March 1st, 2020

POLICY

The Division of Rehabilitative Services (DRS) provides services to people with disabilities. The AIDS Medicaid Waiver Case Management Services are considered essential services.

DRS Billing

AFC will provide reimbursement as a fee for service to all DRS case management subcontractors. The agreed upon reimbursement rate are adjusted by deducting a 10% administration fee from the amount approved by DHS-DRS.

ELIGIBILITY

AIDS Medicaid Waiver Case Management
The Illinois Department of Human Services (DHS) has waiver services available for individuals who qualify. AIDS Waiver case managers perform an assessment, called a determination of need (DON), to see if an individual qualifies for waiver services. If an individual qualifies for waiver services, the individual may be able to get additional home and community-based services such as in-home independent living supports, respite care, training programs for life and work skills job coaching, residential living arrangements, and adaptive equipment.
Service Activities:
• Initial assessment and reassessment every year • Development of a comprehensive individualized care plan for non-Managed Care customers • Coordination of services required to implement the plan for non-Managed Care customers • Continuous client monitoring to assess the efficacy of the services
One (1) Unit of Service: An individual service plan, a client-centered assessment, face-to-face visits, phone contact, care conference meetings, and timely reassessment using any of these service modalities.
Total Clients Per FTE: up to 45 for case managed customers, up to 100 for Managed Care customers

PROCEDURES

Billing procedures are as follows for the two distinct scenarios.

NOTE: All billing information must be submitted by the fifth (5th) calendar day of each month for the preceding month's services. This preceding month is considered the current billing month.

AIDS Waiver Program

Case Management	$138.10 per client/monthly. Phone contact will be required once monthly with a face-to-face contact every other month
Assessment	$110.48 per client. One-time only
Reassessment	$55.24 per client. At least once every year
Mileage	Federal rate in effect (as of January 1, 2018 the rate is $0.545mile). Please Note, DRS will not pay for less than 4 miles in one trip.

Managed Care Organization

Case Associate Reassessment	$110.48. At least once every year

Case Associate –AIDS MCO billing after entering MCO	$46.00 per client/monthly
Mileage	$0.56/mile

PROCESSING TIMEFRAME – N/A

1. All DRS subcontractors must submit data to AFC by entering client-level data into the database within seven (7) business days of client interaction to ensure proper timeliness of service provision tracking data.
2. All billing information must be submitted by the fifth (5th) calendar day of each month for the preceding month's services. This preceding month is considered the current billing month.
3. By the fifth (5th) calendar day of each month, Subcontractor will submit to AFC a DRS Electronic Billing Verification Form verifying that the subcontractor has completed electronic entry of the agency's DRS billing submission in the data base for the preceding month. **This form must be faxed to 312-334-0924 to the attention of the Client and Services Data Manager at AFC.**

REQUIRED FORMS
Appendix 34. DRS Electronic Billing Verification Form
Appendix 35. DRS Retroactive Billing Electronic Verification Form

REQUIRED DOCUMENTATION - N/A

PROVIDE SYSTEM - N/A

HAB / OTHER PERFORMANCE MEASUREMENT - N/A

38. Financial Assistance: Emergency Financial Assistance (EFA)

PROCEDURE:	38	EFFECTIVE DATE:	March 1st, 2020

POLICY
Financial Assistance: EFA includes the provision of food vouchers. These are supportive services needed to ensure that clients remain in primary care and achieve improved health outcomes. These services are directed to HIV-positive clients; however, they can also be delivered to HIV-affected individuals, including partners or family members of HIV-positive persons when the service supports a health outcome for the HIV-infected client.

ELIGIBILITY
Clients must meet the following eligibility criteria to receive emergency food:

- Client's income is at or below 500% of the federal poverty level;
- Client affirms that they do not receive assistance from Public Aid (Link Card), or that the assistance is inadequate to meet their nutritional needs;
- Client affirms that they are not receiving food from Vital Bridges or any other Ryan White-funded food pantry*; and
- Client affirms that they are not able to access other local food pantries*.

*Clients may receive food vouchers if they are accessing Ryan White or other funded food pantries only if these sources do not meet the health or medical needs of the client or if the assistance is unable to meet the need.

PROCEDURES – Client

- The client must be enrolled in the AFC client-level database, be receiving any level of case management services and must complete the Food Assistance Assessment as part of the Care Plan prior to accessing emergency food cards through the case management agency.
- The client must cooperate with their case manager, apply for, and use all appropriate options for obtaining food assistance.

PROCEDURES – Agency

- The case manager will assess the client's long and short-term food needs and available resources. The case manager and client will develop a plan to meet the client's needs. The plan will be documented in the client electronic record in the care plan and progress notes located in the Database System. Case managers will reassess client food assistance needs on an ongoing basis (at least every six months).
- As part of the assessment and planning process, the case manager will discuss with the client other food assistance programs/options that are available and help the client apply for other resources. Other sources of food assistance that could be utilized include:
    - Supplemental Nutrition Assistance Program (SNAP or "Link Card" or "food stamps");
    - Neighborhood food pantries or soup kitchens; and/or
    - Ryan White-funded grocery service.
- Case managers must document in the client record when the AFC-funded emergency food voucher is used and a rationale for why this was the preferred mode of assistance.
- Each agency will have a contact person whose responsibilities include enforcing emergency food voucher guidelines and procedures, monitoring case manager's use of food vouchers, and submitting

documentation of food voucher usage to AFC. The usage of food vouchers should be entered into the client-level database.

- The agency must follow up with the client when there are problems or misuse of the AFC-funded emergency food cards. Repeated client misuse of the service will lead to loss of assistance privileges.
- The agency will be financially responsible for any food cards that are not logged or are lost or stolen. Frequent or continuous violations of these guidelines by case managers or agencies may result in the suspension of emergency food cards by the agency.
- As the number of cards are limited, the agency should distribute the food cards based only upon exigent needs of clients.

PROCEDURES – AFC

1. AFC staff will monitor and maintain and the Provide database used in documenting emergency food vouchers.
2. AFC staff will distribute food vouchers based upon the availability of funding.
3. AFC will notify agencies/case managers of any problems related to use of the emergency food cards in a timely manner.
4. AFC will notify agencies if funds for emergency food voucher inventory are restricted or unavailable.
5. AFC will provide agencies with food vouchers if funds are available, and the agency has no other source for this resource.
6. AFC will notify the agency of any unauthorized use of food vouchers that violate the established guidelines. Any unauthorized food voucher disbursements will not be paid for by AFC and are the responsibility of the agency.
7. On a quarterly basis, AFC will report all food assistance data to the Ryan White funding source.

REQUIRED FORMS – N/A

REQUIRED DOCUMENTATION
Care Plan

39. Financial Assistance: Housing and Utilities

PROCEDURE:	39	EFFECTIVE DATE:	March 1st, 2020

POLICY

Financial Assistance: housing and utility services are supportive services provided for housing and utility emergencies. It is a needs-based assistance program designed to ensure that clients remain in primary care and achieve improved health outcomes. These services are used 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/maintain affordable housing.

AFC will determine the specific funding source used, including IDPH, HOPWA STRMU or Ryan White Part A funding streams.

ELIGIBILITY

<table>
<tr><th colspan="2">Housing/Utility services</th></tr>
<tr><td colspan="2">Emergency housing and utility assistance programs are designed to promote long-term housing stability. Assistance is needs-based and is not intended to be a long-term solution.</td></tr>
<tr><td colspan="2">Criteria/Required Documentation:</td></tr>
<tr><td>• Households in imminent danger of eviction</td><td>• Households that are currently homeless (Note: must be able to document the inability to pay rent/utilities in the future without this assistance)</td></tr>
<tr><td>• Households in imminent danger of foreclosure</td><td>• Households currently receiving HOPWA STRMU or Ryan White Part A must be able to document positive HIV status</td></tr>
<tr><td>• Households in imminent danger of homelessness</td><td></td></tr>
<tr><td colspan="2">Temporary Economic Crisis/Required Documentation: Households must be able to document a temporary economic crisis beyond their control including:</td></tr>
<tr><td>• Loss of employment</td><td>• Illegal eviction by landlord</td></tr>
<tr><td>• Medical disability or emergency</td><td>• Displacement by government or private action</td></tr>
<tr><td>• Loss or delay of a public benefit</td><td>• Natural disaster</td></tr>
<tr><td>• Substantial change in household composition</td><td>• Transition from homelessness into permanent housing</td></tr>
<tr><td>• Victimization by criminal activity (including domestic violence)</td><td>• Transition into more affordable housing that promotes long-term stability.</td></tr>
<tr><td colspan="2">Types and Amounts of Assistance:</td></tr>
<tr><td colspan="2">1. Payment cannot exceed $1,000.00 for Ryan White Part A funds, $1,500 for HOPWA funds, $1,200 for EFSP and $1500 for HPF, or 3 months arrears as these are the maximum allowable 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.
2. Payments for security deposits must match the amount written on the client's lease.
3. Any payment made, regardless of how much it may be below the cap amount, will be counted as one out of the four allowable payments in a 24-month period.
4. It is allowable for a client to obtain both a rent payment and a utility payment in the same month with one application if the sum of both payments is at or below the cap amount and there is adequate supporting documentation. This type of scenario, when properly documented, can be considered use of one out of the four allowable payments in a 24-month period.</td></tr>
</table>

5. If there is documented need for assistance greater than the cap in the same application, it will be considered use of two payments. The second payment MUST resolve the balance and MUST come from a different funding stream.
6. Clients with no income may get assistance for a 90-day period

PROCEDURES – N/A

1. Case manager must review client eligibility and temporary economic crisis scenario, obtain documentation supporting the crisis scenario and submit supporting eligibility documentation. If eligibility and temporary crisis scenario cannot be documented, the client is not eligible for assistance.
2. Complete requisite application forms; provide narrative that describes the temporary crisis scenario in detail.
3. Submit the application package to AFC. Submission to AFC does not guarantee approval.

Incomplete Documentation

If the client is not able to provide supporting documentation of an eligible temporary economic crisis, the case manager can move forward with submitting an incomplete application and AFC will provide an official denial letter. The denial letter from AFC will state all the reasons for the application denial. The Case Manager should share the denial letter with the client and explain it if necessary. AFC's decisions will always be based on the narrative that is provided in the application and the documentation that is submitted to support it.

Denial

It should be noted that AFC reserves the right to deny emergency assistance to any client who regularly and routinely experiences economic crises. "Regularly and routinely" is defined as any client who applies for emergency assistance every six months over a 24-month period. NOTE: Clients who are denied can appeal to AFC.

Responsibilities of Client/Applicant:

- All applicants for AFC Housing and Utility Assistance must be enrolled in the central client registry at AFC and currently working with an AFC-funded case manager.
- Applicants must provide adequate documentation that they are experiencing a temporary economic crisis beyond their control.
- Applicants are not to engage in physically and/or verbally threatening behavior toward their case manager or AFC staff at any time. Physical or verbal threats will be cause for application denial.
- Discriminatory remarks and harassment regarding, 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 Case Manager:

- The case manager will work with the clients to submit all required forms and documentation.
- The case manager will complete all pending applications within 14 business days of receiving the confirmation letter from AFC Housing staff.

The case manager 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:

1. 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).

2. AFC will inform the case manager 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.

REQUIRED FORMS
Appendix 37a. AFC Emergency Flexible Financial Fund Policy
Appendix 37b. AFC Emergency Financial Assistance Application

REQUIRED DOCUMENTATION - N/A
Refer to eligibility criteria and temporary economic crisis section.

40. Food Bank/Home Delivered Meals

PROCEDURE:	40	EFFECTIVE DATE:	March 1st, 2020

POLICY

Food bank/home delivered meal services are considered supportive services needed to ensure that clients remain in primary care and achieve improved health outcomes. These services are directed to HIV-positive clients; however, they can also be delivered to HIV-affected individuals, including partners or family members of HIV-positive persons when the service supports a health outcome for the HIV-infected client.

ELIGIBILITY

Food Bank/Home Delivered Meals	
Food Bank/Home Delivered Meals involves the provision of actual food and/or meals.	
Service Activities:	
• Provide vouchers (not money) to clients to purchase food as groceries or cooked meals	• Provide essential household supplies, hygiene products and cleaning supplies
• Home delivered meals and food pantry access	• Provision of foods or nutritional supplements by practitioners other than registered dieticians
Other Requirements:	
• Services must be reported. One-time food vouchers cards and/or intermittent provision is considered to be Emergency Financial Assistance and should not be reported/requested for funding in this category	• Nutritional counseling by a non-licensed or non-registered dietitian including nutritional supplements should be reported as food Bank/Home Delivered Meals category
One (1) Unit of Service: A single voucher or, meal, food or supply items	

PROCEDURES

Invoices must be created by client and uploaded in the client database monthly for billing purposes.

PROCESSING TIMEFRAME

All invoices must be submitted by the 10th of the month for the previous month's services. Invoices submitted for a given month are paid before the end of the following month

REQUIRED FORMS

Appendix 2. Invoice Template

41. Legal Assistance Services

PROCEDURE:	41	EFFECTIVE DATE:	March 1st, 2020

POLICY

Legal assistance services are considered supportive services needed to ensure that clients remain in primary care and achieve improved health outcomes. These services are directed to HIV-positive clients; however, they can also be delivered to HIV-affected individuals, including partners or family members of HIV-positive persons when the service supports a health outcome for the HIV-infected client.

ELIGIBILITY

<table>
<tr><th colspan="2">Legal Assistance</th></tr>
<tr><td colspan="2">Legal Assistance services are delivered by an attorney to resolve legal matters, provide legal direction or offer advice in relation to Ryan White service utilization.</td></tr>
<tr><td colspan="2">Service Activities:</td></tr>
<tr><td>• Death/disability planning, including placement for guardianship of minor children including drafting Last Will and Testament, preparation of custodial options for legal dependents, including standby guardianship, joint custody or adoption</td><td>• Litigation of discrimination or breach of confidentiality as it relates to Ryan White service utilization</td></tr>
<tr><td>• Powers of attorney, do-not resuscitate orders, activities to facilitate eligibility of benefits and permanency planning</td><td>• Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits
.</td></tr>
<tr><td colspan="2">One (1) Unit of Service: A single 30-minute face-to-face visit or a single 15-minute phone contact</td></tr>
</table>

PROCEDURES

Invoices must be created by client and uploaded in the client database monthly for billing purposes.

PROCESSING TIMEFRAME

All invoices must be submitted by the 10th of the month for the previous month's services. Invoices submitted for a given month are paid before the end of the following month

REQUIRED FORMS

Appendix 2. Invoice template

42. Psychosocial Services

PROCEDURE:	42	EFFECTIVE DATE:	March 1st, 2020

POLICY

Psychosocial services are considered supportive services needed to ensure that clients remain in primary care and achieve improved health outcomes. These services are directed to HIV-positive clients; however, they can also be delivered to HIV-affected individuals, including partners or family members of HIV-positive persons when the service supports a health outcome for the HIV-infected client.

ELIGIBILITY

Psychosocial Services
Psychosocial Services are support and counseling activities.
Service Activities: Counseling for child abuse and neglect counseling, HIV support groups, pastoral counseling, caregiver support and bereavement counseling
One (1) Unit of Service: a single individual or group session

PROCEDURES

Invoices must be created by client and uploaded in the client database monthly for billing purposes.

PROCESSING TIMEFRAME

All invoices must be submitted by the 10th of the month for the previous month's services. Invoices submitted for a given month are paid before the end of the following month

REQUIRED FORMS

Appendix 2. Invoice template

43. Housing

PROCEDURE:	43	EFFECTIVE DATE:	March 1st, 2020

POLICY

Housing services are considered supportive services needed to ensure that clients remain in primary care and achieve improved health outcomes. These services are directed to HIV-positive clients; however, they can also be delivered to HIV-affected individuals, including partners or family members of HIV-positive persons when the service supports a health outcome for the HIV-infected client.

ELIGIBILITY

RW Housing Services	
Housing Services: Provision of short-term assistance to support housing that enables an individual or family to gain or maintain medical care Eligible housing can include housing that provides direct medical or supportive housing, such as residential mental health services, foster care, or assisted living residential services, as well as housing that does not.	
Service Activities:	
• Referral services including assessment, search, placement, advocacy, and the fees associated with these activities	• Ensure that patients/clients are receiving unduplicated support from a single case manager within the Ryan White system to leverage funding
• Coordinate with Outreach Services as well as with HIV prevention services to assist with linkage-to-care services	
One (1) Unit of Service: A single "night" of stay	

PROCEDURES

Invoices must be created by client and uploaded in the client database monthly for billing purposes.

PROCESSING TIMEFRAME

All invoices must be submitted by the 10th of the month for the previous month's services. Invoices submitted for a given month are paid before the end of the following month

REQUIRED FORMS

Appendix 2. Invoice template

44. AFC Internal Housing Programs

PROCEDURE:	44	EFFECTIVE DATE:	March 1st, 2020

The AIDS Foundation of Chicago's Supportive Housing Programs (SHP) provides permanent supportive housing with wraparound services to homeless individuals and families. AFC leads and coordinates a collaboration of partner agencies to provide a seamless link to permanent supportive housing to achieve these primary goals:

- Maintain housing stability
- Increase and/or maintain income
- Improve the health of our clients
- Improve quality of life & client self-sufficiency

INTENSIVE CASE MANAGEMENT

Intensive Housing Case Managers will assess client needs at intake, develop service plans, set goals, identify community resources, make appropriate referrals, link clients to primary care, accompany client to medical appointments as frequently as possible and advocate on the Client's behalf when necessary. All services housing case managers provide are in an effort to help clients reach their individualized goals and remain stably housed. Establishing safe, affordable housing and providing wraparound services through intensive case management is a proven model of service delivery in helping homeless individuals and families improve their health and social functioning.

SHP HOPWA ELIGIBILITY

Low-income persons (at or below 80 percent of area median income) diagnosed with HIV/AIDS and have family that is eligible to receive HOPWA-funded assistance. AFC SHP Program Coordinator will facilitate referrals from our Tenant Based Rental Assistance waitlist and verify eligibility via submitted documentation that supports prospective Clients meet these criteria. Some programs may require additional documentation to determine eligibility.

REFERRALS

Referrals to HOPWA programs are made internally from AFC's Housing Navigation waiting list. When vacancies become available, the SHP Program Coordinator will reach out to the Housing Navigation Program Manager for Clients who meet the specific requirements of the HOPWA program that has vacancies.

AFC's SUBSIDIZED TENANT EMPOWERMENT PROGRAM (STEP)

The principal purpose of AFC's Subsidized Tenant Empowerment Program is to increase the housing stability and self-sufficiency of low-income individuals and families who are living with HIV/AIDS in the Chicago EMSA. The program components include long-term (TBRA) subsidies or Low-Income Housing Trust Fund (LIHTF) units, clients are also connected to low touch non-medical support services through Housing Technicians.

HOUSING TECHICIANS

At program intake, Housing Technicians are responsible for assessing the client's overall housing needs. This includes, unit location (for scattered site TBRA) or matching a client to vacant LIHTF unit in AFC's special initiatives portfolio. The HT is responsible for conducting a Housing Quality Standards of all units prior to client's signing a

lease and or move in. At intake, Housing Techs and clients will also set annual goals to improve housing stability and self-sufficiency, this may include financial counseling to increase income and decrease expenses. Housing Technicians are required to conduct 6-month program reassessments for each client to assure that clients are mainlining housing stability and or to mediate any housing related challenges (i.e. landlord issues). Although Housing Techs are only required to complete 6-month reassessments, clients are encouraged to work with Housing Techs as needed (i.e. unit relocation, Emergency Financial Assistance). Annually, Housing Techs are required to complete program recertification (includes: assisting clients with lease renewals, completing program rental payment processing paperwork).

STEP HOPWA Eligibility

Housing Technicians are required to verify the following program eligibility requirements at intake:

- Low Income: 80% AMI or lower
- HIV+

Referrals

Referrals to all AFC HOPWA programs (SHP/STEP) are made internally from AFC's Housing Navigation waiting list.

45. Transportation Services

PROCEDURE:	45	EFFECTIVE DATE:	March 1st, 2020

POLICY

Transportation services are supportive services designed to provide subsidized transportation for case managed clients to healthcare service and limited social service appointments to achieve improved health outcomes and ultimately viral load suppression. Transportation services include bus passes, train passes, taxi services and rideshare programs such as Uber.

These services are limited and should be used strategically by case managers to address immediate transportation needs while also assisting clients in gaining access to long-term subsidized transportation via other payer sources. Other payer sources that can be utilized for transportation needs include but are not limited to Medicaid, Regional Transportation Authority (RTA), Chicago Transit Authority (CTA) special user passes and services, private or marketplace insurances, as well as local community transportation services.

These services are directed to HIV-positive clients; however, can also be delivered to HIV-affected individuals, including partners or family members of HIV-positive persons when the service supports a health outcome for the HIV-infected client.

Types of qualifying HRSA defined services used under transportation assistance include:

- Ambulatory/outpatient medical care (doctor's visits, non-medical HIV consults, lab work, and specialty care appointments)
- Substance abuse services (provided under the care of a physician or other qualified professionals in an outpatient setting)
- Mental health services (psychological or psychiatric services rendered by licensed/qualified professionals)
- Oral health care (diagnostic or preventative oral health visits by qualified professionals)
- Food pantry services
- Legal assistance services
- Case management services of all types

ELIGIBILITY

All clients must meet the following eligibility criteria to utilize transportation services:

1. The client must be enrolled in the client database and be receiving any level of case management services; and
2. The client must cooperate with his or her case manager and apply for and use all appropriate available transportation options (e.g., Medicaid/ Medicare, RTA special user's pass, RTA Seniors Ride Free Program); and
3. The client must have two or more documented Medicare complaints within a six-month period and/or has challenges accessing transportation through Medicaid Managed Care. These documented challenges allow the client to access Ryan White funded medical transportation services for no more than three months without an additional documented attempt at using Medicaid-funded medical transportation;
4. Client's income is at or below 500% of the federal poverty level; and

5. Client affirms that he/she has no other transportation resources available to him/her; and Client affirms that he/she does not have an RTA reduced fare card or Para-transit service /cannot afford the

cost of paratransit services or is not eligible. If the client has an RTA reduced fare card and meets the criteria above, they are eligible to receive reduced fare Ventra CTA or Pace cards; and

6. Client affirms that public transportation does not reasonably serve point of origin or destination (excludes Ventra).

Taxi and Ride Sharing Exceptions

If requesting taxi or ride sharing services, in addition to meeting all the above eligibility criteria, a client must also meet at least *one* of the following criteria:

- Client has demonstrated difficulty ambulating (i.e., cannot climb stairs, cannot walk more than 20 feet);
- Client has a documented physical disability that impedes safe access to public transportation;
- Client affirms that public transportation does not serve point of origin or destination; and/or
- Client affirms that they are traveling with more than two infants or toddlers.

PROCEDURES – Client

1. The client must accurately answer the Transportation Assessment as a part of the Care Plan (SOP 6) prior to accessing transportation through AFC.
2. The client must cooperate with his/her case manager, apply for, and use all appropriate transportation assistance available to them. If the client has difficulty accessing the Medicare, he/she must inform his/her case manager and complete the Medicare Complaint Form.
3. The client must communicate through verbal or written means that lack of access to transportation assistance will result in non-adherence to necessary medical and supportive services care.
4. Clients requesting gas cards must provide the case manager with accurate information on the type of appointment, pick-up address, destination address, and origin address. The client must agree to make no unauthorized stops during the course of the ride.
5. *(FOR RIDE SHARING AND TAXI SERVICE ONLY)* When accessing a taxicab service, the client must provide the case manager with accurate information on the type of appointment, pick-up address, destination address, and time taxicab service is needed. The client must also be ready to leave at the designated time for which the taxicab is scheduled. The client must agree to make no unauthorized stops during the course of the ride. (Clients in need of round-trip service can arrange for a single cab to transport them both ways if the scheduled wait time is less than ten minutes. If the wait time is expected to be longer than ten minutes, two separate taxicab orders must be completed, and each logged as two separate trips.)
6. Clients are prohibited from sharing Uber or other ride sharing services with others
7. Clients are prohibited from ordering Uber or other ride sharing services and/or other AFC contracted Taxi Services on their own behalf.

PROCEDURES – Agency

1. *(FOR VENTRA/PACE ONLY) AFC will* purchase and distribute Ventra and Pace transportation passes to funded subcontractors once every four months. The amount of fare cards distributed to agencies will be based on quarterly utilization. It will be each agency's responsibility to document all cards distributed into the client-level database system within 48 hours of utilization. Each quarter, agencies will receive a distribution of Ventra and/or Pace cards under Ryan White Part A, Part B, and MACA Programs. Ventra CTA and Pace card allotments will be monitored closely by AFC. Distribution will be based on the number of cards documented in the client- level base database and the number of unused cards left at each organization. The amount of this allocation may change depending of AFC's funding availability for transportation services and may be used to purchase Ventra and Pace client

fare cards only. 80% of quarterly fare card allotment must be utilized and reflected in AFC' Provide database before an additional distribution is considered and/or authorized. Ventra Cards are worth $3.00 and are valid for up to three rides within 2 hours of use. Pace Cards are worth $2.30 and are valid for one hour. Metra charges are based upon geographical area. Transit cards will only be distributed to supervisors during the Contractor Administrator's meeting. If the supervisor is unable to attend the Contractor Administrator's meeting and would like a co-worker to retrieve Ventra CTA and/or Pace cards on their behalf, supervisors' must contact AFC to confirm arrangements

2. (*FOR METRA PASSES ONLY*) Requests for client Metra passes **must be pre-approved** by AFC prior to purchase. Agencies should contact AFC and submit the "Client Transit Card Authorization and Reimbursement Request Form". This authorization will be valid only for 20 business days after the date of AFC's authorization and will be considered VOID after that time. In order to be reimbursed, agencies must scan and e-mail a copy of the signed authorization form, a copy of agency check used to purchase the client Metra passes receipt for purchase provided by Metra to AFC no later than 15 business days after purchasing the Metra passes. As February 28 is the end of the Part-A contract period, NO transportation requests will be approved from January 15 to February 28 of each year as AFC may not be able to reimburse the agencies for the purchase of these cards. AFC Care and Finance program departments will closely monitor tracking of utilization in the client database.
3. *(FOR GAS CARDS ONLY)* Collaborative subcontractors will receive from the AFC a given amount of gas cards to be distributed to clients with a documented need to attend healthcare and limited social service appointments only. These services are defined by the Health Resource Service Administration (HRSA) as ambulatory outpatient primary care (doctors' visits, non-HIV medical consults, lab work, and specialty care appointments), substance abuse services (services provided under the care of a physician, or other qualified professional in an outpatient setting), mental health (psychological or psychiatric services rendered by licensed/qualified staff but does not include peer-led support groups), oral health care (diagnostic or preventative oral health visits by qualified professional), food pantry services, legal assistance services and supportive services case management. A client living in the city or suburban may receive one $10.00 gas card only if the round trip is more than 20 miles away from the provider and after the full assessment of need has been completed. If the trip is between 21 and 100 miles, the client may receive two $10.00 gas cards. Any trips in excess of 100 miles round trip require prior approval of AFC Program Staff. Agencies will not be reimbursed for purchasing gas cards. AFC will maintain an inventory of gas cards that agencies may request for as part of their quarterly allocation. Agencies should contact AFC and submit the "Client Transit Card Authorization and Reimbursement Request Form" to request new cards, however, 80% of quarterly transit card allotment must be utilized and reflected in AFC' Provide database before an additional distribution is considered and/or authorized.
4. The agency/case manager will keep all taxicab service personal identification numbers (PIN) confidential and will protect them from client access. Under no circumstances shall a case manager disclose their PIN number to a client.
5. (FOR TAXI AND RIDE SHARING SERVICES) AFC funded Ryan White Case Managers are required to obtain authorization from AFC for any single taxi ride that is anticipated to exceed $100.00. Case Managers must also obtain prior authorization from AFC for clients who require more than three rides within a 7-day period. Those who fail to comply may result in suspension of transportation scheduling privileges. It is strongly recommended that all AFC funded RW case managers have access to an employment related email account and mobile phone device when ordering ride-sharing services.
6. For case managers ordering ride-sharing services, you are prohibited from ordering a ride for multiple clients. Clients must have their own personal Uber or other ride sharing service or Taxi individually

ordered by a case manager. Case managers are authorized to schedule Three (3) round trip (2-way) taxi or shared rides within a 7-business day period for clients to attend their medical appointments.

PROCEDURES – AFC

- AFC staff will maintain client central registries for both case management and transportation services.
- AFC will provide timely responses to any special request for transportation approval.
- AFC will notify agencies/case managers of any problems related to use of the transportation services in a timely manner.
- AFC will notify agencies if transportation funds for transportation services are restricted or unavailable.
- AFC will provide agencies with transportation assistance if funds are available, and the agency has no other source for this resource.
- AFC will notify the agency of any unauthorized ride or rides that violate the established guidelines. Any unauthorized rides will not be paid for by AFC and are the responsibility of the agency.
- AFC staff will assign a personal identification number (PIN) to each person authorized to order taxicabs.
- AFC will reconcile the agencies transportation logs with the billings submitted by the taxicab companies.
- AFC will provide case management agencies with information on van service agencies and the areas they serve.

PROCESSING TIMEFRAME – N/A

- Mother and Child Alliance (MACA) enrolled clients can utilize taxi or ride sharing services. The service must be authorized and ordered by AFC Care Team. The MACA case manager must certify the client in the database system within 48 hours of AFC approval.
- Client fare card requests are valid for 20 business days after the date of AFC approval.
- To be reimbursed for client fare card purchases, agencies must submit the appropriate documentation within 15 business days after purchase. Refer to #8 in Agency procedures section.

REQUIRED FORMS
Appendix 38. Fare Card Authorization and Reimbursement Request Form
Appendix 39. Medicare Complaint Form

REQUIRED DOCUMENTATION - N/A

46. Health Insurance Premium & Co-Pay Assistance Program

PROCEDURE:	46	EFFECTIVE DATE:	March 1st, 2020

POLICY
These services are designed to provide co-pay assistance for Ryan White clients who have a current eligibility assessment and care plan in Provide. These services are defined by the Health Resource Service Administration (HRSA) as ***Health Insurance Premium and Cost Sharing Assistance*** or the provision of financial assistance or eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles. This service category allows for co-payments and out of pocket costs related to outpatient ambulatory care, oral health care, substance abuse and mental health services. A cap of $4,000 has been implemented per client per year.

ELIGIBILITY:
A client must meet all the following eligibility criteria in order to be eligible for this service:

1. The client must be enrolled in Provide and be receiving any level of case management services; and
2. Client must have a current eligibility assessment and care plan in place

Responsibilities of Client:
Client must provide itemized invoice of services received to case manager in a timely manner.

Responsibilities of Case Management Cooperative Agency:

1. The case manager must complete a payment request record and scan the client invoice into Provide in a timely manner.
2. The case manager must document HIV relatedness for every invoice requested to be paid.
3. The case manager must ensure that the invoice amount matches the amount requested in the Provide payment request.
4. The case manager can back bill for payments, not to exceed any dates prior to July 1 in the previous year.
5. The case manager must ensure that total cost requested to be paid are only for HIV-related services that do not include medication services, or emergency room visits.
6. Invoices incurred after case management enrollment can only be paid.
7. Case managers can only process one invoice per insured client per year for any out of network services.

Responsibilities of the AIDS Foundation of Chicago (AFC)
1. AFC staff will Review payment request record and approve for payment on a daily basis.
2. AFC will complete a note in Provide informing case managers of any rejected payment requests.
3. AFC will reconcile all payments at the end of the month for payment requests approved for the prior month and send to IDPH for approval.

Responsibilities of IDPH/Pool Administrators
1. IDPH staff will approve AFCs request within 72 hours and forward to pool administrators for payment

2. Pool administrators will review payment documents and cut check within three business days of receipt from IDPH

CASE MANAGEMENT TEAM QUALIFICATION POLICIES

47. Case Manager & Supervisor Qualifications

PROCEDURE:	47	EFFECTIVE DATE:	March 1st, 2020

POLICY
AFC has set minimum education and/or experience standards for case managers for both medical and non-medical case management service providers.

PROCEDURES

1. Funded agencies must provide the notification of change in personnel and training request form and resumes of all case manager and supervisor to the AFC by emailing support@aidschicago.jitbit.com. Agencies should send resumes for new and prospective employment candidates that do not meet the qualifications outlined below BEFORE employment is extended. Salaries that exceed AFC grant requirements will not be funded.
2. All case manager and supervisor candidates must complete required trainings.

Case Manager Qualifications
All funded agencies must comply with the educational requirements for case managers. Medical Case management candidates must meet one or more of the following minimum education and/or experience requirements:

- Master's / Bachelor's degree in any human services field;
- A registered nurse;
- Master's / Bachelor's degree in any non-human services field with at least 2 years of case management experience; or
- A 2-year Associate's degree in any human services field with at least 4 years of case management experience.

Non-Medical Case managers must comply with the below requirements.

- At least 2-3 years of direct service experience working in the field of HIV service provision. Computer proficiency is required, as well as the ability to relate to people of diverse backgrounds, cultures, races, sexual orientation and gender identities or expression.

Supervisor Qualifications

All agencies must ensure that supervisory teams are competent in case management procedures and have supervisory experience. Supervisors must meet minimum educational standards and have previous management experience.

- Master's / Bachelor's degree in any human services field; or
- A registered nurse; and
- Must have at least 2 years of supervisory experience.
- Minimum of 2 years of direct case management service delivery experience is preferred.

REQUIRED FORMS
Appendix 40. Notification of Change in Agency Personnel and Training Request Form

Appendix 41. Sample Medical Case Manager Job Description
Appendix 42. Sample Non-Medical Case Manager Job Description

48. Certification & Training

PROCEDURE:	48	EFFECTIVE DATE:	March 1 2020

POLICY

Collaborative sub-contractors including all Ryan White direct service providers must participate in standardized quality trainings as well as on-going professional development. The Case Manager Competencies Training includes a combination of 6 online session and 3 days of in-person training via structured learning activities designed to address areas that significantly affect case manager and supervisor's knowledge, skills and ability to provide high quality services. Trainees should strive for consistent attendance during the training sessions and will participate in a Final Exam Scenario. To ensure that all case managers maintain a minimal level of proficiency, AFC requires that case managers complete the Case Management Re-Certification no less than every three years. By the end of the contract year (February 28 for Part A and March 31 for Part B,) the case manager must have completed the 12-mandatory annual trainings, or their Medical Case Management certification will be revoked.

Required Trainings

1. Four trainings completed by medical case managers must be clinical trainings to maintain their Medical Case Manager certification.
2. Cultural Competency Training
3. DRS Update meetings for all DRS-funded staff and their DRS Supervisors
4. Supervisor Trainings conducted by AFC for Supervisors
5. Semi Annual Case Manager Updates hosted by AFC
6. Other mandatory trainings as requested by AFC or alternate funding entities
7. Abused and Neglected Child Reporting Act (ANCRA) all new staff must complete the "Acknowledgement of Mandated Reporter Status" form prior to employment and complete the Illinois Mandated Reporter online training for both new medical and non-medical case managers.

Optional Trainings

AFC encourages funded agencies to participate in scheduled trainings. Training calendars are updated on the AFC website and the AFC Learning Management System. Non-AFC sponsored trainings can count toward the required 12 trainings if approval is provided in advance by the Training Manager at AFC.

1. MATEC and AFC Trainings
2. Information and Resources Clinics
3. Introduction to DRS
4. Quarterly Service Updates / Supervisory Strategies
5. Local, regional and/or national conferences

GENERAL PROCEDURES

1. All direct service staff funded by AFC including case managers, retention specialists, medical benefits staff, peers etc. must complete no less than 12 AFC-approved trainings per program year. Training requests must be reported within 30 days of attendance in client database. If training attendance/completion is not reported to AFC within the required timeframe of training, the training will not be counted toward the required 12 trainings. Note, Medical Case Management Competencies, Introduction to DRS, and local /

regional coalition (CAHISC) or staff meetings do not count toward the 12 required trainings. Daily attendance at conferences will be applied towards the 12 trainings requirement using the Request for Conference Credit Application form.

2. AFC will provide an updated training schedule on its website and on the Learning Management System.
3. Case Managers can access reports on their training achievements as needed in the client database.
4. Case Managers and all Supervisors of AFC-funded case managers must complete a re-certification exam every three years to remain certified to provide medical case management.
5. If the case manager or supervisor terminates employment and is rehired to the original agency within 2 years, their case management certification will still be valid.
6. Case management trainings transfer from agency to agency.
7. All training participants must arrive to training prior to start time. Any participants that arrive more than 15 minutes late, and/or depart more than 15 minutes prior to end time will not receive credit for the training. Three consecutive documented late appearances may lead to temporary suspension of case manager from all AFC trainings. At this time, the case manager's supervisor will be responsible for client services.

MEDICAL CASE MANAGEMENT COMPETENCIES TRAINING PROCEDURES

1. Case managers and supervisors will complete an online pre-test as a pre-requisite to the competency training.
2. Case managers and supervisors must complete all Competencies modules. Missed modules will result in an "incomplete" and must be completed.
3. Overall score of all modules must be "passing" or no less than 75% or they must be retaken until a passing score is obtained.
4. AFC-Funded Medical Case Managers and supervisors must complete AFC's Medical Case Management Competencies Training Certification course.
5. Case managers and supervisors will complete post-tests after each of the modules of the Competencies training to assess their mastery of the topics covered.
6. AFC will compile post-test results and compute the Total Module Score based on completeness and clarity of the eligibility assessment, data entry, care planning and progress notes.
7. Case managers and supervisors will complete a take home Final Exam to assess eligibility assessment, data entry, care planning and progress note knowledge base.
8. Final Exams must be completed and submitted to AFC within two weeks of the last training session. Late submissions will result in a 5% per-day deduction of the overall Total Module Score for each day the final exam is late. Final Exams not submitted within two weeks will result in automatic failure.
9. AFC will compute the final Certification Score by summing the module post-test scores for a Total Post-Test Score and adding it to the Final Exam Scenario score. A combined score of 75% or better will be considered "certified" as Medical Case Managers. AFC will generate a Professional Development Plan for individuals with lower scores on key modules. These plans will be provided to Supervisors to assist with capacity building and training. Case managers who receive a combined score lower than 75%, or lower than a 75% on their scenario will not be certified nor will they be permitted to provide medical case management services; but are able to provide non-medical case management and supportive services. These individuals are encouraged to repeat the training.
10. AFC will generate individualized scoring reports and will return these profiles within four weeks of the exam submission.

NON-MEDICAL CASE MANAGEMENT TRAINING PROCEDURES

1. Non-Medical case managers must complete AFC's Non-Medical Case Management Competencies Training.
2. AFC will compute the final Certification Score by summing the module post-test scores for a Total Post-Test Score and adding it to the Final Exam Scenario score. A combined score of 75% or better will be considered "certified" as Non-Medical Case Managers. AFC will generate a Professional Development Plan for individuals with lower scores on key modules. These plans will be provided to Supervisors to assist with capacity building and training. Case managers who receive a combined score lower than 75% will not be certified as medical case managers; but are able to provide non-medical case management and supportive services. These individuals are encouraged to repeat the training.

PROCESSING TIMEFRAME

1. Case managers and all case manager Supervisors for AFC funded case managers must complete no less than 12 AFC approved trainings per calendar year.
2. Training attendance must be reported to AFC no less than 30 days after the training session is completed.

REQUIRED FORMS

Appendix 21. Acknowledgement of Mandated Reporter Status
Appendix 40. Notification of Change in Agency Personnel and Training Request Form
Appendix 41. Sample Medical Case Manager Job Description
Appendix 42. Sample Non-Medical Case Manager Job Description

REQUIRED DOCUMENTATION

Request for Training Credit Application (documented in Provide)
Request for Conference Credit Application (documented in Provide)

49. Case Management Supervision

PROCEDURE:	49	EFFECTIVE DATE:	March 1st, 2020

POLICY
All case management agencies will be funded to perform limited supervisory duties. Supervisors are required to conduct supervision sessions with case management teams. Supervisors must have at least two years of management experience and successfully complete the Case Management Competencies.

Supervisor Qualification
All agencies must ensure that supervisory teams are competent in case management procedures and have supervisory experience. Supervisors must meet minimum educational standards and have previous management experience.

- Master's / Bachelor's degree in any human services field; or
- A registered nurse; and
- Must have at least 2 years of supervisory experience.
- Minimum of 2 years of direct case management service delivery experience.

PROCEDURES
Also refer to AFC's contractual agreement Exhibit A.

1. Funded agencies must provide a supervision to case managers on an ongoing basis.
2. Supervision must address client treatment coordination, care plan development, individual case consultation, client care, case manager performance and case manager skills development. Supervision must also address identified deficiencies and corrective action plans.
3. Supervision must be documented, retained and made available for utilization at meetings and programmatic/administrative site visits. Documentation may include meeting agendas, minutes, notes in client charts and/or personnel files. Only client specific supervision is to be documented in the client level database, administrative or professional development supervisory notes should be maintained in a separate and secure location.
4. Supervisors must conduct routine reviews of case management charts with 25% of case manager charts reviewed annually. Quarterly reviews are strongly encouraged. Charts can also be reviewed using peer reviews or agency established quality management teams.
5. Should a case manager resign or be terminated, it is the expectation of the AIDS Foundation that the funded case management supervisor staff will submit to AFC a "notification of change in personnel" form and provide support and services to all assigned case management clients.
6. If an agency designates an "Interim Case Manager Supervisor" who will function as a supervisor for less than six months, the designee staff person only needs to meet the supervisor training and meeting attendance requirements.
7. Supervisors should serve as an intermediary in grievance proceedings.
8. Supervisors should monitor each case manager's adherence to the required 12 AFC approved trainings. Refer to procedure 9 *Case Manager & Supervisor Qualifications*.
9. Supervisors should attend supervisor-specific trainings as hosted by AFC.

10. All AFC funded case manager supervisors must receive a passing score on the Case Management Competencies training within three months of hire. AFC funded case management supervisors must pass a recertification exam as case managers no less than every three years.

REQUIRED DOCUMENTATION

1. Client specific notes in client dataset annually for 25% of clients
2. Documentation of case management supervision

50. Case Load Monitoring for Case Management Services

PROCEDURE:	50	EFFECTIVE DATE:	March 1st, 2020

POLICY
The Collaborative established caseload thresholds for case management services. Caseload monitoring by subcontracted agencies and AFC is necessary to ensure responsiveness to client needs throughout the EMA. Additionally, caseload monitoring ensures fiscal accountability of allocated resources allowing for the redistribution of resources where necessary. Client-to-case manager ratios must be aligned with Collaborative standards.

CASE LOAD REQUIREMENTS
The maximum number of cases required by AFC is based on funding regulations as follows:

1. Intensive DRS Case Management Program
    a. 30-45 Regular DRS Waiver client: 1 case manager
    b. 90 – 100 MCO client: 1 case manager
2. Intensive Corrections Management Program: 25-30 clients: 1 case manager
3. Intensive Supportive Housing Case Management Program: 15 clients: 1 case manager
4. Intensive MACA Case Management Program: 12-15 clients: 1 case manager
5. RW Medical Case Management: 25 – 45 clients: 1 case manager
6. RW Non-Medical Case Management: 25-100 clients: 1 case manager

PROCEDURES

1. Use the database report to review client-to-case manager ratios to determine caseload size as needed.
2. AFC will review subcontractor caseload size on a regular basis.
3. Agencies that exceed the current Collaborative client-to-case manager ratio will be monitored AFC will intervene to re-allocate cases to other providers.
4. Agencies have a right to request that AFC hold referrals due to reaching the maximum case lad threshold
5. Agencies that do not meet the minimum caseload requirement after 3 months of service provision will be under corrective action. Continuous trends in not meeting minimum case load requirement may jeopardize funding
6. Report any client-to-case manager ratios that do not meet Cooperative standards in quarterly AFC reports with an explanation and plan for managing / increasing ratios.

TIMEFRAME

1. Agencies must have achieved a minimum caseload of 25 within 3 months of service provision.

REQUIRED FORMS – N/A

QUALITY MANAGEMENT POLICIES

51. Quarterly Reporting

PROCEDURE:	51	EFFECTIVE DATE:	March 1st, 2020

POLICY
AFC uses quarterly reports to hold subcontractors accountable to service scopes, as a tool to learn about new activities, successes, barriers, gaps, client needs, and to manage quality management efforts. AFC will send formal responses to agencies to follow up on technical assistance requests and offer suggestions as needed.

ELIGIBILITY – N/A

PROCEDURES

1. Submit a quarterly narrative report to AFC. The narrative report must include the following information: scope of services list, personnel changes, program changes, status of budget allocation, barriers, successes, quality improvement activities, explanation of program income if any and technical assistance needs. Quarterly reports should describe the provision of services and especially any challenges in providing services or explanation of lack of or rapid progress toward scope completion.
2. Upon receipt of the quarterly report, AFC Care Team Staff will review and notify subcontractors if there are any concerns or comments regarding the report. AFC will also respond to any requests for policy clarification or technical assistance needs. Any requests made for supplemental funds due to client needs will be considered and discussed during quarterly AFC expenditure review meetings and budget adjustments will be made accordingly.

REQUIRED FORMS
Appendix 43. Quarterly Progress Report Narrative

REQUIRED DOCUMENTATION – N/A

52. Quality Management & Technical Assistance

PROCEDURE:	52	EFFECTIVE DATE:	March 1st, 2020

POLICY
Funded agencies are required to develop and adhere to a comprehensive quality management plan assessing the adequacy, appropriateness and effectiveness of services. Quality management plans must include mechanisms to test internal controls against documented performance metrics. Quality management efforts must be aligned with Federal, State and local funding quality requirements. Annually, each funded agency must submit its current quality management plan and a report of activities aligned with the plan.

The quality management plan must include the following areas:

1. Quality management overview
2. Agency/program quality management statement
3. Agency service portfolio
4. Quality management team structure
5. Information collection and dissemination
6. Performance indicators
7. Goals

AFC will test these factors through an analysis of quarterly reporting submissions, satisfaction survey analysis, site visits and audit of case files, fiscal reports and other administrative/programmatic functions.

ELIGIBILITY – N/A

PROCEDURES

1. Submit a quality management plan annually to AFC basing performance indicators on established AFC, HIV/AIDS Bureau (HAB) Quality Management, HRSA Performance Standards, as well as national best standards in the establishment of sound care service indicators and benchmarks. The plan submitted may be the agency's overall plan but it must include case management scopes.
2. Review the publication and dissemination of relevant guidelines and program standards.
3. Request technical assistance where necessary to proactively ensure the highest quality standards.
4. Works towards becoming proficient in areas of expertise (i.e., youth, women's services, transgender, etc. and request AFC support in areas that agency is having difficulties.

PROCESSING TIMEFRAME
Annual quality management plan

REQUIRED FORMS
Appendix 44. Action Plan

REQUIRED DOCUMENTATION
Quality Management Plan

PROVIDE SYSTEM – N/A
HAB / OTHER PERFORMANCE MEASUREMENT – N/A

53. Agency Site Visits

PROCEDURE:	53	EFFECTIVE DATE:	March 1st, 2020

POLICY
AFC will conduct annual administrative, programmatic, fiscal and quality management site visits to all funded agencies to ensure that said agency is adhering to performance metrics set by HRSA and those outlined in their respective quality management plan. Agencies with identified deficiencies are responsible for developing and implementing corrective action planning.

PROCEDURES

1. AFC will provide 30 days advanced notice when scheduling the site visit. AFC will provide the agency with the requisite forms/checklists and Record Review form prior to the site visit.
2. AFC will review the Universal Tool, electronic client charts through the client database for case management at AFC and through documentation provided for fee for service categories at the agency, fiscal reports/budgets, surveys and any other programmatic documentation.
3. AFC will host a collaborative debriefing session to discuss observations and findings. The final site visit report will address any specific deficiencies along with recommended corrective actions, the agency's site visit score and highlight program best practices.
4. Agencies may dispute any findings and/or request clarification of the site visit results within 30 days of the agencies of the site visit report.
5. Agencies must submit a written corrective action plan to AFC 30 days after receipt of site visit report

REQUIRED FORMS
Appendix 45. Fiscal Supporting Audit Document
Appendix 46. Universal Tool – IL RW Subcontract Site Visit Review
Appendix 47. Site Visit Corrective Action Plan (CAP)

REQUIRED DOCUMENTATION – N/A

54. Consumer Input

PROCEDURE:	54	EFFECTIVE DATE:	March 1st, 2020

POLICY
All subcontractors must have a structure and ongoing efforts to obtain input from clients in the design and delivery of services in the form of one of the following:

Consumer Advisory Board (CAB)

Recruit service recipients to be part of a formal board. Using created bylaws, rules of engagement and created agenda items, use CAB as a sounding board to vet program plans and generate ideas.

Client Satisfaction Surveys

Survey service recipients on a regular basis to evaluate program successes as well as areas of improvement

Suggestion Box

Implement a suggestion box to get continuous feedback from service recipients. Review contents regular and act upon reasonable suggestions.

NEWLY IMPLENTED POLICIES

55. Case Management Hours of Operation

PROCEDURE:	55	EFFECTIVE DATE:	June 1st, 2020

POLICY
All case management subcontractors must have office hours available outside non-traditional hours no less than twice per week to cater to all client needs and ensure accessibility.

PROCEDURE
All case management agencies funded by AFC must implement **one or more** of the following procedures to meet the above standard:-

- Offer in person and telehealth case management services at least twice a week from 5pm – 7pm
- Offer weekend hours of in person and telehealth case management services as needed
- Offer early morning in person or in person case management services at least twice a week from 7am – 9am

Please note: Subcontractors must allow for flexible case management hours outside the traditional 9am -5pm hours to ensure this policy is followed. Agencies with multiple case managers may assign each week to a specific case manager to reduce the burden on one case manager. At no time should a case manager be left alone with clients in an office site without support.

56. Sliding Fee Scale

PROCEDURE:	56	EFFECTIVE DATE:	June 1st, 2020

Policy

Following guidance provided by the Illinois Department of Public Health to meet its' federal requirements, a sliding fee scale has been implemented. Clients will be charged the sliding scale fees listed below for four core categories including outpatient ambulatory, oral health care, substance abuse outpatient, and mental health services. The fees assessed will be based on the program participant's household income according to the chart below. Services to all persons in need of care, regardless of income will not cease based on their inability to pay the assessed fees. Clients should be assured that their CURRENT and FUTURE services are not dependent on their ability to pay these fees.

Household % FPL	**Fee Amount**
0 – 140	$0.00
141 – 200	$0.50
201 – 300	$1.00
301 – 400	$1.50
401 – 500	$2.00
501 and over	$2.50

A yearly cap based on the program participant's household income has been implemented as outlined below. Note, "yearly" is based on the program year, which runs April 1st through March 31st.

Household % FPL	**Fee Amount**
0 – 140	$0.00
141 – 200	$50.00
201 – 300	$100.00
301 – 400	$150.00
401 – 500	$200.00
501 and over	$250.00

Specific income poverty levels can be found on the Department of Health & Human Services website here: https://aspe.hhs.gov/

Note that if a client's income fluctuates in the future, existing charges will not be modified, but the client cap will be modified.

Procedures

1. AFC Care department staff will run a report quarterly in the Provide database on services provided to the client that have incurred a fee to be collected from client.
2. Care department staff will reach out to clients individually to collect monies owed. AFC Care staff will reach out no less than three times to collect these fees from the clients. Refer to appendix 48 for a script for collecting funds.
3. Only clients that owe a fee of more than $1 will be contacted quarterly. If by the end of the year the client has not accrued more than $0.50 in fees, the fees will be collected at that time.
4. Clients will send fees owed directly to AFC Care department staff or give monies directly to assigned case manager to be sent to AFC Care department, whichever process is easier for the client.
5. Case Managers will provide clients with a receipt, and mail collected fees to AFC to the attention of Bashirat Olayanju at 200 W Monroe Street, Suite 1150, Chicago, IL, 60606
6. Neither AFC staff nor case managers at any point should provide change to client if the client does not have the exact fee amount. This will be re-iterated when AFC Care department staff contact clients quarterly
7. Collected fees will be applied to client's account in the Provide database.
8. Collected fees will be reconciled at quarterly meetings between care and finance teams.
9. At no time will the family members of clients be contacted regarding the fee.
10. If a client chooses to pay more than the fee owed, if the amount owed at the end of the year is not up to the amount originally paid, the clients forfeits the difference

Required Forms
N/A

Required Documentation
AFC Care department will apply collected fees into client's profile in Provide database.
Appendix 48. Sliding Fee Scale Collection Call Script
Appendix 49. Sample Receipt for Payment

APPENDIX LIST

SOP Section	Appendix Name
03. Payer of Last Resort	Appendix 1. Affidavit of No Insurance Coverage
04. Payment for Billable Services	Appendix 2. Invoice Template
07. Health Care Access & Navigation	Appendix 1. Affidavit of No Insurance Coverage
08. Memorandum of Agreement	Appendix 3. Sample Inter-Agency Memorandums of Agreement
09. Confidentiality & Releases of Information	Appendix 4. Authorization to Release Information Script
09. Confidentiality & Releases of Information	Appendix 5. Authorization to Release Information (AFC)
09. Confidentiality & Releases of Information	Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
10. Language Translation	Appendix 7. Foreign Language Translation Request Form
10. Language Translation	Appendix 8. Sign Language Interpretation Request Form
12. Incident Reporting	Appendix 9. Incident Reporting Form
13. Grievance Reporting	Appendix 11. Sample Agency Grievance Rights and Responsibilities
13. Grievance Reporting	Appendix 12. Grievance Tracking Form
13. Grievance Reporting	Appendix 13. Service Complaint Inquiry Form AFC
15. Document Retention	Appendix 14. Confidentiality Violation Report Form (can be completed electronically in Provide)
16. Client Satisfaction Survey/Need	Appendix 15. Client Satisfaction Survey Template
17. Health Literacy	Appendix 16. Health Literacy Assessment
17. Health Literacy	Appendix 17. Risk Assessment Tool
18. Screening & Referral for Case Management Services	Appendix 18. AFC RW Case Management Level of Need Analysis
18. Screening & Referral for Case Management Services	Appendix 19. Client Screening and Placement Form (for AFC staff only)
18. Screening & Referral for Case Management Services	Appendix 20. Affordable Health Care Act Passport
19. Intake & Eligibility Assessment	Appendix 1. Affidavit of No Insurance Coverage
19. Intake & Eligibility Assessment	Appendix 5. Authorization to Release Information (AFC)
19. Intake & Eligibility Assessment	Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
19. Intake & Eligibility Assessment	Appendix 10. Partner Services Acknowledgement
19. Intake & Eligibility Assessment	Appendix 22. Household Income Statement

19. Intake & Eligibility Assessment	Appendix 23. RW Initial Assessment/Reassessment Checklist (Not Required)
19. Intake & Eligibility Assessment	Appendix 24. Client Intake and Reassessment Form (Not Required)
19. Intake & Eligibility Assessment	Appendix 25. Client Screening and Feedback Form (Not Required)
19. Intake & Eligibility Assessment	Appendix 26. Medical Update Form (Recommended. Not Required)
19. Intake & Eligibility Assessment	Appendix 33. Rights, Responsibilities, and Grievance Procedures (IDPH)
19. Intake & Eligibility Assessment	Appendix 36. Employee Oath of Confidentiality
20. Comprehensive Reassessment	Appendix 27. Care Plan Template
21. Mandatory Reporting for Case Management	Appendix 14. Confidentiality Violation Report Form (can be completed electronically in Provide)
21. Mandatory Reporting for Case Management	Appendix 21. Acknowledgement of Mandated Reporter Status
22. Partner Services for Case Management	Appendix 10. Partner Services Acknowledgement
23. Client Transfer, Discharge/Closure	Appendix 28. Case Management Discharge Summary
24. Comprehensive Care Planning	Appendix 21. Acknowledgement of Mandated Reporter Status
24. Comprehensive Care Planning	Appendix 26. Medical Update Form (Recommended. Not Required)
24. Comprehensive Care Planning	Appendix 27. Care Plan Template
25. Determining Level of Need	Appendix 29. Karnofsky Acuity Assessment Scale Tool
26. Eligibility Reassessment	Appendix 26. Medical Update Form (Recommended. Not Required)
26. Eligibility Reassessment	Appendix 27. Care Plan Template
26. Eligibility Reassessment	Appendix 29. Karnofsky Acuity Assessment Scale Tool
27. Referral Coordination & Follow-Up	Appendix 5. Authorization to Release Information (AFC)
27. Referral Coordination & Follow-Up	Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
27. Referral Coordination & Follow-Up	Appendix 30. Sample Referral Letter and Verification Form
28. Care Coordination & Care Conferencing	Appendix 5. Authorization to Release Information (AFC)
28. Care Coordination & Care Conferencing	Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
28. Care Coordination & Care Conferencing	Appendix 26. Medical Update Form (Recommended. Not Required)
28. Care Coordination & Care Conferencing	Appendix 31. Medical Case Management Case Conferencing Agenda

28. Care Coordination & Care Conferencing	Appendix 32. Case Conferencing Staffing Form
30. Care Planning for Non-Medical Case Management	Appendix 27. Care Plan Template
31. Referral Coordination & Follow-Up for Non-Medical Case Management	Appendix 5. Authorization to Release Information (AFC)
31. Referral Coordination & Follow-Up for Non-Medical Case Management	Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
31. Referral Coordination & Follow-Up for Non-Medical Case Management	Appendix 30. Sample Referral Letter and Verification Form
32. Care Coordination for Non-Medical Case Management	Appendix 5. Authorization to Release Information (AFC)
32. Care Coordination for Non-Medical Case Management	Appendix 6. Authorization to Release Health Information Privacy Practice Notice (IDPH)
33. Ambulatory/Outpatient Medical Care	Appendix 2. Invoice Template
34. Mental Health Services	Appendix 2. Invoice Template
35. Oral Health Care	Appendix 2. Invoice Template
36. Substance Abuse Outpatient Services	Appendix 2. Invoice Template
37. AIDS Medicaid Waiver Case Management Services/DRS	Appendix 34. DRS Electronic Billing Verification Form
37. AIDS Medicaid Waiver Case Management Services/DRS	Appendix 35. DRS Retroactive Billing Electronic Verification Form
39. Financial Assistance: Housing & Utilities	Appendix 37a. AFC Emergency Flexible Financial Fund Policy
39. Financial Assistance: Housing & Utilities	Appendix 37b. AFC Emergency Financial Assistance Application
40. Food Bank/Home Delivered Meals	Appendix 2. Invoice Template
41. Legal Assistance Services	Appendix 2. Invoice Template
42. Psychosocial Services	Appendix 2. Invoice Template
43. Housing	Appendix 2. Invoice Template
45. Transportation Services	Appendix 38. Fare Card Authorization and Reimbursement Request Form
45. Transportation Services	Appendix 39. Medicare Complaint Form
47. Case Manager & Supervisor Qualifications	Appendix 40. Notification of Change in Agency Personnel and Training Request Form
47. Case Manager & Supervisor Qualifications	Appendix 41. Sample Medical Case Manager Job Description
47. Case Manager & Supervisor Qualifications	Appendix 42. Sample Non-Medical Case Manager Job Description
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52. Quality Management & Technical Assistance	Appendix 44. Action Plan
53. Agency Site Visits	Appendix 45. Fiscal Supporting Audit Document
53. Agency Site Visits	Appendix 46. Universal Tool – IL RW Subcontract Site Visit Review
53. Agency Site Visits	Appendix 47. Site Visit Corrective Action Plan (CAP)
56. Sliding Fee Scale	Appendix 48. Sliding Fee Scale Collection Call Script
56. Sliding Fee Scale	Appendix 49. Sample Receipt for Payment