AIDSNET
REQUEST FOR PROPOSALS
FOR 2018-2020 HIV SERVICES
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The following resources are available at http://www.aidsnetpa.org/resources-for-grantees.php for download as Adobe files:

- Supplements to the Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania – February 2015

- Annual HIV Surveillance Summary Report
GENERAL INFORMATION

Introduction

AIDSNET is a private, non-profit organization created to prevent the spread of HIV Disease and meet the health care and supportive service needs of people infected with, and affected by, the disease. Founded in 1991, “[t]he mission of AIDSNET is to Build Healthier Communities By Planning and Funding HIV Care and Prevention Services.” As one of seven Regional Sub-recipients in the Commonwealth of Pennsylvania, AIDSNET serves the counties of Berks, Carbon, Lehigh, Monroe, Northampton and Schuylkill.

The goals of AIDSNET are to develop and implement:

- A coordinated and unified regional HIV prevention program that includes education and risk reduction strategies;
- A coordinated and unified regional HIV care program through which persons infected with HIV and their families have access to basic health care and human services regardless of where they live or their ability to pay;
- A coordinated and unified regional HIV housing program through which persons living with HIV and their families have access to appropriate housing, based upon their special needs and the stage of their illness; and
- A regional network of community-based service providers through which integrated and comprehensive components of regional programs are delivered to neighborhoods and communities in ways that are cost-effective, responsive to changing needs and meet quality standards.

AIDSNET seeks to accomplish these goals by allocating the necessary funding for services in the areas of prevention and care.

Purpose

The purpose of this Request for Proposals (RFP) is to fund projects designed to provide HIV prevention and care services to individuals who reside within the six-county AIDSNET service area. This RFP is issued by AIDSNET, which should be the sole point of contact for this document. Responses to this RFP will be accepted from public or private non-profit organizations that propose to develop and/or continue eligible activities in the six-county region.

Minimum Applicant Requirements

- Applicant must be a not-for-profit 501(c)(3) organization.
- Applicant can have no record of unsatisfactory performance. Applicant must not be presently debarred, suspended, proposed for debatement, declared ineligible or voluntarily excluded from participation in this transaction by any local, state or federal department or agency.
• Applicant must have the ability to maintain adequate files and records to meet statistical reporting requirements.
• Applicant must have the administrative and fiscal capability to provide and manage the proposed services on a reimbursement basis and ensure adequate documentation related to services provided.
• Applicant must demonstrate the capacity to perform all elements of the proposed scope of work and have the capacity to enter into a Subgrant with AIDSNET.
• Applicant must possess the appropriate license(s) and certification(s) issued by the Commonwealth of Pennsylvania (if required based on the services proposed). Applicant must meet other presentation and participation requirements listed in this Request for Proposals (RFP).

Prime Program Sub-recipient Responsibility

Each organization selected for funding will be required to assume full responsibility and begin to provide all services offered in its proposal or those services negotiated separately, whether or not it provides them directly, by July 1, 2018. Further, Program Sub-recipients may not enter into a grant agreement with another provider for services or functions offered through this proposal without the written permission of AIDSNET. It is expected that the contracting agency will provide services in accordance with the procedures described in this RFP, the executed grant agreement, and Federal and State guidelines.

Funding

Each year, AIDSNET receives funding from the Pennsylvania Department of Health, Bureau of Communicable Diseases, Division of HIV (Division). The funding comes from three grant programs: one state and two federal sources. State funds are from the Division and have the greatest flexibility in their use. AIDSNET uses the bulk of these dollars for prevention activities, which generally are not eligible costs under the other two programs. However, AIDSNET can use these funds to supplement care and housing activities covered by the other two funding sources, if necessary.

AIDSNET’s second funding source is The Housing Opportunities for Persons with AIDS (HOPWA) Program, funded by the United States Department of Housing and Urban Development (HUD), Community Planning and Development Division. Funding for the program flows from HUD to the Division to AIDSNET and is intended to provide communities with the resources and incentives for meeting the housing needs of persons with HIV disease and their families. AIDSNET uses the funds to assist eligible clients and families in the six-county service area with housing-related services, such as on-going monthly rental assistance, short-term rent and utility assistance, and security deposits.

The third and largest funding source is Rebate Funds. Increased financial resources within Ryan White HIV/AIDS Program (RWHAP) Part B program and AIDS Drug Assistance Program
(ADAP\textsuperscript{1}), in part due to rebates, comprise an increasing share of the overall national ADAP budget. Federal guidelines require the expenditure of rebate funds before Part B grant funds. Therefore, for the 2018-2020 grant years, the Division has decided to fund all RWHAP eligible Care services with Rebate Funds, and they must be treated just like any other RWHAP Part B award. These funds are intended to help communities increase the availability of primary health care and support services (to reduce utilization of more costly inpatient care); increase access to care for underserved populations and improve the quality of life of those affected by the epidemic. For a comprehensive review of the use of Rebate Funds, please refer to the National Alliance of State and Territorial AIDS Directors Ryan White HIV/AIDS Program Part B and ADAP Uses of Rebate Funds July 2017\textsuperscript{2}

The Division and AIDSNET operate on a \textbf{July 1 through June 30 fiscal year}. During the 2018-2020 agreement, AIDSNET anticipates funding from the Division as follows:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>State Funds 11068</th>
<th>HOPWA Funds</th>
<th>Rebate Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-2019</td>
<td>$446,530</td>
<td>$351,902</td>
<td>$1,716,840</td>
<td>$2,515,272</td>
</tr>
<tr>
<td>2019-2020</td>
<td>$446,530</td>
<td>$351,902</td>
<td>$1,716,840</td>
<td>$2,515,272</td>
</tr>
<tr>
<td>Totals</td>
<td>$893,060</td>
<td>$703,804</td>
<td>$3,433,680</td>
<td>$5,030,544</td>
</tr>
</tbody>
</table>

Although the anticipated funding from the Division has been outlined above, AIDSNET reserves the right not to fund all or some of the proposals received, either because of funding constraints or because of the quality of the proposals. Therefore, applicants should not anticipate receiving financial support before receipt of funding notification from AIDSNET. However, even in the case of proposals receiving funding, AIDSNET is not liable for any costs incurred by the applicant prior to the effective date of the grant agreement.

The selected Program Sub-recipients will be expected to enter into a Standard Grant Agreement that will cover a two-year period from July 1, 2018, through June 30, 2020. A copy of the current Standard Grant Agreement can be viewed at the AIDSNET website.\textsuperscript{3}

\textbf{Services Eligible for Funding}

As mentioned previously, AIDSNET will fund services in the areas of prevention, care and housing. Eligible services are covered in detail in Appendix A. When applying for services, applicants should keep in mind funding priorities. A review of new Ryan White (RW) funding guidelines, the new PA RW Part B Program Services Standards, trends in utilization of services, and consultation of AIDSNET Planning Committee members, resulted in the revised prioritization of services tables below.

\textsuperscript{1} ADAP in PA is known as the Special Pharmaceutical Benefits Program or SPBP
\textsuperscript{2} https://www.nastad.org/resource/ryan-white-hiv-aids-program-part-b-and-adap-uses-rebate-funds
\textsuperscript{3} http://www.aidsnetpa.org/resources-for-grantees.php
• The Prioritization of Care Services table was changed to accommodate the Pennsylvania Ryan White HIV Service Standards and the delineation of Medical vs. Non-Medical Case Management activities.

<table>
<thead>
<tr>
<th></th>
<th>Improving Health Outcomes</th>
<th>Improving Access to Needed Services</th>
<th>Supportive Services for Continuity of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Case Management</td>
<td>Non-Medical Case Management</td>
<td>Behavioral Health Services</td>
<td>(Mental Health, Substance Abuse)</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Health insurance Premium Cost &amp; Sharing Assistance</td>
<td>Legal</td>
<td></td>
</tr>
<tr>
<td>Outpatient/Ambulatory Health Services</td>
<td>Housing Assistance</td>
<td>Psychosocial Support Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Transportation</td>
<td>Emergency Financial Assistance</td>
<td></td>
</tr>
</tbody>
</table>

• The prioritization of Risk Behaviors for Prevention services table remained the same to reflect the Division of HIV prioritization, while acknowledging the high incidence of heterosexual transmission in the region due to intravenous drug use.

| People with HIV          | Men who have sex with men (MSM) | Intravenous drug users (IDUs) | High Risk Heterosexuals |

Please review the new PA RW Part B Program Services Standards and accompanying Clarification Notice #16-02 and FAQ sheets (Appendix B) thoroughly before completing your proposal. The standards, which include major changes, define eligible services, as well as service, tracking, and monitoring requirements. Do not assume that the activities formerly eligible remain in place or are unchanged. For instance, the activities required to meet the standard of Medical Case Management (MCM) require a tremendous increase in effort and suggests the need for additional case managers (CMs) and supervisors if space for expansion is available. Organizations applying for MCM should consider client to CM ratios, CM to supervisor ratios, and barriers to hire and house additional staff to implement the service. Another example is Medical Transportation; these funds can no longer be used to transport a client to social services such as Medicaid, Medicare or Social Security offices. In addition, Non-Medical Case Management has been re-added to the list of eligible services, and Emergency Financial Services has been expanded to include coverage of utilities and short-term-rental assistance. **Note:** The standards were under review by the Division and replies to frequently asked questions sent to the Division were answered and emailed on 2/7/18. If changes occur, AIDSNET will immediately inform all care providers.
Proposals may include funding requests for a wide range of allowable costs, including sufficient program staff to support the program and other direct and indirect expenditures that are appropriate to the project. Organizations submitting proposals for care services should keep in mind that AIDSNET is the payer of last resort, as described in Federal and State regulations. Invoices for services that are eligible for coverage or reimbursement by other resources (medical assistance, Medicare, employer insurance, private insurance, other programs, etc.), must first be submitted to these programs on behalf of the client and denied before AIDSNET will consider reimbursing the Provider Sub-recipient for the cost of the service. As a general statement, medical services must be directly related to HIV disease.

Responses to the RFP
All responses to this RFP are required to be prepared using font size 12. Proposals must include information on the subjects described in the “Proposal Components” section. A checklist of requirements to assist applicants in preparing their response to this RFP, a signature page and a proposal summary sheet are included as Appendix C. The material requested should be presented in the order it is described below and listed in the checklist.

Proposals should be prepared simply and economically, providing a straightforward and concise description of the intent and ability of the interested party to meet the requirements of this RFP. Please take note that AIDSNET has implemented page restrictions, which can be found in the description of the proposal components. In addition, please number all of the pages in the proposal.

In preparing a response to this RFP, please keep in mind that the quality of the proposal weighs heavily in funding decisions. Therefore, please take the time to be accurate in describing the statement of the problem and the services to address the stated needs. In addition, please be thorough in the review of the proposal before it is submitted. As funding gets tighter, allocations decisions become more difficult. Just because an organization was funded for a specific service previously is not a guarantee that AIDSNET will support it in the coming year. Therefore, agencies that have been funded previously should be careful not to simply submit the same material submitted in the past. In addition, agencies that have been funded previously should take seriously the comments from AIDSNET’s staff and Allocations Committee regarding their past proposals.

Improper Consideration

Applicant will not offer (either directly or through an intermediary) any improper consideration such as, but not limited to, cash, discounts, service, the provision of travel or entertainment, or an item of value to any officer, employee or agent of AIDSNET in an attempt to secure favorable treatment regarding this RFP. AIDSNET, by written notice, may terminate any contract if it determines that any improper consideration as described above was offered to any officer, employee or agent of AIDSNET with respect to the proposal and award process. This prohibition will apply to any amendment, extension or evaluation process once a subgrant has been awarded. Applicant will immediately report any attempt by an AIDSNET officer, employee or agent to solicit (either directly or through an intermediary) improper consideration from Applicant. The report will be made to the supervisor or manager charged with the supervision of the employee.
In the event of a termination under this provision, AIDSNET is entitled to pursue any available legal remedies.

**Inaccuracies or Misrepresentations**

In the course of the RFP process or in the administration of a resulting subgrant, if AIDSNET determines that the applicant has made a material misstatement or misrepresentation or that materially inaccurate information has been provided to AIDSNET, the applicant may be terminated from the RFP process. In the event a subgrant has been awarded, the contract may be immediately terminated.

**News Releases**

News releases pertaining to this RFP or the project to which it relates should not be made until AIDSNET and the Division have approved the proposal and the applicant has a fully executed grant agreement with AIDSNET.

**Rejection of Proposals**

AIDSNET reserves the right to reject any and all proposals as a result of this RFP or to negotiate separately with competing applicants for all or any part of the services described therein. Furthermore, should the evaluation of the applications demonstrate that there are not sufficient proposals of quality to meet the needs of the region; AIDSNET reserves the right to contact organizations submitting quality proposals to determine their level of interest in providing the applicable services. In such cases, the applicants contacted will be given an opportunity to submit addendums to their proposals for these additional services. The addendums will be evaluated using the same criteria as the initial submissions. Should the revised proposals be of sufficient quality, the highest rated applicant(s) will be recommended for funding. If this additional step fails to produce a sufficient number of quality proposals, a subsequent RFP will be issued for the applicable services.

**Proposal Due Date**

**Proposals must be received by AIDSNET by 3:00 p.m., Monday, March 26, 2018. AIDSNET is located at 31 South Commerce Way, Suite 400, Bethlehem, PA 18017-8992.** To be considered, the original and 9 copies of a complete response to the RFP using the format provided must be submitted to AIDSNET. The applicant should not distribute copies of the proposal in response to this RFP to any other parties.

Each proposal submitted by the March 26, 2018, deadline will be reviewed by AIDSNET’s staff for completeness and accuracy. Any proposal that does not provide all of the information requested in this RFP may be eliminated from selection. Applicants may be contacted by AIDSNET staff for clarification of particular responses.

This proposal description and all details must remain firm until at least July 1, 2018.
Pre-Proposal Conference

A pre-proposal conference will be held from 10:00 a.m. to noon on Monday, February 26, 2018, in AIDSNET’s Conference Room, 31 S. Commerce Way, Suite 400, Bethlehem, Pennsylvania. The purpose of this pre-proposal conference is to clarify any points in the RFP that may not be clearly understood and provide an overview of the financial forms that are part of this RFP. The pre-proposal conference is for information only. Answers to questions asked that change or substantially clarify the RFP will be affirmed in writing. Such answers should not be considered official until receipt of the February 26 meeting notes.

The Fiscal Officer will determine prior to this meeting if there is a need for an afternoon meeting from 1:30 to 3:30 pm to review the fiscal documents in detail. This determination will depend on the number of requests for assistance received prior to the February 26 meeting. If the requests for assistance are few, the Fiscal Officer will instead arrange to meet with interested parties in person or via telephone at a mutually acceptable time.

Attending the pre-proposal conference is not mandatory. However, it is highly recommended that a decision-maker participating in the preparation of the organization’s response to this RFP and the person who will be responsible for the preparation of the financial forms attend the pre-proposal conference.

When inclement weather causes transportation problems or locally hazardous conditions, AIDSNET gives consideration to the personal safety of others in evaluating their ability to attend the pre-proposal conference. In the interest of the safety and welfare of the service provider, AIDSNET may cancel the pre-proposal meeting due to inclement weather. In the event of inclement weather, service providers should call AIDSNET for cancellation information at 610-882-1119 at 8:00 a.m. on February 26, 2018. If the pre-proposal conference is cancelled due to inclement weather, it will be rescheduled for Wednesday, February 28, 2018.
PROPOSAL COMPONENTS

Section I: Organizational Profile (Maximum 1 page)

Provide a brief history of the organization, including mission statement, date formed, length of existence, targeted population(s), services provided and major changes in the organization over the last 12 months.

Section II: Cultural Competency (Maximum 1 page)

Briefly describe your organization’s capacity to provide services to the population(s) targeted in your proposal, while recognizing the role of culture in comprehensive and supportive care. Describe how clients’ language, cultural, educational, religious, and gender barriers to accessing services will be minimized by your program. Cite specific examples relating to cultural sensitivities of people living with HIV (i.e. distrust, provider/medical community, gender inequalities and stereotyping). Please explain if any forms, brochures, medication instructions or other healthcare guidelines provided by your agency will be available in the language and reading level of the client, and be inclusive of gender identities and partner/family makeups. Also, discuss how increased cultural sensitivity will enable staff and board members who attend any cultural competency trainings to share information with the whole organization.

Section III: Personnel (No page limitation)

Please include the names and job titles of administrative and programmatic personnel who will be engaged in the provision of services. (See Appendix D for guidelines for standardized prevention job titles, education and experience.) Indicate where the personnel will be physically located during the time they are engaged in the work. Include each staff person’s education and employment experience. Indicate the responsibilities each person will have in this project and how long each employee has been with the agency. Also, please include an organizational chart of the entire agency (indicating names of current employees for each position), current resumes (for non-vacant positions) and job descriptions. Resumes must include training and continuing education received throughout the year relating to their current job duties. In addition, please include a brief narrative describing how supervision of direct service staff will be conducted, and by which supervisor.

Section IV: Needs Assessment (Maximum 4 pages)

State in succinct terms that the applicant understands the problem being addressed in the response to this RFP. Identify specific problems and/or needs that you want to solve in the areas of client care and prevention through the services you are proposing. Include any needs assessments or surveys as addendums to the proposal document. Provide summarized needs data pertaining to this problem or service need. Please cite the source of the data in footnotes. Applicable local data collected by the organization enhances the proposal. When using internal statistics, applicants using percentages must parenthetically include the numerator and denominator. If an applicant is
requesting funds for case management services, any caseloads quoted must consist of clients receiving Part B case management services. Any clients receiving Part C services and not being case managed cannot be counted in data describing the population to be served under this proposal. In order to be reimbursed by Part B funding, caseloads must be limited to clients who will be case managed.

If an applicant is requesting funds for prevention activities, internal statistics must be identified as duplicated or unduplicated clients.

Section V: Description of Services to be Funded (Maximum 2 pages for each proposed care service and prevention intervention)

Please describe only the service(s) for which funding is being requested. The scope of the service description must include the following for each activity. If the organization is applying for funding for more than one activity, please discuss each of the points listed below for each activity before proceeding to the next activity.

- **Service Description** – The Service Description explains, in detail, the activities or events planned to achieve each stated objective. So that staff and Allocations Committee members reviewing the proposals may get a better sense of the services to be provided, please describe the activities in detailed, narrative form. Include as attachments any curriculum(s) used or, if extensive, a reasonable summary of the curriculum(s) that will provide the Allocations Committee with a sense of what the curriculum covers and accomplishes.

- **Goals** – Goals should describe the overall intent of the service. They do not necessarily need to be measurable.

- **Objectives** – Objectives should be outcome-based and should address the desired effect(s) of the service(s) provided. Include all care and prevention outcomes in this section. The objectives should be realistic, measurable and able to be evaluated. Outcome-based objectives will be required for all contracted services. As guidance, AIDSNET’s outcome-based objectives for fiscal year 2018-2019 are included in this RFP as Appendix E for prevention outcomes and Appendix F for care services. The outcome-based objectives listed in Appendices E and F are intended to be minimum standards, and it is expected that the agencies’ outcome-based objectives will at least address the components listed. Agencies are welcome to establish higher standards by including more rigorous or additional outcome-based objectives in the proposal. Outcomes included in the proposal will be incorporated into contracts and reporting requirements.

- **Evaluation** – Describe how you are going to evaluate the effectiveness of the proposed services (care and prevention) in meeting the defined objectives, including all efforts aimed at measuring Consumer Satisfaction. If your agency has developed an evaluation plan or evaluation tool(s), please describe and explain its use in this section and attach a copy as an appendix to this proposal.

- **Prior Program Experience** – Briefly describe the agency’s experience in providing the service(s) for which the applicant is requesting funding. Experience should show previous work done by individuals who will be assigned to this project, as well as that of the agency.
If the agency has not provided the service(s) it proposes to implement, propose a timeline for adapting, planning, training and implementation. For prevention interventions, applicants should take into account the following program implementation considerations:
  o Recruitment plan
  o Strategy for hard to reach populations
  o Setting a realistic number of individuals to reach/sessions to provide
  o Allotted time for each session
  o Program incentives that are acceptable to the PA-DOH guidelines
  o Having a “safe” space to provide the intervention(s)
  o Managing staff turn over

• Personnel – Please provide the name(s) of the person(s) who will be providing the service, as well as supervision/oversight.

**Section VI: Prevention Intervention Plan Spreadsheet (Please print out on legal size paper)**

Organizations interested in applying for prevention services must complete the Prevention Intervention Plan spreadsheet. See Appendix G for instructions and spreadsheet.

**Section VII: Fiscal Forms**

See Appendix H for fiscal forms to be completed and Appendix I for instructions.

**Section VIII: Quality Management (No page limitation)**

The applicant must include a QM Plan [including anticipated Quality Improvement (QI) projects to be addressed during the funding year] with its response to this RFP. At minimum, the plan must address the program(s) to be funded by AIDSNET. For applicants that are part of a larger organization, please limit the QM submitted to those program(s) the proposal is requesting to be funded.

**Section IX: Additional documentation**

Provide original and 9 copies of any documentation referenced in the proposal

In addition, provide the following supporting documentation in the order listed:

• One copy of the list of current members of the organization’s Board of Directors to include the following:
  o the designation of officers and committee chairs;
  o county of residence;
  o employer and positions;
  o affiliation with other HIV/AIDS-related services/organizations
  o demographics: racial/ethnic make-up; any consumers, etc.
• One copy of the organization’s Internal Revenue Service determination letter evidencing 501(c) status, if appropriate;
• One copy of the organization’s most recent audit; and
• One copy of the organization’s management letter.
APPENDIX A

Description of Eligible Services
APPENDIX A
DESCRIPTION OF ELIGIBLE SERVICES

CARE SERVICES ¹
Funded by Rebate Funds and/or State Funds

Emergency Financial Assistance (EFA):
The provision of limited one-time or short-term payments to assist RWHAP clients with an emergent need for paying for essential utilities, housing – including hotel/motel vouchers (TBRA and mortgage assistance are funded by HOPWA), food (including groceries, food vouchers, and food stamps), transportation and medication, when other resources are not available. EFA can occur as direct payments to agencies or the establishment of voucher programs.

Food Bank, Home & Congregate Meals:
The provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

Health Education/Risk Reduction:
The provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include education on risk reduction, health coverage options, health literacy and treatment adherence education.

Health Insurance Premium & Cost Sharing Assistance (HIP):
The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. This includes premium payments, risk pools, co-insurance, co-payments, and deductibles. Health insurance also includes standalone dental insurance.

Home and Community-Based Health Services:
Includes skilled health services furnished in an integrated setting appropriate to the client’s needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services and appropriate mental health, developmental, and rehabilitation services (This service is negotiated through a letter of agreement.).

Housing Services:
The provision of services that provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family gain or maintain outpatient/ambulatory health services and treatment. Housing related referral services include assessment, search, placement, advocacy, and fees associated with these services. Housing services can include housing that provides some type of medical or supportive services (such as

¹ These are general descriptions. For a complete documentation, please refer to the PA RW Part B Program Service Standards found in Appendix B
residential substance use disorder services or mental health services, residential foster care, or assisted living residential services).

**Medical Case Management Services (MCM):** The provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments. Key activities include: (1) initial assessment of service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of services required to implement the plan, (4) client monitoring to assess the efficacy of the plan, and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services.

**Medical Transportation Services:** The provision of non-emergency transportation services, directly or through voucher, to a client so that he or she may access or be retained in core medical and support services. Transport to and from inpatient, emergency room, and urgent care type facilities do not qualify.

**Mental Health Services:** The provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services to eligible RWHAP clients. Services are based on a treatment plan, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers (This service is negotiated through a letter of agreement).

**Non-Medical Case Management (NMCM):** Includes the provision of guidance and assistance in accessing, medical, social, community, legal, financial, and other needed services. Non-Medical Case Management may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, and other state and local health care and supportive services, or health insurance Marketplace plans. NMCM does not include Treatment Adherence Services or involve coordination and follow-up of medical treatments, as Medical Case Management does.

**Oral Health Care:** Includes outpatient diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the state or jurisdiction, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants (This service may also be negotiated through a letter of agreement.).

**Other Professional Services/Legal:** The provision of legal services to and/or on behalf of individuals living with HIV and involving legal matters related to or arising from their HIV disease. Services include: preparation of healthcare power of attorney (including do-not-resuscitate orders), durable powers of attorney, and living wills; assistance with public benefits
such as Social Security Disability Insurance; and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP.

**Other Professional Services/Permanency Planning:** The provision of services to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including social services counseling or legal counsel regarding the drafting of wills or delegating powers of attorney, and preparation for custody options for legal dependents, including standby guardianship, joint custody, or adoption.

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

**Psychosocial Support:** The provision of group or individual support and counseling services to assist clients in addressing behavioral and physical health concerns. Services may include child abuse and neglect counseling, HIV support groups, pastoral care/counseling, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian, but excludes the provision of nutritional supplements.

**Substance Abuse Outpatient Care:** The provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

HOPWA is part of care services and it is required that all Program Sub-recipients receiving case management funding apply for and offer HOPWA services to clients. Housing services can be funded by HOPWA or Rebate Funds under the Emergency Financial Assistance and Housing Services categories.

**Housing Assistance:** There are several categories of assistance available through HOPWA funding. Below is a list of the housing services funded by AIDSNET for the 2018-2020 subgrant:
• Short-term rent, mortgage and utility payments to prevent the homelessness of the eligible tenant or mortgage holder living in a dwelling.
• Tenant-based rental assistance, including assistance for shared housing arrangements.
• Permanent Housing Placement for first-month’s rent and/or security deposit.
• Supportive Services – Case Management.

PREVENTION SERVICES ²
Funded by STATE 11068

Pennsylvania Department of Health, Bureau of Communicable Diseases, Division of HIV (Division) supports the following recommended High Impact Prevention activities for People Living with HIV. See detailed fact sheets for each intervention at https://effectiveinterventions.cdc.gov/

ARTAS
Anti-Retroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention to link individuals who have been recently diagnosed with HIV to medical care. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self-efficacy) and Humanistic Psychology. SBCM is a case management model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC). ARTAS consists of up to five client sessions conducted over a 90-day period or until the client links to medical care – whichever comes first. ARTAS views the community as a resource for the client and client sessions are encouraged to take place outside the office or wherever the client feels most comfortable. Following the final client session, the client may be linked to a long-term/Ryan White case manager and/or another service delivery system to address his/her longer term barriers to remaining in care, such as substance use treatment, mental health services. This intervention may also be used to reengage client’s that have been lost to follow-up back in medical care.

Healthy Relationships
Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills, building self-efficacy, and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. The sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

Partnership for Health – Safer Sex (PfH)
Partnership for Health (PfH) uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients’ knowledge, skills, and motivations to practice

² These are general guidelines for prevention services. For detailed guidance, please refer to the April 10, 2015 Interim Policy Guidance on the Implementation of High Impact Prevention Activities in Appendix J.
safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention. Implementation of PfH includes development of clinic and staff “buy-in” and training.

If your agency is currently funded to provide any of the following interventions, you may apply to continue the provision of the intervention(s) during the 2018-2020 grant agreement.

**CLEAR**
Choosing Life: Empowerment! Action! Results! (CLEAR) is an evidence-based, health promotion intervention for males and females ages 16 and older living with HIV/AIDS or at high-risk for HIV. CLEAR is a client-centered program delivered one-on-one using cognitive behavioral techniques to change behavior. The intervention provides clients with the skills necessary to be able to make healthy choices for their lives. The Centers for Disease Control and Prevention's (CDC's) guidelines on Comprehensive Risk Counseling and Services (CRCS), formerly known as Prevention Case Management (PCM), identify CLEAR as a structured intervention that may be integrated into CRCS programs.

**Personal Cognitive Counseling (PCC)**
Personalized Cognitive Counseling (PCC) is an individual-level, single session counseling intervention designed to reduce unprotected anal intercourse (UAI) among men who have sex with men (MSM) who are repeat testers for HIV. PCC focuses on the person’s self-justification (thoughts, attitudes and beliefs) he uses when deciding whether or not to engage in high-risk sexual behavior. PCC is a 30- to 50-minute intervention conducted as a component of Counseling, Testing, and Referral Service (CTRS) for MSM who meet the screening criteria. PCC is a five-step process. The counselor assists the client to: (1) recall a memorable episode of UAI; (2) complete the PCC Questionnaire – list of self-justifications to rationalize risky behavior; (3) discuss the episode and his thoughts/feelings; (4) identify the self-justifications that facilitated the episode; and (5) discuss what he will do in the future.

**VOICES/VOCES**
Video Opportunities for Innovative Condom Education & Safer Sex: A group-level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Health educators convene groups of 4-8 clinic patients in a room that allows privacy for discussions. VOICES/VOCES is based on the theory of Reasoned Action, which explains how people’s behaviors are guided by their attitudes, beliefs, and experiences as well as by how they believe others think they should act in a given circumstance. Groups are gender and ethnic specific, so that participants can develop prevention strategies appropriate for their culture. Information on HIV/STD risk behavior and condom use is delivered by viewing a culturally specific video. Skills in condom use and negotiation are modeled in the videos, then role-played and practiced by participants during the facilitated group discussion that follows. A poster board is used to present features of various condom brands in English and Spanish. At the end of the single, 45-minute session, participants are given samples of the types of condoms they have identified as best meeting their needs.
Requests to provide Strategies/Interventions from the CDC’s Compendium of Effective Behavioral Interventions not listed above, or that you are not currently funded to provide, must receive prior written approval from the Division. For these requests to be considered, the following information (at a minimum) must be included in your proposal:

- The identified activity/intervention/strategy (include explanation of adaptation, if applicable)
- The target population to be served.
- A brief summary of how you determined the need for this intervention to include:
  - Identified geographic area to be served (zip code, or set of zip codes)
  - Cite all epi data that you used to determine the target population.
  - Why this specific intervention was selected.
- Current capacity to implement the intervention
- Anticipated capacity building and/or training needs identified.
- Implementation plan, and Monitoring & Evaluation Key Activities (must include SMART objectives, including number of clients to be served)
- Anticipated annual budget for the intervention.
APPENDIX B THROUGH B-4

Pennsylvania Ryan White Part B Program Service Standards
and Accompanying Policy Clarifications
Appendix B

Pennsylvania Ryan White Part B
Program Service Standards

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I. EMERGENCY FINANCIAL ASSISTANCE

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

2. SUBRECIPIENT shall ensure that funds are available to people with HIV/AIDS who present an emergency need, which has resulted from an unexpected occurrence or set of circumstances demanding immediate course of action. Emergency financial assistance is the provision of short-term payments to assist with emergency expenses for essential services (i.e. utilities, housing, and medication) when other resources are not available.

3. SUBRECIPIENT shall ensure that proper documentation of emergency situations is presented. This documentation shall be in the form of shut off notices for essential utilities (gas & electric), letter of eviction from a landlord, or a letter denying coverage for medications from the applicant’s insurance SUBRECIPIENT and the Special Pharmaceutical Benefits Program.

4. SUBRECIPIENT shall ensure, for the purpose of relocation, documentation of the necessity of housing services to enable the applicant to gain or maintain access and compliance with HIV related medical care and treatment documentation must be recorded in the applicant’s file.

5. SUBRECIPIENT shall ensure that intake sites submitting applications for emergency financial assistance have already pre-screened and pre-approved clients, based upon standards and qualifications provided for in these service provisions.

6. SUBRECIPIENT shall ensure funds are available to persons diagnosed with AIDS and HIV related illnesses and their families and significant others when there is a direct benefit to the individual with HIV and/or AIDS regardless of race, sex, religion, sexual orientation, marital status, national origin, and place of citizenship.

7. SUBRECIPIENT shall ensure these funds are available when the client possesses insufficient or no resources; these are to be the funds of last resort.

8. SUBRECIPIENT shall ensure a record is maintained concerning the eligibility of clients applying for assistance and those who are not awarded services and the reasons for denial of services. The eligibility documentation shall include:
   a. Current photo ID
   b. Current copy of Ryan White services eligibility certification
   c. Certification of Emergent Necessity and Financial Counseling Forms
9. SUBRECIPIENT shall ensure that it provides an appeals process for those whose application is denied for Ryan White emergency needs. In the event that appeals are unsuccessful on the SUBRECIPIENT level, the process shall provide for the final level of appeals to be a designee of the regional sub recipient.

10. SUBRECIPIENT shall maintain supporting documentation of funds on file for each applicant. The information must include:
   a. Physician certification of diagnosis
   b. Completed Application Form
   c. Informed consent for service form

11. SUBRECIPIENT shall ensure that EFA funds are maintained in a separate account. Fiscal monitoring of these funds is provided by the agency’s Accountant, Board Treasures, and auditors, and is subject to review by regional grantee.

12. SUBRECIPIENT shall ensure emergency financial assistance funds are provided as direct payments for:
   a. First and last month rent
   b. Pharmaceutical assistance (for HIV specific medications not covered by any form of insurance and not obtainable through the Special Pharmaceutical Benefits Program (SPBP)
   c. Essential utilities such as gas, electric and heating oil.

13. EFA assistance will be limited to person with HIV/AIDS whose income is at or below 500% of the federal poverty level (FPL).

14. SUBRECIPIENT shall ensure that RW funds are not used to supplement food stamps unless the client cannot obtain nutritional supplements which are prescribed by a physician or a registered certified dietitian outside of an ambulatory or medical visit. In this situation, RW funds may be used as a one-time purchase using EFA funding.

15. SUBRECIPIENT shall ensure funds are not to be given directly to consumers requesting services, but made on the client’s behalf of the consumer in the form of checks to vendors who provided approved services.

16. SUBRECIPIENT shall ensure the referring intake site provides for the financial counseling to each client requesting emergency funds by appropriately trained staff, and explores all available resources prior to using the fund. Documentation will be made regarding exploration of resources and reason(s) the resource(s) were not available, as a part of the application for funds.

17. SUBRECIPIENT shall ensure that funds used represent the minimum amount needed to avert an interruption of utility services or eviction. A financial plan to satisfy the remaining balance must be included in the application.
18. SUBRECIPIENT shall ensure the approved, standardized application is completed with a statement of need based upon income and expenses, and provide documentation of income and expenses to support the request for assistance.

19. SUBRECIPIENT shall ensure a written “Consent for Service Form” is signed by the client, dated, and witnessed during a face-to-face visit with the referring intake site.

20. SUBRECIPIENT shall ensure the regional subrecipient is made aware of the written process for approving or disapproving an applicant’s request for emergency funds.

21. SUBRECIPIENT shall ensure a comprehensive database is maintained on all EFA awards. The data base shall contain: nature of the request, amount of grant, demographic data, decisions made relative to an application, and reports required by funding sources.

22. SUBRECIPIENT shall ensure utilization of the standardized approved forms for documentation of client services.

23. SUBRECIPIENT shall ensure that the standards used in evaluating applications and determining funding eligibility are only those standards approved for Ryan White emergency needs funds.

II. FOOD BANK, HOME and CONGREGATE MEALS

1. SUBRECIPIENT agrees that Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following: personal hygiene products, household cleaning supplies, water filtration/purification systems in communities where issues of water safety exist. Unallowable costs include household appliances, pet foods, alcohol, tobacco, and other non-essential products.

2. SUBRECIPIENT shall assure and agree to produce meals and/or food packages which include high quality foods appropriate for individuals with HIV infection which are culturally appropriate, nutritionally balanced, and which are appealing to those receiving the service.

3. SUBRECIPIENT shall ensure that it maintains a kitchen in a manner consistent with local health standards and must maintain licensure requirements necessary to prepare, serve, and/or deliver meals to the target population. It shall take all necessary steps and precautions to ensure that food delivered and/or served is safe.

4. SUBRECIPIENT shall ensure that all meals and food packages shall meet food safety standards as set forth by the Commonwealth and local regulations.
5. SUBRECIPIENT shall ensure that all new staff and volunteers are provided appropriate orientation and training in safe food handling, food preparation, serving, packaging, delivery, and storage.

6. SUBRECIPIENT shall ensure that a Nutritionist provides oversight for the selection, preparation and distribution of meals and other food item/packages.

7. SUBRECIPIENT shall ensure that HIV infected persons are provided culturally sensitive and appropriate information regarding nutrition needs.

8. SUBRECIPIENT shall ensure that these food-related programs are publicized throughout the region, through in-house referrals, and other RW funded programs, to ensure case managers, other SUBRECIPIENTs of HIV-related services and the community is aware of the program and criteria for access.

9. SUBRECIPIENT shall assure that a method for gathering consumer feedback, including information regarding desired foods to be included in menus and food packages, is produced within thirty (30) days of the initiation of this contract. It is further agreed by the SUBRECIPIENT that client feedback will be reflected in actual menus and food packages.

10. SUBRECIPIENT agrees that an internal Quality Assurance process shall be set in place for all funded food programs. This shall include, but not be limited to:
   a. No less than a quarterly random review of the contents of food packages distributed by the food bank, congregate meal program, and home delivered meal program.
   b. This shall be performed by individuals who have formal nutrition backgrounds such as a Nutritionist or Registered Dietician, and Assure that Nutritional Supplements are current.

There are several types of food programs with service provisions associated with each type: Food Bank, Delivered Meals, and Congregate Meals. See below for the service provisions associated with each type:

**FOOD BANK**

11. SUBRECIPIENT shall report the following unit of service: Food Bank Visits – the number of visits to the agency’s food bank, made by HIV positive clients and others who are not HIV infected, if the provision of such service can be construed to have at least an indirect benefit to a person with HIV infection.

12. SUBRECIPIENT agrees that prior to issuing food or food packages that an assessment will be completed of the consumer’s nutritional needs, general health, living situation (including if they live alone or with others), housing (including if what type of cooking facilities are available), and ability (or caregiver) to prepare food.
13. SUBRECIPIENT agrees if no Nutritional assessment has been completed on the individual, they will be referred to the Nutritionist for an assessment. Refusal by the client shall not affect their use of the Food Bank.

14. SUBRECIPIENT assures that if food is purchased in bulk and delivered to consumers in individual packages that the individuals handling the foodstuffs shall especially be subject to the service provisions regarding orientation and continuing education requirements for food handlers. SUBRECIPIENT further assures that if food is purchased in bulk that the consumer will not be allowed to "self-serve" under any circumstances.

**DELIVERED MEALS**

15. The Unit of Service to be provided is Delivered Meals.

16. SUBRECIPIENT shall submit a plan for home delivered meals provided under this contract to the regional grantee within 30 days of the initiation of the contract. SUBRECIPIENT agrees to include in this schedule the projected number of individuals to be served, the days that they shall be provided (including holidays, if any), and approximate times, that the service will be provided.

17. SUBRECIPIENT shall recruit volunteers who will act as drivers, food handlers and delivery persons to support this program.

18. SUBRECIPIENT shall assure that individuals volunteering as food handlers will especially be subject to the service provisions regarding orientation and continuing education requirements for food handlers, as previously specified.

19. SUBRECIPIENT shall ensure documentation of demographics in CAREWare and client file (i.e., EMR, paper chart, etc.) is used to identify consumers served on a daily basis by race, gender, age and geographic location. This reporting mechanism shall be reviewed with the regional grantee upon request.

20. SUBRECIPIENT shall, with appropriate documentation, ensure there will be contact with the referring agency when services are initiated and discontinued.

**CONGREGATE MEALS**

21. SUBRECIPIENT shall report the following unit of service as: Congregate Meals – The number of meals provided to HIV positive clients and others who are not HIV infected, (if the provision of such service can be construed to have at least an indirect benefit to a person with HIV infection), in a group setting.

22. SUBRECIPIENT shall ensure that it provides culturally and community appropriate congregate meals to the consumers that it serves.
23. SUBRECIPIENT assures that each HIV positive individual in attendance may have one guest if desired.

24. SUBRECIPIENT shall submit the schedule for congregate meals served under this contract upon request. SUBRECIPIENT agrees to include in this schedule the physical sites; days and times that congregate meals shall take place during the contract period ensure that there is a “Log/Sign-In” sheet at each of the congregate dinners.

25. SUBRECIPIENT agrees to develop a protocol that assures that eligible beneficiaries and their guests utilize the congregate meal program.

26. SUBRECIPIENT shall ensure that an assigned appropriate staff member attends the congregate meals program. Staff shall provide information regarding HIV/AIDS related services available to them, and link individuals with appropriate health and social service resources.

27. SUBRECIPIENT shall, whenever possible, make provisions for other speakers to address the group during the communal dinners to ensure updated information on HIV/AIDS treatments and supportive services available to the participants.

28. SUBRECIPIENT must ensure a Nutritionist or Dietitian assists in all meal planning preparation.

**NUTRITIONAL SUPPLEMENTS**

29. SUBRECIPIENT acknowledges that the acceptable Unit of Service is Cans – The number of cans of nutritional drinks/powder mixes provided to HIV positive clients. This total also includes the number of cans of vitamin and mineral products.

30. SUBRECIPIENT shall ensure that a log be developed to document distribution of nutritional supplements. This log will include: Name or Unique Identifier of the consumer, amount and date distributed.

31. SUBRECIPIENT shall ensure that it maintain records on each client regarding the number of nutritional supplements distributed.

32. SUBRECIPIENT agrees that prior to issuing nutritional supplements that a general assessment must be completed which includes the consumer’s: Nutritional needs, general health, and living situation.

33. If no Nutritional assessment has been completed on the individual, they will be referred to the Nutritionist for an assessment. Refusal by the client may affect their use of Nutritional Supplement activity.

34. SUBRECIPIENT shall ensure that a nutritionist works closely with staff to assure services are recorded and followed up.
35. SUBRECIPIENT shall ensure that a nutritionist oversees the dissemination of nutritional supplements to consumers

36. SUBRECIPIENT shall ensure that the outcome of nutritional services is evaluated by the use of voluntary self-reporting client questionnaires and client attendance records.

37. SUBRECIPIENT shall determine a policy regarding the maximum number of cans to be distributed to one consumer in a one-month period within the first thirty (30) days after the initiation of this contract.

38. All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional.

III. HEALTH EDUCATION/ RISK REDUCTION

1. SUBRECIPIENT agrees that Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:
   a. Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention.
   b. Education on reduction of risk during pregnancy and transmission risks with breastfeeding when appropriate.
   c. Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage).
   d. Health literacy
   e. Treatment adherence education

2. SUBRECIPIENT agrees that Health Education/Risk Reduction services cannot be delivered anonymously.

3. SUBRECIPIENT shall ensure that it employs staff with appropriate educational background, and training compliance shall be maintained to meet all standards regarding:
   a. Staff Credentialing Files:
      i. SUBRECIPIENTS will maintain training files for all part-time or full time care (including consultants) and supervisory staff.
ii. This will include all licensed and non-licensed staff providing educational services to consumers with HIV about HIV transmission and prevention. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help consumers with HIV improve their health status.

iii. SUBRECIPIENT shall ensure that all staff have completed training in HIV related care, appropriate to their level of care interaction.

b. Documentation Requirements:
   i. SUBRECIPIENTS will maintain a standardized format order/chronology of standard consumer information forms.
   ii. A completed intake sheet/assessment shall include at a minimum: Client name; address and phone number; mode of transmission and other demographic information as required by CAREWare
   iii. A determination if Health Education/Risk Reduction services are appropriate.
   iv. A consumer rights form, and consent for services signed by the consumer during the first face-to-face contact

c. Clinical Supervision Staff Orientation
   i. All SUBRECIPIENTs will adhere to the Pennsylvania state guidelines, as well as discipline specific regulations, to provide supervision to all clinical staff

4. SUBRECIPIENT shall ensure that it maintains a log of all referrals of clients for Medical Case Management, Mental Health, and other relevant services. PaDOH reserves the right to review this information on request. This information shall also be reflected in the client’s progress notes as appropriate

5. SUBRECIPIENT shall ensure that progress notes will be regularly documented in the client’s chart in the Data Assessment/Plan (DAP) Format, or a system which includes the counselor’s:
   a. relevant observations of the interaction
   b. an analysis/evaluation of the interaction, and
   c. the plan of action resulting from the interaction

6. SUBRECIPIENT shall ensure consumers receiving Health Education/Risk Reduction services are moved to an inactive status when the client chooses not to participate in services for a period of ninety (90) days, when a client is non-compliant, or their behavior is contrary to the philosophy of the agency. The agency may keep a case open beyond the ninety (90) day period if it is the policy of the agency to do so.
7. The selection of an appropriate Effective Behavioral Intervention shall be made. It must be listed in the CDC’s Compendium of Effective Behavioral Interventions, and among those supported by the Pennsylvania Department of Health.

IV. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

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 RWHAP funds for health insurance premium and cost-sharing assistance, a RWHAP Part recipient must implement a methodology that incorporates the following requirements:

1. Subrecipients must ensure that clients are buying health coverage that, at a minimum, 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 outpatient/ambulatory health services; and,

2. Subrecipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

3. The service provision consists of either or both of the following:
   a. Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
   b. Paying for standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
   c. Paying cost-sharing on behalf of the client.

Traditionally, RWHAP Parts A and B funding support health insurance premiums and cost-sharing assistance. If a RWHAP Part C or D recipient has the resources to provide this service, an equitable enrollment policy should be in place and it must be cost-effective and sustainable.

V. Home and Community-Based Health Services

1. SUBRECIPIENT shall insure the client is:
   a. Determined to be RW eligible
   b. Is determined in need of services by a physician or licensed clinical care provider.

2. SUBRECIPIENT will ensure that all clients have a case manager at the time they are accepted for service.
3. SUBRECIPIENT will ensure all services are provided by licensed care providers.

4. Services may include;
   a. Appropriate mental health, developmental, and rehabilitation services
   b. Day treatment or other partial hospitalization services
   c. Durable medical equipment
   d. Home health aide services and personal care services in the home

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

6. SUBRECIPIENT shall ensure services are of last resort.

VI. HOME HEALTH CARE

1. SUBRECIPIENT shall ensure that the consumer is given an overview of home health care services as well as an overview of the roles and responsibilities of the nurse, home health care, and other SUBRECIPIENTs involved, during their admission to the program.

2. The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

3. SUBRECIPIENT shall assure that individuals meet the following eligibility requirements must:
   a. Be HIV infected
   b. Reside within the Commonwealth of Pa
   c. Must be homebound, this does not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

4. SUBRECIPIENT agrees to obtain demographic and personal information adequate to accept the referral. This information shall be documented in the client chart.

5. SUBRECIPIENT agrees to develop a protocol, which will be followed beginning at the referral process, intake completion and assessment, to receiving services through the program. This protocol shall be developed within 90 days of the contracts initiation, should be available for review by the by the regional grantee upon request.

6. SUBRECIPIENT agrees that after receiving the referral that a date and time will be set for the assessment. Depending upon the referral and request, an appropriate assessment will be made either for:
   a. Home health aide services, or
   b. skilled nursing care
7. SUBRECIPIENT agrees that individuals requiring services as indicated by the assessment shall be recommended for services. Upon receiving orders from the client’s physician, they shall be provided services.

8. SUBRECIPIENT shall further assure that reassessments must occur on a regular basis in order to guarantee client eligibility for the program. The agency shall develop a protocol, which provides for this reassessment on a consistent and equitable basis. This protocol shall be developed within 90 days, and made available for review by the regional grantee upon request.

9. SUBRECIPIENT will ensure that all clients have a case manager at the time they are accepted for service.

10. SUBRECIPIENT shall ensure that a nursing plan is developed for each client accepted into this program. The plan will indicate whether the home health aide or nurse will provide services or specialized care and shall include the goals and activities involved, including dates as appropriate. This shall be documented in the client chart.

11. SUBRECIPIENT shall assure that a client chart or file shall be developed for each client. This will include, but not be limited to: Referral, intake and assessment information, service care plans (with specific goals), HIV/AIDS diagnoses documentation and release of information, nursing and home health aide notes, other discipline notes, as well as documentation of doctor’s orders, discharges summaries, specialty and other services which are required and/or customary.

12. SUBRECIPIENT shall determine, in conjunction with certifying agencies and other insurance SUBRECIPIENTs, the minimum amount of education required for homemakers, home health aides, in-home personal attendants, and other paraprofessional staff providing services with this program. This shall be placed in an agency manual and shall be available for review upon request.

13. SUBRECIPIENT shall further assure that all professional staff shall have obtained the requisite amount of education required to fulfill their positions and are currently certified or registered with the appropriate professional agency.

14. SUBRECIPIENT further ensures that all staff are trained and skilled in the following areas which are of particular concern for this activity;
   a. Recognition of neglect and/or abuse
   b. Skilled first aid, and
   c. Each individual must have at least basic certification in Cardio-Pulmonary Resuscitation (CPR) with ninety (90) days of the contracts initiation.
   d. Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parental feeding).
e. Preventive and specialty care  
f. Wound care  
g. Routine diagnostics testing administered in the home  
h. Other medical therapies

15. SUBRECIPIENT agrees to produce a policy that establishes clear lines of responsibility and accountability for employees in providing services for individuals receiving all services under this contract. The policy may be in the form of a Personnel Description with explanations (if necessary). After completion, it shall be placed in a SUBRECIPIENT manual, and be made available upon request.

16. SUBRECIPIENT shall ensure that staff keeps other appropriate health care SUBRECIPIENTs, and medical case management SUBRECIPIENTs, updated on the consumer’s condition, as appropriate. SUBRECIPIENT further agrees to use a Release of Confidential Information, which conforms to the appropriate Commonwealth of Pennsylvania requirements.

17. SUBRECIPIENT shall assure that a policy be developed within the first forty-five (45) days of the initiation of this contract regarding availability of staff should the need be identified that the consumer needs to be transported. If the SUBRECIPIENT decides to supply this, the policy shall assure that paraprofessional or professional staff providing the service will have a valid driver’s license and access to an insured vehicle. The SUBRECIPIENT, as the agency authorizing this transport, shall assume all liability. Furthermore, the agency’s insurance must be in compliance with all relevant liability laws. Should the SUBRECIPIENT decide not to provide this service, it shall be stated clearly in the policy.

18. SUBRECIPIENT shall ensure that both paraprofessional and professional staff will immediately inform their direct supervisor should the consumer experience a life-threatening crisis during the time the staff is present. Immediate and appropriate action, depending upon the qualifications of the staff person involved, must be taken to address the crisis. This determination as to whether a life-threatening crisis is being experienced must be based on established written agency protocol.

19. SUBRECIPIENT agrees to produce a written protocol for responding to crisis situations. After produced, all staff must be informed of the content, with a written copy easily accessible to personnel. If it doesn’t already exist, the protocol shall be developed no later than sixty (60) days.

20. SUBRECIPIENT agrees that paraprofessional staff shall complete daily logs, or comparable documentation.
21. SUBRECIPIENT agrees that paraprofessional staff, under the direction of their direct supervisor, shall complete progress notes and other consumer documentation in the DAP (Data Assessment Plan) format. SUBRECIPIENT further agrees that each face to face, telephone and other contact with the consumer is recorded in the consumer’s file.

22. SUBRECIPIENT agrees that both paid and volunteer staff providing services with this program shall be provided supervision on a regular and ongoing basis in order to assess the performance of staff and ensure that services are being provided appropriately and effectively. This supervision will include an evaluation component both individual’s knowledge and understanding of HIV.

23. SUBRECIPIENT assures that a policy is in place for each paraprofessional and professional staff person providing services to have a direct supervisor available for consultation on an immediate basis in case the need should arise. The policy will include at a minimum:
   a. A monthly review of client records
   b. Observation must be performed for each paraprofessional staff person at least once each three-month period, and
   c. May be in either an announced (where the staff person knows) or unannounced format of the supervisor’s visit.

24. SUBRECIPIENT agrees to produce a policy to verify staff attendance and time spent in regards to the services provided by this program. The policy must include:
   a. Verification by the consumer that the staff person(s) provided services, date, time entered, time left, and general services provided. Staff must make a detailed note in cases where anything was “out of the ordinary;”
   b. Random field/spot checks by supervisor or coordinator
   c. Other methods which the SUBRECIPIENT normally may use.

25. Clients may be terminated for the following reasons:
   a. no longer needing the service and requesting termination;
   b. no longer needing the service according to a re-evaluation completed by the program; or
   c. inappropriate behavior of the client toward program staff.

26. SUBRECIPIENT shall maintain certifications required by, and follow all guidance provided through the Pennsylvania Department of Health/Division of Primary Care (for Home Health Care), and requirements of Medicare for Home Health Programs.

VII. Hospice Services

1. Hospice Services are end-of-life care services provided to clients in the terminal stage, of an HIV-related illness. Allowable services are:
   a. Mental health counseling
   b. Nursing care
c. Palliative therapeutics
d. Physician services
e. Room and board

2. Subrecipients shall assure that services are provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services.
   a. This service category does not extend to skilled nursing facilities or nursing homes.

3. Subrecipient must assure that a physician certify that a patient is terminally ill and has a defined life expectancy of six months or less.

4. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling.

5. Palliative therapies must be consistent with those covered under Pennsylvania’s Medicaid programs.

VIII. HOUSING SERVICES

1. SUBRECIPIENT agrees that Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family gain or maintain outpatient/ambulatory health services. Housing related referral services include assessment, search, placement, advocacy, and fees associated with these services. Housing services can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services).

2. SUBRECIPIENT must document the amount of time spent assisting each client and the assistance provided; and shall further provide those specific services allowable.

3. SUBRECIPIENT shall ensure that it determines eligibility requirements for low-income homeless symptomatic people living with HIV who are requesting placement and are prepared for independent living.

4. SUBRECIPIENT shall ensure that an initial intake is conducted on all clients with the goal of linking these clients to HIV/AIDS case management services as appropriate and obtaining required social and medical services. This intake will be recorded on an official intake document and conducted face-to-face. The intake information will include, but not be limited to:
   a. Demographic information on the patient
   b. HIV status
   c. A clear statement of the client’s needs and/ or presenting problem
d. An individualized written housing plan consistent with RWHAP Housing Policy 11-01.
e. A determination as to whether the client meets the criteria established by the agency and is acceptable for services.

5. SUBRECIPIENT agrees that transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness. To maintain an individualized housing plan updated annually. Housing services must also include the development of a written individualized permanent housing plan. SUBRECIPIENTs must provide a copy of the individualized written housing plan upon request.

6. Eligible housing services can include housing that provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services).

7. SUBRECIPIENT shall document the necessity of housing services for the purpose of access to or adherence to HIV-related outpatient/ambulatory health services.

8. SUBRECIPIENT further agrees to have mechanisms in place to allow newly identified clients access to housing services. SUBRECIPIENTs must assess every client’s housing needs at least annually to determine the need for new or additional services.

9. SUBRECIPIENT agrees that transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness, and the duration of this assistance does not exceed 24 months. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients and SUBRECIPIENTs consider using HUD’s definition as their standard.

10. SUBRECIPIENT agrees that Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments. Housing services, as described here, replaces the guidance provided in PCN 11-01.

11. SUBRECIPIENT shall ensure that a “Consent to Service Form is signed by the consumer, dated, and witnessed during the first face-to-face contact. This form will include the agencies general expectation of the client, grievance procedure, consequences of non-compliance with the plan, relevant re-entry requirements, and assurance of privacy and confidentiality.

12. SUBRECIPIENT shall ensure that each client receiving (housing) support services has progress notes completed and must be placed in each client’s file.
IX. LINGUISTIC SERVICES (Translation and Interpretation)

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

2. SUBRECIPIENT shall ensure that all interpreters employed must adhere to the Code of Ethics as determined by the Registry of Interpreters for the Deaf. Furthermore, services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

3. SUBRECIPIENT shall ensure that linguistic services are provided to individuals certified eligible for Ryan White services on an as-needed basis for either deaf and hard-of-hearing clients or those with Limited English Proficiency, so that individuals shall be able to access HIV services including but not limited to medical appointments, Medical Case Management, HIV Testing and Linkage to Care (TALC), and other health-related services as necessary. Individuals involved in HIV planning activities are also eligible for services.

4. SUBRECIPIENT shall ensure that documentation of linguistic services includes but is not limited to the following:
   a. referral source, reason for referral and site where service is provided;
   b. Ryan White eligibility certification for client
   c. name and address of person providing the service;
   d. amount of time required and dollar amount charged.

5. SUBRECIPIENT shall make available to the assigned Program Analyst, consumers, and HIV/AIDS service SUBRECIPIENTs a listing of all languages that can be interpreted or translated to people with Limited English Proficiency.

6. SUBRECIPIENT will ensure that translators and interpreters possess a combination of training and experience that enables them to provide quality services.

7. SUBRECIPIENT will ensure that written translations are accurate and culturally appropriate.

8. SUBRECIPIENT will develop and follow written protocol for processing requests for services, and for the delivery and monitoring of these services. PaDOH Program Analyst will be informed before changes are made to the protocols.

9. SUBRECIPIENT shall develop system for feedback both from consumers and SUBRECIPIENTs regarding the quality of linguistic services.
10. SUBRECIPIENT is responsible to receive interpretation and translation requests by fax or by telephone between the hours of 9:00 a.m. and 4:00 p.m. Monday through Friday (except holidays).

11. SUBRECIPIENT shall make telephone interpretation services available in emergency situations between the hours of 9:00 a.m. and 4:00 p.m., Monday through Friday (except holidays).

X. MEDICAL CASE MANAGEMENT (Including Treatment Adherence Services)

1. SUBRECIPIENT agrees that Medical Case Management services (including treatment adherence) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV / AIDS treatments. Key activities include:
   a. initial assessment of service needs;
   b. development of a comprehensive, individualized service plan;
   c. coordination of services required to implement the plan;
   d. client monitoring to assess the efficacy of the plan; and
   e. periodic re-evaluation and adaptation of the plan as necessary over the life of the client.
   f. including client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

2. SUBRECIPIENT shall ensure that when necessary, and with the client’s consent, that it will communicate with other agencies providing medical case management services to avoid duplication and assure coordination of service.

3. SUBRECIPIENT shall ensure that for any client presenting for medical case management services, either face to face or by phone, the medical case manager will respond to the client within one week of the request.

4. SUBRECIPIENT agrees that all clients will be certified as a Ryan White Eligible Beneficiary within thirty (30) days after initial contact with the client as evidenced by the completion of the PADOH Ryan White Certification Form which is to be placed in the client’s file. In addition:
   a. SUBRECIPIENT will abide by the Ryan White Certification
Parameters:

i. HIV status must be verified once per lifetime. Identity, insurance status, residency, and client income must be verified every six months.

ii. Verification that a person has had a viral load, CD4 count, or is receiving antiretroviral therapy must occur once a year.

iii. Client certification of eligibility, at any access point of care in the region, is valid for all services.

iv. If a person is not certified or is unable to acquire certification, they cannot continue to receive Ryan White funded services.

v. The process of certification should not be a barrier to providing care for an individual in need of services.

vi. Services should be provided until such time as a person is deemed ineligible.

b. SUBRECIPIENT agrees to follow the Ryan White certification process:

Medical Case Management (MCM) and Outpatient Ambulatory Health Services (OAHS)

i. SUBRECIPIENTs are primarily responsible for certification. However, this does not exempt other Care services SUBRECIPIENTs from initiating certification, to facilitate access to Care services and ensure continuity of care.

ii. All SUBRECIPIENTs making referrals to other Ryan White services must include written confirmation of eligibility certification in their referral.

iii. Clients with current documentation on file may be certified without being physically present.

iv. For clients without current documentation on file, certification will take place at the client’s next MCM encounter.

v. Persons receiving Ryan White services who do not get MCM through Ryan White funded services, or for whom their next appointment for MCM is more than 60 days away, must be certified by the first SUBRECIPIENT from whom services are received.

vi. Certification should be completed within 30 days from the time of intake/reassessment. A client may not continue to receive Ryan White services if they have not satisfied all certification requirements. Ryan White services may be renewed at any point after the client has satisfied certification requirements.

vii. Once the client is deemed eligible, the SUBRECIPIENT may count the service units provided to that client as “Ryan White service units” from the moment of intake but no more than 30 days prior to completing certification.
1) If the documentation subsequently determines that the client is not eligible, those services may not be counted as “Ryan White service units” and the client may not be considered a Ryan White client. If a client is determined to be ineligible for Ryan White funded services, the SUBRECIPIENT may still provide services, but may not use Ryan White funds.

2) If a person is deemed ineligible, services should be tracked in CAREWare as unfunded services.

3) The agency completing the certification must maintain all certification documents.

4) All clients are to be reassessed and recertified every six months based on the date of their initial certification or recertification. Clients not certified within thirty days of their expiration date are ineligible to receive Ryan White services until they are certified.

5) If the SUBRECIPIENT is unable to provide services absent Ryan White support, they must document making appropriate referrals to other SUBRECIPIENTS who may provide service absent Ryan White funding.

13. SUBRECIPIENT agrees that efforts to contact a client will continue for eight (8) weeks after receiving an initial referral, at which time case shall be terminated and SUBRECIPIENT will develop written protocols to be followed related to attempts to contact clients and termination procedures.

14. SUBRECIPIENT shall obtain every six (6) months documentation from every client’s HIV medical provider with prescribing privileges (e.g. doctor of osteopathic medicine, medical doctor, nurse practitioner and/or physician’s assistant) dates of medical visits, dates and values of CD4 counts, dates and values of viral loads, and most recent HIV antiretroviral medications prescribed in the preceding six (6) months. The documentation must be kept in the client’s file.

15. SUBRECIPIENT shall incorporate the information received every six (6) months from the client’s HIV medical provider (HIV medical visits, CD4 counts, viral loads, and HIV antiretroviral medications prescribed) into the client’s assessment, utilize the information in developing and evaluating the client’s service care plan goals, and use as a basis for treatment adherence activities.
16. Prior to a client’s assessment, SUBRECIPIENT must ensure that the client is given an overview of case management services as well as an overview of the roles and responsibilities of the case manager and the client. The client’s file must contain a form signed (Client/Medical Case Manager Agreement) by that client and the medical case manager which indicates that the client has received this overview of medical case management services, including his/her rights and responsibilities, as well as the roles and responsibilities of the medical case manager. If this form does not already exist, it must be created by the SUBRECIPIENT no later than thirty (30) days after the beginning of the Ryan White Fiscal Year.

17. SUBRECIPIENT shall ensure that the Agreement for Medical Case Management includes:
   a. the client’s decision to receive medical case management at the agency;
   b. the definition of medical case management;
   c. the right to change or discontinue services;
   d. consequences of non-compliance with the medical case manager or agency, and;
   e. Relevant re-entry requirements.

   If these forms do not already exist, they must be created by the SUBRECIPIENT no later than thirty (30) days after the initiation of this contract.

18. SUBRECIPIENT shall ensure that the client is given and either reads, or is read, the document, signs and dates a Medical Case Management Agreement; an agency grievance procedure form, and release forms that detail the relevant confidentiality laws.

19. SUBRECIPIENT shall ensure that in addition to the Medical Case Management Agreement, each client is verbally informed of client rights and responsibilities and is provided a written “Bill of Client Rights and Responsibilities,” (hereafter referred to as the “Bill of Client Rights,” which includes but is not limited to:
   a. statements regarding non-discrimination;
   b. expectations for respect and dignity to be mutually maintained by each client and staff member;
   c. services for which each client is potentially eligible;
   d. costs, if any, for services not specific to medical case management;
   e. statement of client’s right to refuse treatment or services;
   f. statement of client’s right and responsibility to participate in service choices;
   g. assurance regarding service accessibility;
   h. assurances, rights, and responsibilities regarding client privacy;
   i. assurances, rights and responsibilities regarding client confidentiality;
   j. rights and limits regarding client access to records;
   k. the right to receive quality services from qualified personnel;
   l. Statement of client’s responsibility to provide accurate and complete information relevant to case management services being provided.
20. SUBRECIPIENT shall ensure that a written policy is maintained on file and made accessible to all relevant staff, which explains how clients are informed about the “Bill of Client Rights.”

21. SUBRECIPIENT shall ensure that each client who consents to receive medical case management services receives the standardized medical case management comprehensive assessment as soon as possible after intake and within 30 days of the client’s referral from Client Services to identify the client’s needs, problems, strengths, and resources. This assessment must be done under circumstances (e.g. time and location) agreeable to the client and will at a minimum, include the following areas:

a. date of Client Services referral and assessment;
b. demographics
c. client and emergency contact information
d. general client information (disability, employment, education and immigration status, language, and previous medical case management services
e. documentation of available identifications available to client (PA photo, SSI card, insurance, birth certificate, HIV status)
f. health insurance
g. medical care information (medical provider information, date of HIV and/or AIDS diagnosis, hospitalizations)
h. medical status
i. opportunistic infections
j. HIV related symptoms
k. other medical conditions (including pregnancy and pre-natal care)
l. HIV medications including antiretroviral prophylaxis for opportunistic infections
m. dental needs
n. medication adherence
o. health literacy assessment
p. domestic violence
q. financial status
r. living arrangements
s. family history
t. support system
u. legal issues
v. mental health
w. drug/alcohol history
x. secondary prevention
y. summary (client strengths/resources, barriers to care, and narrative of issues identified that are addressed in Services Care Plan)
22. SUBRECIPIENT shall ensure that elements of the standardized assessment are not deleted but may make additions to them as required by clinical needs of their medical case management practice.

24. SUBRECIPIENT shall ensure that at the completion of the assessment, each client and respective medical case manager develop an individual medical case management Service Care Plan. This plan includes, at a minimum:
   a. a long-term goal which incorporates elements of the medical case management process (assessment, linkage, coordination of services, advocacy and monitoring)
   b. seven predefined short term goals inherent to medical case management (retention in HIV medical care, other medical issues, antiretroviral adherence, secondary risk reduction, maintenance of optimal level of emotional health, management of disease of addiction, other bio-psychosocial barriers to care)
   c. at any given time, a client should be working on a minimum of two (2) or more realistic, measurable and mutually acceptable goals which are directly based on information from the assessment
   d. action steps required to achieve each goal (a minimum of two), including target date(s) for accomplishment and specific action steps for which the client and/or designated representative, and case manager, are responsible
   e. the outcome of client progress pertaining to completion of each action step towards meeting goal (completed, partially completed, not completed)
   f. space for signatures by the client, medical case manager, and supervisor

24. SUBRECIPIENT shall ensure that when the medical case management Service Care Plan is completed, both the client and medical case manager sign the plan.

25. SUBRECIPIENT shall ensure that the Service Care Plan for any client is reviewed and revised every six (6) months. The date completed or revised must be noted on the plan.

26. SUBRECIPIENT shall ensure that elements of the standardized Service Care Plan are not deleted but may make additions to them as required by clinical needs of their medical case management practice.

27. SUBRECIPIENT shall ensure that the medical case manager has at a minimum:
   a. face to face contact with any client receiving medical case management at least every three (3) months; more if client’s situation dictates such an action
b. accompaniment to medical visits are required annually (MCMs are to demonstrate and document collaboration and coordination with the clinical care team)
c. home visits are recommended but not required
d. phone contact should be on-going as needed

28. SUBRECIPIENT agrees that each accompaniment to a medical visit shall be documented in the client’s progress notes detailing the specifics of that visit. If a client refuses to allow accompaniment to a medical visit, it must be noted in the client’s progress notes.

29. SUBRECIPIENT shall ensure that recipients of medical case management services receive Treatment Adherence Counseling (education and support to ensure readiness for, and compliance with complex HIV treatments).

30. SUBRECIPIENT agrees to provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

31. SUBRECIPIENT shall ensure that the client’s adherence to HIV treatment (e.g. keeping medical appointments, taking prescribed medications, refilling prescriptions, etc.) must be assessed at a minimum, at least once every three months and during the initial and yearly assessment.

32. SUBRECIPIENT shall ensure that documentation in client progress notes and service care plan demonstrate that a treatment adherence assessment has been completed, treatment adherence plan to address the problems has been developed and treatment adherence activities have been implemented.

33. SUBRECIPIENT shall ensure that all clients are assessed for health literacy and based on findings, the medical case manager will develop ongoing strategies to assist client with health related and other information.

34. SUBRECIPIENT shall ensure that clients will be reassessed on a yearly basis in key areas indicated in service provision #21. A new service care plan must be completed based on the reassessment of the client.

35. SUBRECIPIENT shall ensure that confidentiality is maintained by SUBRECIPIENTs, which includes both paid and unpaid personnel. The SUBRECIPIENT agrees to comply with Pennsylvania Act 148 (amended to Act 59 in 2011) (Confidentiality of HIV-Related Information Act) A written policy regarding client confidentiality, including PA Act 59 must be kept on file and be easily accessible to staff.
36. SUBRECIPIENT shall ensure that when information is requested from the SUBRECIPIENT, that an Authorization to Release HIV Related Confidential Information Form which meets the requirements of the Pa Commonwealth statute is explained to the client prior to their signing the form and information being released to or received from other organizations or agencies. If these forms do not already exist, they must be created by the SUBRECIPIENT no later than thirty (30) days after the initiation of this contract.

37. SUBRECIPIENT shall ensure that each client receiving medical case management services is informed of agency grievance procedures. Each client must receive and read, or be read, the contents of the grievance form, sign and date the form. The elements of the grievance procedures must include at a minimum:
   a. an explanation of the time frame within which grievances may be filed;
   b. an explanation of the process by which clients may appeal negative decisions;
   c. Compliance with any existing grievance procedures established by outside agencies which provide governance to the SUBRECIPIENT.

   If this form does not already exist, it must be produced by the SUBRECIPIENT within thirty (30) days after the initiation of this contract.

38. SUBRECIPIENT agrees that progress notes will be written in DAP (Data Assessment Plan) format. SUBRECIPIENT further agrees that as a result of each face to face or phone contact with the client the following is noted and recorded in the progress note:
   a. assessment of progress toward goal achievement as delineated in the Service Care Plan;
   b. Results of the action steps delineated in the plan; c) changes, additions or deletions to current services.

39. SUBRECIPIENT shall ensure that medical case management services are terminated when:
   a. the client, in consultation with the medical case manager, indicates medical case management services are no longer necessary, or that the client’s needs may be better met by another SUBRECIPIENT;
   b. when three (3) months have lapsed since the client initiated contact with the case manager;
   c. the client moves to a new service area;
   d. the client becomes eligible for otherwise funded HIV medical case management services;
   e. the client is placed or located in an institutional setting in which case management services are either unnecessary or the respective institution is responsible for providing medical case management services;
   f. the client acts in such a way as to endanger the case manager or agency personnel as per the SUBRECIPIENT’s written policies and procedures; and
g. The client otherwise chooses to terminate service with the SUBRECIPIENT.

40. SUBRECIPIENT shall ensure that when a client chooses to terminate services, the respective medical case manager facilitates referral through the Client Services to facilitate access to services from an alternative MCM SUBRECIPIENT.

41. SUBRECIPIENT shall ensure that all medical case managers funded in whole or in part with RW Part B funds meet the minimum educational qualifications. These requirements are: each case manager must have a bachelor’s degree in social work, psychology or sociology or other related field; or, for nurses, be classified as a registered nurse.

42. SUBRECIPIENT shall ensure that a copy of the medical case manager’s degree, or transcript documenting the degree awarded, is part of his/her personnel file.

43. SUBRECIPIENT ensures that medical case management supervisors shall meet the minimum educational requirements outlined for case managers. It is agreed by SUBRECIPIENT that a Bachelor’s degree is required, but a Master’s degree is preferred with two years of experience performing Social Work or Medical Case Management activities.

44. SUBRECIPIENT agrees that the purpose of supervision is to:
   a. Improve client clinical outcomes.
   b. Enhance the HIV medical case manager’s professional skills, knowledge and attitudes to achieve competency in providing quality care.
   c. Assist in professional growth and development of the worker.

45. SUBRECIPIENT shall ensure that each case manager is assigned to a clinical supervisor and receives supervision. Supervision must include at a minimum:
   a. face-to-face supervision once every two (2) weeks, and
   b. A bi-annual review of client charts.
   c. Supervision with medical case managers is to be documented in progress notes (includes clinical recommendations by the case management supervisor, specific action steps taken by the case manager regarding the client and associated outcomes).
   d. Supervisor will keep a supervisory log (includes the dates of supervision sessions and the names of clients discussed with case managers during meeting.

46. SUBRECIPIENT shall assure that chart reviews include but are not limited to:
   a. frequency of contact with client, including face to face contacts
   b. client retention and case closure
   c. review of service care plan
   d. review of treatment adherence activities
e. follow-up on client’s medical appointments  
f. follow-up on referrals, including but not limited to drug/alcohol and mental health treatment

47. SUBRECIPIENT shall have policies and procedures assuring cultural and linguistic needs of clients are addressed in its delivery of medical case management services.

48. SUBRECIPIENT shall have policies and procedures addressing coverage of cases when the assigned medical case manager is unavailable.

XI. MEDICAL NUTRITION THERAPY

1. SUBRECIPIENT shall ensure that Medical Nutrition Therapy including nutritional supplements is provided by a Licensed Registered Dietitian outside of a primary care visit. The provision of food may be provided pursuant to a physician’s recommendation, and a nutritional plan developed by a licensed registered dietitian who will conduct an initial assessment of each consumer. The initial assessment can be administered by a series of questions concerning the consumers understanding of nutrition. In subsequent counseling sessions, the licensed registered dietitian will discuss the consumers' understanding of nutrition and changes in eating patterns that have occurred while participating in this program.

2. SUBRECIPIENT shall ensure that the initial nutritional assessment, which includes, but is not limited to:
   a. A review of the clients’ medical information, medications, supplements taken, when and how, and;
   b. Consideration of individual personal and cultural food preferences, budget, living situation, cooking skills and facilities.

3. SUBRECIPIENT shall ensure that the licensed registered dietitian consults with each consumer’s physician prior to designing a dietary plan specific to the patient’s needs.

4. SUBRECIPIENT shall ensure that clients receive individual nutritional assessments, nutritional follow-up counseling as needed, therapeutic diets and nutritional information on an individual or group basis.

5. SUBRECIPIENT shall ensure that it develops an individualized nutrition plan for each individual seen, including an assessment of over-the-counter and prescribed medications regimen of each client as it relates to his/her nutritional needs. This plan shall further reflect the needs, circumstances, and food preferences of each patient. The nutritional counselor will consider the individual's personal, cultural, and food preferences, budget, living situation, cooking facilities and skills. This plan shall be integrated into the consumer’s total primary health care plan. The service plan shall be developed based on the client's assessment information.
6. SUBRECIPIENT shall ensure that the nutritional counseling plan includes the following:
   a. Assessment of nutrition/dietary intake;
   b. Individual/cultural food preferences;
   c. Weight, height, medications, allergy history and history of other chronic disease such as hypertension, diabetes;
   d. Use of appetite enhancers or suppressors, supplements, complementary therapies, vitamin and mineral supplements;
   e. The assessment of client’s nutrition related symptoms, for example, patterns of chewing, swallowing, nausea, vomiting, diarrhea, constipation;
   f. The assessment of the need for nutritional supplements;
   g. Socio-economic factors associated with nutrition, for example, availability of food and appliances
   h. Agreed upon time for reassessment of nutritional plan
   i. Evidence of reassessment of nutritional health status of the client and the appropriateness of the care plan as agreed upon by the client and the counselor. This must be documented.

7. SUBRECIPIENT shall ensure that the nutritional counseling it provides includes, but is not limited to:
   a. what food to eat in order to support the body’s ability to fight infection; good nutrition;
   b. malnutrition;
   c. how to protect the immune system,
   d. calorie dense adequate nutrition,
   e. food safety,
   f. vitamin and mineral needs,
   g. managing food related symptoms,
   h. information about supplemental nutritional regimens and
   i. Potential interactions.

8. SUBRECIPIENT further assures that each client will be instructed and/or counseled in taking medications, including requirements as to scheduling and adherence issues, food-drug interactions, drug-drug interactions, drug-supplement interactions, and potential side effects.
   a. Nutritional services and nutritional supplements not provided by a licensed registered dietitian shall be considered a support service.
   b. Food not provided pursuant to a physician’s recommendation, and a nutritional plan developed by a licensed registered dietitian also shall be considered a supportive service.

9. SUBRECIPIENT shall ensure that the staff person providing nutritional services be responsible for maintaining clients records in relation to this program. Records will include, but not be limited to a minimum of:
   a. The individual client nutritional/dietary plan;
b. Nutritional progress notes for each client counseling session conducted under this contract;
c. Progress notes connected with the follow-up sessions shall indicate client progress in following the recommendations of their dietary plan.

10. SUBRECIPIENT shall ensure that it assess changes in nutritional intake for participating clients. Changes will be assessed in patients who have more than three (3) sessions.

11. SUBRECIPIENT shall ensure the program is publicized to medical case managers, other SUBRECIPIENTs of HIV-related services, and the community is aware of the program and its criteria for enrollment.

12. SUBRECIPIENT shall ensure documentation in the form of a reporting mechanism, is used to identify race, gender, age and geographic location of each client served.

13. SUBRECIPIENT shall ensure there will be a follow-up with the referring department or agency when services are started and when discontinued.

14. SUBRECIPIENT shall ensure the licensed registered dietitian communicates with each client’s physician through a written consultation form, which the patient is responsible for giving to their physician.

15. SUBRECIPIENT shall ensure the licensed registered dietitian implements an assessment documentation form to evaluate the effectiveness and impact of the nutritional counseling on each patient.

16. SUBRECIPIENT shall be responsible for evaluating changes in the consumer's nutrition related knowledge and behavior. This shall be accomplished through a written or face-to-face instrument that will be developed by the licensed registered dietitian.

17. SUBRECIPIENT shall ensure that it develops a nutritional referral mechanism for clients.

18. SUBRECIPIENT shall ensure documentation of termination of services. This includes, but not limited to: date of termination, reason for termination, and referrals provided.

XII. MEDICAL TRANSPORTATION SERVICES

1. SUBRECIPIENT shall ensure that Medical Transportation is to provide nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.
2. SUBRECIPIENT shall design and implement a creative and innovative approach to regional transportation for eligible individuals. Services shall be implemented through the following modes of transportation as feasible in each county of the EMA, beginning with least costly modes of transportation and progressing to higher cost modes. SUBRECIPIENT is responsible for assuring that the least costly mode of transportation is utilized whenever possible and appropriate.
   a. Car or Van (mileage reimbursement)
   b. Public transit (tokens, pass)
   c. Taxi cab

3. Services may be implemented through cooperative agreements with potential subcontractors, prior to finalizing and implementing the formal procurement and selection process. All services, once implemented, will function concurrently.

4. Transportation can only be provided for travel to any of the following services:
   a. Medical care services
   b. Hospitals
   c. Pharmacies
   d. Dental care services
   e. Mental health services
   f. Medical suppliers
   g. Food and nutrition services

2. SUBRECIPIENT may use these funds to provide transportation by:
   a. Providing tokens, trans-passes, taxi vouchers or mileage reimbursements to SUBRECIPIENTS to cover the fare for public transit, taxi cab or private automobiles which is available when clients have the physical and mental capacity to use such services;
   b. Entering into contracts with SUBRECIPIENTS of integrated or public transit services,
   c. Including nonprofit agencies, transit authorities and licensed common carriers.

3. SUBRECIPIENT will ensure that any and all transport has the appropriate insurance coverage for the transport of groups and/or individuals.

4. SUBRECIPIENT shall ensure this in the following manner:
   a. Require, verify and document that commercial transportation vendors are licensed;
   b. Require, verify and document that non-commercial transport, are properly licensed and insured (This shall include volunteers); Insurance coverage information will be kept on file and made available upon the request.

5. SUBRECIPIENT assures that individuals receiving services have been diagnosed with HIV and it is documented in clients’ charts prior to providing service.
6. SUBRECIPIENT further assures that priority will be given to non-ambulatory individuals and or individuals unable to travel alone.

7. SUBRECIPIENT shall assure that transportation services provided under these provisions will not to be used for:
   a. Social or recreational purposes and should be non-stop to destination and back,
   b. Medical emergencies or situations that would normally be referred to an ambulance service or "911"

8. SUBRECIPIENT shall ensure proper documentation for all services received. Documentation shall include:
   a. Client demographics (to include client identifier, race, age and address),
   b. Whether trips were one-way or round trip,
   c. Purpose of trip,
   d. Mode of transportation provided client.

9. Eligibility
   a. SUBRECIPIENT agrees to develop a method for determining current consumer Medical Assistance (MA) eligibility.
   b. SUBRECIPIENT shall maintain information on the number of MA eligible/ineligible consumers, and those on MA.
   c. SUBRECIPIENT agrees that in instances where the client needs to be accompanied by an escort, that the SUBRECIPIENT will make the decision as to how many other individuals may accompany the client.

10. SUBRECIPIENT will contact the appropriate transport carrier(s) and provide the details of the transport needs. The driver will assist individuals, door-to-door, to gain access to and from the vehicle, including hands-on escorting or aiding those in wheelchairs. Drivers are not required to move consumers/clients from one level/floor to another.

11. SUBRECIPIENT is responsible to receive transportation request by fax, by mail or by telephone between the hours of 8:00 a.m. and 4:00 p.m. Monday through Friday (except holidays).

12. SUBRECIPIENT will arrange, through subcontracted transportation carriers, to provide holiday, weekend and evening transportation services when possible.

13. SUBRECIPIENT shall ensure that drivers keep logbooks that records trips, fuel purchased, and maintenance activities; this should include:
   a. Number of transported clients.
   b. Beginning and ending location of each trip.
   c. Number of miles.
   d. Duration of trip.
14. SUBRECIPIENT shall thoroughly investigate all accidents and keep record of police reports.

XIII. MENTAL HEALTH SERVICES

1. SUBRECIPIENT agrees to subcontract with credentialed SUBRECIPIENT agencies to provide treatment services which are goal oriented and designed to maximize the personal and informal resources, linking clients to community and formal resources as needed and to assure that these resources are the least restrictive as possible to provide specialized services for persons living with HIV/AIDS.

2. Service SUBRECIPIENT credentialing compliance shall be maintained to meet all standards regarding:
   a. Staffing Credentialing Files: SUBRECIPIENTs will maintain credentialing files for all part-time or full time care (including consultants) and supervisory staff. This will include all licensed and non-licensed staff (e.g., psychiatrists, psychologists, physicians, nurses, and social workers) that provides direct care to consumers. Staff credentials will meet the minimum requirements of the position description guidelines.
   b. Documentation Requirements: SUBRECIPIENTs will maintain: a standardized format order/chronology of standard consumer information forms; a completed intake sheet; a consumer rights form, signed and dated by the consumer; signed and dated consent for treatment and consent for medication; and signed and dated release of information.
   c. Clinical Supervision Staff Orientation: All SUBRECIPIENTs will adhere to the Pennsylvania Commonwealth guidelines as well as discipline specific regulations, to provide supervision to all clinical staff. The supervisory director of any multidisciplinary team is the individual who holds the highest degree of accountability by licensure, generally the psychiatrist.
   d. Staff Training: SUBRECIPIENT ensures that within the first sixty- (60) days after the initiation of this contract that it shall review the policy regarding the training of staff. This policy shall address the need for training staff, as well as, provide a specific plan for initial and ongoing training of staff. Each agency will show evidence of the implementation of the plan, as well as, provide feedback from the organization's mental health clinicians regarding the fulfillment of this plan. It is accepted by SUBRECIPIENT that each agency plan will be updated yearly.
   e. Physical Plant Standards: SUBRECIPIENT will be expected to adhere to all standards, laws and guidelines that are established by state and local governments, for facilities providing mental health services
   f. SUBRECIPIENT will develop a network of qualified and experienced SUBRECIPIENTs of mental health services to persons with HIV disease and/or families during the contract period.
g. SUBRECIPIENT will establish program quality assurance measures (i.e. training, consumer satisfaction, clinical outcomes, utilization data, evaluation), and implement such during appropriate times throughout the contract period.

3. Record Keeping and Documentation:

   a. For each client who is provided mental health counseling: SUBRECIPIENT agrees to keep a record of where the client is from and the mode of HIV transmission, as well as relevant demographic information. This information shall be provided upon request.

   b. SUBRECIPIENT shall develop and strengthen linkages with other mental health agencies that provide mental health services to affected populations. It shall also cooperate with other agencies that provide information and education to the above-targeted populations. A record of these contacts shall be kept at each contracted service SUBRECIPIENT agency, and be made available to the regional grantee upon request.

   c. SUBRECIPIENT ensures that it will coordinate mental health counseling services with other agencies providing like services when possible, in order to prevent duplication of services. SUBRECIPIENT and the agencies accept the requirement that this requires the client’s consent.

   d. SUBRECIPIENT agrees to keep a record of all referrals of clients to other agencies offering case management, substance abuse treatment, other mental health treatment or psychiatric services, and other services as they are requested.

   e. SUBRECIPIENT agrees to make this record available to PaDOH through the contracted SUBRECIPIENT upon request. In addition, where applicable this information will be reflected in the client’s progress notes.

   f. SUBRECIPIENT shall ensure that all client files are kept in a safe environment for confidentiality purposes.

4. Pre Intake/Waiting List:

   a. SUBRECIPIENT shall ensure that a client is placed on a waiting list for services with the client’s consent, and only if no other appropriate agencies are able to provide necessary services or willing or able to accept the client. Written documentation of the waiting client’s status and agencies approached must become a part of the client’s file.

   b. SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) agrees to make a full attempt to connect clients to services prior to placing them on a waiting list.

5. Intake and Assessment:

   a. SUBRECIPIENT through contracted service SUBRECIPIENT agencies ensures that an initial intake will be completed on each client no later than five (5) working days after the client has been accepted for treatment.
b. SUBRECIPIENT shall ensure that an intake document will be utilized for the initial intake of each client referred or who has requested services. The intake information shall include, but not be limited to:
   i. Basic demographic information on the patient;
   ii. A clear statement of the client’s needs and/or presenting problem(s);
   iii. A determination as to whether the client meets the criteria established by the agency and is acceptable for mental health counseling

c. If the client does not meet the criteria, the intake clinician shall refer the client to the appropriate source and document attempts at referral

d. SUBRECIPIENT ensures that a written psychosocial evaluation will be completed on clients by the third visit. The evaluation shall include, but shall not be limited to:
   i. Referral source;
   ii. Date opened;
   iii. reason for referral;
   iv. family/community resources, indicating name, relationship to client and means of contacting, and an indication as to whether resource(s) is (are) identified by client or by someone else as supportive;
   v. financial sources of income, indicating how the client is managing and type of medical coverage;
   vi. housing/living situation with details, depending upon medical situation and degree of client infirmity;
   vii. personal/social history;
   viii. clinician's impressions; and
   ix. written consent for mental health services

6. SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) shall ensure that a written consent form to provide services, is signed by the client, dated, and witnessed during the first face-to-face contact.

7. Treatment Plan:
   a. SUBRECIPIENT ensures that a comprehensive treatment plan is completed for clients within thirty (30) days of admission to the program. This plan will include issues, goals, and objectives presented by the client as well as those identified in the individual’s psycho-social history and evaluation, and shall be prioritized from the most important to the least. The comprehensive treatment plan shall be revised as clients meet goals, and as new goals arise and are identified.
   b. SUBRECIPIENT ensures that treatment plan will be made up of issues, goals and objectives taken directly from the comprehensive treatment plan. This plan shall include but not be limited to the:
i. Treatment goals and objectives for the period (which shall include but not be limited to the most important ones identified on the priority list);

ii. Action steps, including time frames, related to each service care goal on the treatment plan, and;

iii. A good faith attempt to obtain the signature of the client (or designated representative) on the treatment plan, which acknowledges a client’s agreement with the plan. This plan will be updated every ninety (90) days.

c. SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) ensures that it will incorporate relevant medical information into the client’s treatment plan. SUBRECIPIENT shall obtain this information from each client’s physician unless it is considered unnecessary. This will be determined on a case-by-case basis, and the decision will be documented in the client’s chart.

d. SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) assures that a treatment contract denoting the plan of action is incorporated into a client/agency contract, which is dated and signed by the client and clinician. The contract shall include the agency’s definition of mental health counseling, general expectations of agency/clinician and client, grievance procedures, consequences of non-compliance with the plan, relevant re-entry requirements, and assurance of privacy and confidentiality.

e. In the event that the client is hospitalized for mental health reasons, SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) ensures that, if requested, a copy of the client’s psychosocial evaluation, treatment plan and a summary of the client’s current social and medical status are provided to the HIV Coordinator or Social worker.

f. In the event that the client is hospitalized for medical purposes, SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) ensures that, if requested the client’s psychosocial evaluation, treatment plan, and a summary of the client’s current social and medical status will be provided to the hospital-based HIV Coordinator or Social worker.

g. SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) ensures that progress notes will be regularly documented in the client’s chart. The Data/Assessment/Plan (DAP) format, or a system which includes the clinician’s

   i. Relevant observations of the interactions
   ii. An analysis/evaluation of the interaction, and
   iii. The plan of action resulting from the interaction shall be utilized for progress notes.
8. Discharging/ Noncompliant Clients:
   a. SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) agrees to move a case to inactive status when the client chooses not to use the mental health counseling services for a period of ninety (90) days, when a client is noncompliant, or their behavior is contrary to the philosophy of the agency. The agency may keep a case open beyond the ninety (90) day period if it is the policy of the agency to do so.
   b. SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) shall make a reasonable, documented attempt to assure that an evaluation between the clinician and the client occurs in a face-to-face interview, either when the case becomes inactive, or at/near the closing of the case. The therapist must determine, with the client, whether the agreed upon activities were effective and why. If a face-to-face interview is not possible, then a phone interview will be conducted.
   c. SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) ensures that a written summary and evaluation is completed on each client upon termination of services. The summary will include the effectiveness of the therapy in achieving the goals of constructive personality and behavioral change.
   d. SUBRECIPIENT through their BHS contract (or contracted service SUBRECIPIENT agencies) assures that a client is made aware of his/her case status change through written correspondence.

9. Mental Health - Behavioral Health Consulting Services:
   According to SAMHSA – HRSA Center for Integrated Health Solutions, Behavioral Health integration encompasses the management and delivery of health services so that individuals receive a continuum of preventive and restorative mental health and addiction services, according to their needs over time, and across different levels of the health system. Successful integration involves more than increasing access to behavioral health services through enhanced referral processes or co-location; the system of care delivery is transformed.
   a. SUBRECIPIENT agrees to build and maintain effective relationships with community partners, and, whenever possible, sign a Memorandum of Agreement (MOA) between the implementing agency and community partners to facilitate the referral process.
   b. SUBRECIPIENT agrees to provide consultation to and coordination of care of patients with primary care staff. Identify, refer, and advocate for patients needing specialty behavioral health services and other services as needed.
c. SUBRECIPIENT shall assure that in the event any individual presenting for services and is experiencing a crisis, the SUBRECIPIENT will immediately respond to this crisis. The crisis will be defined as acute emotional distress (i.e., psychosis or grief); suicidal and/or homicidal ideation; physical symptoms which appears emergent in nature, whether caused by HIV or not, and; situations resulting from apparent negligence, violence, or abuse.

d. SUBRECIPIENT shall develop crisis intervention and ensure that services are culturally sensitive and competent, developmentally appropriate, linguistically specific, and sensitivity to sexual and other identity issues.

XIV. Non-Medical Case Management

1. SUBRECIPIENT agrees Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

2. SUBRECIPIENT shall agree to abide by the Ryan White Certification Parameters, as stated in Medical case management.

3. SUBRECIPIENT agrees Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing
   a. Medical
   b. Social
   c. community
   d. legal
   e. financial, and other needed services.

4. SUBRECIPIENT agrees Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as
   a. Medicaid, Medicare Part D
   b. State Pharmacy Assistance Programs
   c. Pharmaceutical Manufacturer’s Patient Assistance Programs
   d. other state or local health care and supportive services
   e. health insurance Marketplace plans.

5. SUBRECIPIENT shall insure several methods of communication be used for management including
   a. face-to-face
   b. phone contact
   c. any other forms of communication deemed appropriate by the RWHAP Part recipient.
6. SUBRECIPIENT shall insure activities include:
   a. Initial assessment of service needs
   b. Development of a comprehensive, individualized care plan
   c. Continuous client monitoring to assess the efficacy of the care plan
   d. Re-evaluation of the care plan at least every 6 months with adaptations as necessary
   e. Ongoing assessment of the client’s and other key family members’ needs and personal support systems

7. SUBRECIPIENT shall ensure that clinicians associated with this program are expected to be current on relevant HIV/AIDS information. Each member of the case management staff is expected to complete at least eight (8) hours of HIV specific continuing education per year. This must be documented by the program and available for review by the regional subrecipient upon request.

XV. OTHER PROFESSIONAL SERVICES (Legal, Reunification, and Tax Preparation Services)

1. SUBRECIPIENT will render Other Professional Services to people living with HIV/AIDS in the Commonwealth of Pennsylvania. Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Funds may be used to support and complement pro bono activities. All legal assistance will be provided under the supervision of an attorney licensed by the Pennsylvania Bar Association Implicit in these service provisions is the responsibility of SUBRECIPIENT to offer and enhance, without charge.

Such services may include:
   a. Assistance with public benefits such as Social Security Disability Insurance (SSDI)
   b. Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP
   c. Preparation of: healthcare power of attorney, durable power of attorney, and living will.
   d. Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including: Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney and Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
   e. 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
2. SUBRECIPIENT will maintain regular office hours that are clearly communicated and based upon times that are most convenient for clients.

3. SUBRECIPIENT shall ensure adequate, professionally credentialed staff is available to meet the goals and objectives of the clients with respect to their legal needs.

4. SUBRECIPIENT shall ensure that an intake and assessment are completed for all clients. The intake/assessment shall include at a minimum: client name; address and phone number; description of their legal needs and determination if those needs are appropriate for short- or long-term legal.

5. SUBRECIPIENT shall respond to any inquiry or request for Other Professional Services by contacting the client or the referring HIV/AIDS-service organization within seventy-two (72) hours of the initial request. SUBRECIPIENT agrees to complete a full assessment and decide whether to accept a case or to make the appropriate referral within a reasonable amount of time after the initial 72 hours, depending on the client's circumstances and urgency of the situation.

6. SUBRECIPIENT shall render Other Professional Services to clients at no charge. These services will include, but not be limited to: direct representation, legal referrals, legal information and advice; and other referrals that are may not be legal, to state, city or federal agencies.

7. SUBRECIPIENT shall develop a client referral documentation system.

8. SUBRECIPIENT shall enhance the availability of Other Professional Services through collaborative efforts with other legal service agencies. A list of collaborating agencies and attorneys shall be provided annually to the regional grantee.

9. Legal services do not include guardianship or adoption of children after the death of their legal caregiver, criminal defense, discrimination or class action litigation unrelated to Ryan White services.

10. SUBRECIPIENT will offer a multitude of legal service issues which include but are not limited to: Wills; Discrimination in employment, housing, and benefits; Custody/visitation rights, Future custody planning, Foster care, and Adoption.

11. SUBRECIPIENT will develop and publish an in-depth manual for Medical Case Managers covering the substantive areas of HIV/AIDS related law. The manual will contain benefits information, advocacy tips and relevant legal forms on all aspects of HIV/AIDS related law for case managers, clients and social workers. The manual will serve as a reference tool for service SUBRECIPIENTs to identify legal problems and take correct actions without needing the assistance of a fee for service attorney. The following is a list of benefits and laws to be covered in the manual:
   a. Social Security, Medicaid, Food Stamps
b. Temporary Assistance for Needy Families (TANF)
c. Discrimination in Employment and Public Accommodation
d. HIV/AIDS-related Medical Assistance
e. HIV/AIDS-related Discrimination
f. Insurance issues
g. Wills, Powers of Attorneys and Living Wills
h. General Advocacy tips
i. How a lawyer and the SUBRECIPIENT can help the client

12. SUBRECIPIENT agrees to develop, print, and distribute this manual, producing updates as needed.

13. SUBRECIPIENT further agrees Other Professional Services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

XVI. ORAL HEALTH CARE

1. SUBRECIPIENT agrees that Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

2. SUBRECIPIENT shall ensure that the following process is utilized in accepting patients and providing treatment: Intake and screening, assessment of patient needs, implementation of the plan, follow-up visits, and reassessment (disposition and termination).

3. SUBRECIPIENT shall ensure a comprehensive treatment plan will be completed and implemented by a qualified SUBRECIPIENT in collaboration with the patient. This is evidenced by the treatment plan being agreed upon by patient and dentist following a discussion of all options.

4. SUBRECIPIENT shall ensure preventive dental health maintenance will occur, as evidenced by documentation of patient education in dental hygiene.

5. SUBRECIPIENT shall ensure that an educational component be included during each primary dental visit, with follow-up as required by the patient and/or program.

6. SUBRECIPIENT shall ensure that a comprehensive evaluation is completed at the initial routine visit and updated at each visit as needed. This is evidenced by documentation of the following:
   a. Confirmation of HIV status with written documentation of laboratory results, or a signed and dated statement of HIV diagnosis from the client’s physician;
   b. A complete dental and, as appropriate, medical history;
c. Diagnostic studies performed within the past six months, which include
   i. CBC with differential;
   ii. Biologic and virologic markers specific to HIV disease;
   iii. Hepatitis serology at baseline;
   iv. Serum chemistries at baseline
   v. PPD yearly;
   vi. RPR/VDRL at baseline.

(These can be requested from, and provided by the patient’s primary medical care provider.)

7. SUBRECIPIENT shall ensure routine dental services under this contract include:
   a. Initial and Check-up Examinations
      i. Full mouth x-rays
      ii. Bite wing x-rays
      iii. Panorex for edentulous
      iv. Panorex plus PA’s for clients with only a few remaining teeth
      v. Exam and treatment plan
      vi. General Cleaning
      vii. Scaling/root planning
   b. Simple filling of cavities
      i. Amalgam restoration
      ii. Resin restoration
      iii. Fluoride trays for dry mouth or high caries rate
   c. Prosthetics
      i. Four (4) units of fixed prosthetics per year
      ii. Post and core for endodontically treated teeth
      iii. Full dentures (one set every seven years, reline at six months post-extraction, one reline every two years)
      iv. Metal partials (for five missing teeth)
      v. Acrylic partials (including immediate partials for front teeth)
      vi. Add on teeth for new extractions
      vii. Simple denture repair
   d. Oral Surgery
      i. Extractions
      ii. Oral lesion biopsies

8. SUBRECIPIENT shall ensure that patients presenting with HIV related gingivitis, periodontitis, acquired anodontia, caries and dento-alveolar abscess, would receive services appropriate for the purpose of eradication of soft/hard tissue pathology in the oral cavity.
   Method:
   a. Exodontia of non-restorable teeth
   b. Excision of granulomatous tissue
   c. Periodontal maintenance
   d. Restoration of carious lesions
e. Replace missing teeth with prosthesis to restore masticatory function

9. SUBRECIPIENT ensures that, for each patient’s individual need, coordination will be maintained between appropriate medical services and the dental program according to his/her medical condition, and the patient chart will reflect this.

10. SUBRECIPIENT shall ensure that universal precautions for infection control are used at all times during treatment to ensure that appropriate infection control is maintained. Evidence of this shall be kept on file and provided upon request.

11. SUBRECIPIENT shall ensure that all dental instruments used for examinations and treatments shall be cleaned and sterilized using current methods and standards for infection control. Evidence of this shall be kept on file and provided upon request.

12. SUBRECIPIENT shall ensure that equipment used for sterilization is properly maintained using current standards for this purpose. Evidence of this shall be kept on file and provided upon request.

13. SUBRECIPIENT ensures that the services of this program are provided in a culturally and linguistically sensitive manner.

14. SUBRECIPIENT shall ensure that all records including but not limited to appointment logs, client logs, activity logs, client charts, and medical records will be made available for review by the regional grantee in order to monitor work performed and reported under this contract. No materials bearing primary client identifiers will be removed from the site.

15. SUBRECIPIENT shall ensure that a record is maintained concerning the number of persons who applied for dental services, any who were not awarded services, and the reasons for the denial of services.

16. SUBRECIPIENT shall ensure that OSHA, CDC and ADA guidelines are strictly observed.

17. SUBRECIPIENT shall ensure that each client is given a Dental Service Reimbursement Form, on agency letterhead, authorizing communication between the agency and the dentist regarding financial need and the arrangement for the reimbursement of dental care.

18. SUBRECIPIENT shall ensure that the dental care SUBRECIPIENT complete a comprehensive dental evaluation at the initial visit, which will be updated as needed. This requirement will be included in any Letter of Agreement with a dental care SUBRECIPIENT.
19. SUBRECIPIENT shall ensure routine dental services for HIV patients occur every six months. SUBRECIPIENT shall ensure routine services under this contract include:
   a. Check-up/routine examinations
   b. Full dentures
   c. full mouth x-rays
   d. crowns and caps
   e. bite wing x-rays
   f. oral surgery
   g. scaling/root planning
   h. simple filling of cavities
   i. amalgam restoration
   j. general cleaning
   k. resin restorations
   l. oral lesion biopsies
   m. Extractions
   n. Removable dentures
   o. Dental implants

20. SUBRECIPIENT shall ensure proper identification and treatment of the most indicative oral manifestations of the HIV/AIDS
   a. Oral Candidiasis, Aphthous Stomatitis and Herpes Simplex with CD4 count of 500 cells/mm or below
   b. Oral Hairy Leukoplakis and Opportunistic Tumors with CD4 count below 200

21. SUBRECIPIENT ensures that, for each individual’s needs, coordination will be maintained between appropriate medical services, including the dental program, according to his/her medical condition, and will be noted in the SUBRECIPIENT patient chart.

22. In cases where transportation may be a deterrent to receiving services, SUBRECIPIENT must ensure that appropriate referral and/or coordination of transportation services is provided to the consumer.

23. SUBRECIPIENT shall ensure that the following process is utilized in accepting patients and providing treatment.
   a. Intake and screening: The responsible personnel will identify from referral calls those clients requiring, seeking, or eligible for dental services.
b. Assessment of patient needs: A comprehensive evaluation to determine the patient’s situation and his or her chief complaint will be gathered by the intake coordinator. In many cases this will be determined as a result of a team process with various persons (staff, dentist, physician, case worker, client, significant other, or other agency) contributing data and perceptions that will help formulate a subjective chief complaint. Also, assurance that the client assessment will be waived for current clients and may be postponed for clients who present with emergency dental problems.

c. Clinical Care Plan: The dentist will gather objective evaluation of the patient’s chief complaint by performing intra- and extra oral screenings. The dentist will implement a clinical care plan with full participation of the client. One of the treatment goals will be to provide education and information to the client and care giver in order that the individual can make informed choices in his/her plan of care.

d. Implementation of the plan: This step will be the translation of the plan into practice through clinical procedures to be performed by the attending dentist, and the education component by the hygienist and/or dentist.

e. Monitoring: Follow-up visits and/or phone calls will be done based on need and severity of clinical problem, the purpose to monitor clinical progress of chief complaint and satisfaction with service.

f. Reassessment: A phone or follow-up visit reevaluation will be conducted within an established time frame or as needs or circumstances change.

g. Disposition and termination: Agreed-upon criteria for continuing the dentist-patient relationship will be developed. These criteria may include the need for extensive dental care beyond the scope of the intended service of the homebound dental program, the need for continuing palliative dental service after the program, and patient satisfaction with the service.

24. SUBRECIPIENT ensures that, for each individual's needs, coordination will be maintained between appropriate medical services, including the dental program, according to his/her medical condition, and will be noted in the provider patient chart.

XVI. Outpatient/Ambulatory Health Services

1. SUBRECIPIENT shall assure Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans, where clients do not stay overnight. Emergency rooms are not considered outpatient settings.

2. SUBRECIPIENT agrees that Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.
3. SUBRECIPIENT shall ensure that any new HIV patient provided treatment under this contract shall receive a comprehensive health history and physical examination during the patient’s initial outpatient visit, with a follow-up visit scheduled within four weeks after the initial visit. It is recommended that the HIV examination be conducted within five days of receipt of the initial request or referral. SUBRECIPIENT further agrees that the agency will provide these services to all existing HIV patients. These services shall include but not be limited to:

a. Documentation of HIV status
b. A comprehensive evaluation, which includes a complete medical history and physical exam, mental status history and evaluation, review of all organ systems, and past and present HIV risk behavior
c. Baseline diagnostic studies. Current laboratory studies including but not limited to: CBC with differential, lymphocyte subsets, biologic and virologic markers specific to HIV disease; hepatitis serology (for adults only), serum chemistries; toxoplasmosis serology (for adults only, if applicable to disease stage); PPD or IGRAT-spot, RPR/VDRL (for sexually active individuals); and PAP screens. SUBRECIPIENT agrees to adjust these studies from time to time, as determined appropriate by the United States Public Health Services (USPHS) and other authorities in the treatment of HIV disease.
d. Allowable activities include: medical history taking, lab testing, treatment management of physical and behavioral health conditions, behavioral risk assessment, subsequent counseling, referral, preventive care and screening, pediatric developmental assessment, prescription, management of medication therapy, treatment adherence, education and counseling on health and prevention issues, and referral to and provision of specialty care related to HIV diagnosis (includes all medical subspecialties even ophthalmic and optometric services).

4. SUBRECIPIENT shall ensure that all charges to HIV patients who receive care under this contract will be made in accordance with Ryan White HIV/AIDS Extension Act of 2009 legislative guidelines and, SUBRECIPIENT further ensures that all services will be billed to third party payers whenever possible.

5. SUBRECIPIENT shall maintain a diagnostic fund sufficient to ensure that uninsured and under-insured patients receive laboratory tests and other diagnostic studies needed to conform to the standard of care per EMA standards.

6. SUBRECIPIENT agrees to provide Medical Case Managers assigned to SUBRECIPIENT’s patients with medical documentation for medical case management services every six (6) months. The following key elements are required: dates of medical visits, dates and values of CD4 counts, dates and values of viral loads, and most recent HIV antiretroviral medications prescribed in the preceding six (6) months.
7. SUBRECIPIENT shall take steps to help ensure that immunizations and prophylactic HIV-specific and HIV-related prescription medications are made available to HIV infected persons regardless of insurance status. SUBRECIPIENT shall ensure that opportunistic infection prophylaxis occurs based on the USPHS guidelines for opportunistic infection prophylaxis and treatment.

8. SUBRECIPIENT shall ensure that a treatment plan is developed and implemented in collaboration with the HIV-infected patients at the first visit after diagnostic test results have been received, and shall be ratified at the next visit or when further follow-up test results are available.
   a. Planned course of HIV antiretroviral medication prescription, medication adherence regimen, and referrals to other services to support the treatment plan.
   b. The treatment plan shall be consistent with the most recent version of the Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents or Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection developed by the Department of Health and Human Services.
   c. SUBRECIPIENT shall note any reasons for exceptions to the aforementioned guidelines in the client’s chart when developing and implementing the treatment plan.
   d. The treatment plan shall be evaluated at each medical visit with the patient.

9. SUBRECIPIENT will schedule patient visits at a minimum of once every six (6) months or as indicated in the Department of Health and Human Services Guidelines for Treatment of HIV.

10. Referrals shall be made by the SUBRECIPIENT for other services related to maintaining the treatment plan, including both HIV Care and Prevention services.

11. SUBRECIPIENT shall ensure that consumers who present for Ambulatory/Outpatient Care with issues/barriers that may preclude them from being adherent to HIV/AIDS treatment and care will be referred to and assigned Medical Case Management Services. SUBRECIPIENT shall ensure that all kept referrals are properly documented in each patient chart.

12. SUBRECIPIENT shall ensure that the Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents or Guidelines for Prevention and Treatment of Opportunistic Infections among HIV-Exposed and HIV-Infected Children developed by the Department of Health and Human Services is followed when:
   a. Screening for latent tuberculosis infection via a tuberculosis skin test or interferon-gamma release assay per the most recent version.
   b. Providing immunizations
c. Conducting health screenings, including mental health screening and substance abuse screening annually or more frequently if clinically indicated, among others.

**Assessing Prophylaxis/ Other**

- d. Assessing for prophylaxis and/or treatment for opportunistic infections.
- e. Other health services as indicated by HIV-infected patient’s age and risk.
- f. For female patients: provision of or referral to routine annual gynecological examination or more frequently if clinically indicated. The examination shall include, but is not limited to, breast examination, pelvic exam, gynecological related medical history, cervical cancer screening, colposcopy if clinically indicated, screening for sexually transmitted infections, pregnancy testing, and family planning. SUBRECIPIENTs who refer for gynecological care shall obtain a report of the examination including the results of the cervical cancer screening and colposcopy (if clinically indicated). SUBRECIPIENTs who do not perform colposcopies onsite shall refer women as clinically appropriate for a colposcopy, assist the women in attending the appointment and obtain a report of the procedure including the result.
- g. For male patients: Colorectal and genital examinations as appropriate, screening for testicular abnormalities, other sexually transmitted diseases and hormone levels. SUBRECIPIENTs who refer for testing shall obtain a report of the examinations including the results.

13. SUBRECIPIENT shall ensure that there is a face-to-face assessment for each HIV-infected patient for the following areas every four to six months or more frequently if clinically indicated. A face-to-face assessment can be extended to annually for those HIV-infected patients who are adherent to therapy with sustained viral suppression and stable clinical status for more than 2-3 years. The assessment should include:
  - a. Review of systems
  - b. Physical examination
  - c. Assessment of treatment plan including assessment for treatment failure and changing therapy, assessment for treatment adherence, and assessment of side effects
  - d. Assessment of activities of daily living
  - e. Assessment of pain and pain management
  - f. Assessment of risk behaviors and provision of prevention referrals as needed
  - g. Assessment of psychosocial needs and provision of referrals as needed
14. SUBRECIPIENT shall ensure that patient chart documentation reflects patient understanding of treatment options, methods for reducing transmission to others and, if appropriate, from mothers to infants. Clinician will thoroughly explain all treatment options, including the consequences of interrupting or missing medications. SUBRECIPIENT shall ensure collaboration with HIV Medical Case Management SUBRECIPIENTS to address consumer issues/barriers to HIV/AIDS treatment adherence and care.

15. Medical Staff Qualifications: SUBRECIPIENT shall assure that any clinician providing outpatient/ambulatory medical care per the contract is HIV qualified. To be an HIV qualified clinician. An individual should be able to show continuous professional development by meeting the following qualifications:

   b. In the immediately preceding 24 months has successfully completed a minimum of 30 hours of Category 1 continuing medical education in the diagnosis and treatment of HIV-infected patients
   c. Recertification in the subspecialty of infectious diseases or initial board certification in infectious diseases in the preceding 12 months.
   d. Physicians and Nurse Practitioners providing outpatient/ambulatory medical care per the contract who do not meet the above qualifications shall be supervised by a physician who does meet the qualifications. Information documenting the above qualifications for the HIV-qualified physician at the SUBRECIPIENT site shall be available to the program analyst upon request.

   e. Physician Assistants on the contract to provide outpatient/ambulatory medical care must be supervised by a physician who meets the above qualifications and in accordance to approved American Medical Association guidelines.
   f. Physician Assistants providing outpatient/ambulatory medical care should be able to show continuous professional development by meeting the following qualifications:

      ii. In the immediately preceding 24 months have successfully completed a minimum of 20 hours of continuing medical education in the diagnosis and treatment of HIV-infected patients; and
      iii. Initial certification or recertification as a Physician Assistant every 6 years or as required by law.

   g. SUBRECIPIENT shall ensure that clinicians associated with this program are expected to be current on relevant HIV/AIDS information. Each member of the medical staff is expected to complete at least eight (8) hours of HIV specific continuing education per year. This must be documented by the program and available for review by the regional subrecipient upon request.
16. SUBRECIPIENT shall ensure that it adheres to the Medicaid reimbursement charges for laboratory tests, vaccines, office visits, and medications detailed above, as agreed with the regional subrecipient.

17. SUBRECIPIENT shall ensure that all patients are made aware of HIV-related services offered by the SUBRECIPIENT, and that other HIV-related referral, treatment, and educational information is made available for all patients.

18. SUBRECIPIENT shall ensure that secondary prevention efforts are integrated into ambulatory/outpatient medical care services for Persons Living with HIV/AIDS. Secondary prevention activities assist persons with HIV/AIDS in maintaining an optimal level of health, and prevent HIV re-infection.

19. SUBRECIPIENT shall ensure that appropriate diagnostic studies are provided. These studies will include, but are not limited to:
   a. CBC with differential
   b. Biologic and virologic markers specific for HIV disease such as HIV viral assays, HIV typology, and CD4 counts
   c. Hepatitis serology and further evaluation of active hepatitis B and/or C as clinically appropriate
   d. Serum chemistries
   e. Toxoplasmosis serology, when appropriate for disease stage.

20. SUBRECIPIENT shall ensure that diagnostic studies will be reported in Ryan White CAREWare monthly and submitted to PaDOH.

21. SUBRECIPIENT shall ensure that the laboratories utilized are State and/or Commonwealth licensed and approved.

22. SUBRECIPIENT shall assure patient understanding of purpose for all diagnostic tests, purpose of referrals, purpose of medications, and medication dosage schedules. Documentation of patient/caretaker verbalization of understanding shall be maintained in the patient’s chart.

23. SUBRECIPIENT shall develop and implement a process for identifying lost-to-care consumers, contacting those identified and encouraging them to re-enter care.

24. SUBRECIPIENT shall document attempts to contact lost-to-care consumers and document results in the consumer’s chart.

XVIII. Outreach Services

W. Outreach Services include the provision of the following three activities:
   a. Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
b. Provision of additional information and education on health care coverage options

c. Reengagement of people who know their status into Outpatient/Ambulatory Health Services

X. Outreach programs must be:

a. Conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior;

b. Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness;

c. Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort; and,

d. Targeted to populations known, through local epidemiologic data or review of service utilization data, to be at disproportionate risk for HIV infection.

Funds may not be used to pay for HIV counseling or testing under this service category. See Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services. Outreach services cannot be delivered anonymously as personally identifiable information is needed from clients for program reporting.

XIX. PSYCHOSOCIAL SUPPORT SERVICES

1. SUBRECIPIENT shall ensure that it employs staff with the appropriate educational background and credentialing. Compliance shall be maintained to meet all standards regarding:

   a. Staffing Credentialing Files:
      
      i. SUBRECIPIENTS will maintain credentialing files for all part-time or full time care (including consultants) and supervisory staff.

      ii. This will include all licensed and non-licensed staff providing support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling, including nutrition counseling by a non-registered dietician (excluding the provision of nutritional supplements).

   b. Documentation Requirements:

      i. SUBRECIPIENTS will maintain a standardized format order/chronology of standard consumer information forms.

      ii. A completed intake sheet/assessment shall include at a minimum: Client name; address and phone number; mode of transmission and other demographic information as required by CAREWare.

         1) A determination if psychosocial support services are appropriate

         2) A consumer rights form, and consent for psychosocial support services signed by the consumer during the first face-to-face contact.

   c. Clinical Supervision Staff Orientation:
i. All SUBRECIPIENTS will adhere to the Pennsylvania State guidelines, as well as discipline specific regulations, to provide supervision to all clinical staff

ii. SUBRECIPIENT agrees all staff providing services per the contract who do not meet the above qualifications shall be supervised by a licensed professional who does meet the qualifications. Information documenting the above qualifications shall be available to the program analyst upon request.

2. SUBRECIPIENT shall ensure that funds appropriated by the recipient are utilized as a payer of last resort for provision of services.

3. SUBRECIPIENT shall ensure that it maintains a log of all referrals of clients for medical case management, mental health, and other relevant services. PaDOH reserves the right to review this information on request. This information shall also be reflected in the client’s progress notes as appropriate.

4. SUBRECIPIENT shall ensure that progress notes will be regularly documented in the client’s chart in the Data Assessment/Plan (DAP) Format, or a system which includes the counselor’s:
   a. Relevant observations of the interaction,
   b. An analysis/evaluation of the interaction, and
   c. The plan of action resulting from the interaction,

5. SUBRECIPIENT shall ensure consumers receiving psychosocial support services are moved to inactive status when the client chooses not to participate in services for a period of ninety (90) days, when a client is non-compliant, or their behavior is contrary to the philosophy of the agency. The agency may keep a case open beyond the ninety (90) day period if it is the policy of the agency to do so.

6. SUBRECIPIENT shall make a reasonable, documented attempt to assure that an evaluation between the counselor and client occurs in a face-to-face interview, either when the case becomes inactive or at the closing of the case. The counselor must determine with the client, whether the agreed upon treatment plans were effective. If a face-to-face interview is not possible, then a phone interview will be conducted. If no contact can be made, this fact shall be documented in the client chart.

XX. Referral for Health Care/Supportive Services
1. SUBRECIPIENT agrees that Referral for Health Care and Support Services directs clients to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

2. SUBRECIPIENT agrees to build and maintain effective relationships with community partners, and, whenever possible, sign a Memorandum of Agreement (MOA) between the implementing agency and community partners to facilitate the referral process.

3. SUBRECIPIENT shall ensure Referral for Health Care includes benefits/entitlement counseling and referral to health care services to assist eligible clients to obtain access to other public and private programs for which they may be eligible. These services may include:
   a. Benefits Counseling: Services should facilitate a client’s access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting clients in identifying all available health and disability benefits supported by funding streams other than Ryan White/State Services funds. Clients should be educated about public and private benefits and entitlement programs and to provide assistance in accessing and securing these benefits.
   b. Health Care Services: Services should assist clients through the health care system and HIV Continuum of Care. Services focus on assisting client’s entry into and movement through the Ryan White Care service delivery network.

4. SUBRECIPIENT agrees all staff must be supervised by a degreed or licensed individual in the fields of health, social services, mental health or possess equivalent experience. Supervision must take place on a bi-weekly basis and be documented (log, CAREWare, EMR). Supervisors must review a 10 percent sample of each staff member’s client records each month for completeness, compliance with these standards, and quality and timeliness of service delivery.

5. SUBRECIPIENT shall develop crisis intervention and ensure that services are culturally sensitive and competent, developmentally appropriate, linguistically specific, and sensitivity to sexual and other identity issues.

XXI. Respite Care

1. SUBRECIPIENT shall ensure that respite care is a periodic, non-continuous care in a community or home-based settings that includes non-medical assistance.
2. SUBRECIPIENT shall ensure that respite care is designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

3. SUBRECIPIENT shall ensure recreational and social activities are allowable program activities as part of a respite care service.

4. SUBRECIPIENT shall ensure provider setting include licensed or certified drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

5. SUBRECIPIENT shall insure funds may not be used for off premise social/recreational activities or to pay for a client’s gym membership.

6. SUBRECIPIENT shall insure funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure.

7. SUBRECIPIENT shall insure that no direct cash payments to clients is permitted.

XXII. SUBSTANCE ABUSE OUTPATIENT CARE

1. SUBRECIPIENT shall ensure that it is currently licensed by the Commonwealth of Pennsylvania to provide substance abuse treatment services, and fully complies with the Commonwealth of Pennsylvania Department of Health and Office of Addiction Services (OAS).

2. SUBRECIPIENT shall ensure that it employs staff with appropriate educational background and substance abuse counseling training, including at a minimum a CAC (Certified Addictions Counselor), who will provide related substance abuse counseling under this contract. Consistent with state staffing regulations, SUBRECIPIENT will assure that staff is provided with ongoing in-service trainings in the field of Substance Abuse treatment.

3. SUBRECIPIENT shall ensure that Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:
   a. Screening
   b. Assessment
   c. Diagnosis, and/or
   d. Treatment of substance use disorder, including:
      i. Pretreatment/recovery readiness programs
      ii. Harm reduction
      iii. Behavioral health counseling associated with substance use disorder
      iv. Outpatient drug-free treatment and counseling
      v. Medication assisted therapy
vi. Neuro-psychiatric pharmaceuticals
vii. Relapse prevention
viii. Acupuncture therapy may be allowable only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.
ix. Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA or HAB- specific guidance

Confidentiality/Consent
4. SUBRECIPIENT shall ensure that a written consent form to provide service is signed by the client, dated and witnessed during the first face-to-face contact.

5. SUBRECIPIENT shall ensure that for each client receiving services, a record is maintained as to the client’s demographics and mode of HIV transmission. This information shall be provided to PADOH upon request.

Intake and Assessment
6. SUBRECIPIENT shall ensure that an initial intake is completed for each client immediately after a referral for substance abuse counseling has been made. This intake shall be no later than seventy-two (72) hours after the referral has been made. An exception will be in cases where the client is being referred by an inpatient facility. When this occurs, a client shall be scheduled for admission to the program within one business day after his/her discharge from the inpatient facility.

7. SUBRECIPIENT shall ensure that an intake document is utilized for the initial intake of each client. The intake information shall include, but not be limited to:
   g. Basic demographic information on the patient;
   h. Referral source and reason for referral;
   i. A clear statement of the client's needs and/or presenting problem(s);
   j. A determination as to whether the client meets the criteria established by the agency and is acceptable for substance abuse counseling. If the client does not meet the criteria, the counselor shall refer the client to the appropriate source and document referral efforts.
   k. Family and community resources, indicating name, relationship to client and means of contract person;
   l. Financial information and information about medical coverage, if any;
   m. Housing and current living situation, as well as any special needs;
   n. Counselor’s assessment.
8. SUBRECIPIENT shall ensure that, if during the initial intake, it is determined that a life-threatening crisis is being experienced by the consumer, intake will be suspended and immediate action taken to address the crisis. This determination as to whether to suspend intake and take immediate action must be based on established, written agency protocol. The written protocol for responding to crisis situations must be easily accessible to personnel. If it does not already exist, or if upon examination the protocol does not meet requirements, the agency must produce the protocol no later than ninety (90) days from the start of the contract period. This protocol must include clear guidelines for determining those crises which need immediate attention and those which are urgent but do not need attention at the moment the SUBRECIPIENT learns about the crisis.

9. SUBRECIPIENT shall ensure upon intake that it indicates for each client whether reimbursement will be expected through private insurance, medical assistance (including Targeted Medical Case Management), Ryan White (Part A, Part B) funding, or any combination of these. SUBRECIPIENT shall assure that all applicable regulations are taken into account in this determination.

Recordkeeping

10. SUBRECIPIENT shall ensure that it maintains a log of all referrals of clients for case management, mental health, and other relevant services. This information shall also be reflected in the client’s progress notes as appropriate.

11. SUBRECIPIENT shall ensure that it obtains the most up to date and relevant medical information possible from each client’s physician in order to ensure continuity of care. This information will be incorporated into the clients’ psychosocial evaluation and treatment plan. Where possible, client’s physician should also sign off on treatment plans.

12. SUBRECIPIENT shall ensure that progress notes will be regularly documented in the client’s chart. SUBRECIPIENT shall use the Data/Assessment/Plan (DAP) Format, or a system which includes the counselor’s:
   a. Relevant observations of the interaction,
   b. An analysis/evaluation of the interaction, and
   c. The plan of action resulting from the interaction shall be utilized for progress notes.

13. SUBRECIPIENT shall ensure that all client files are kept in a safe environment for confidentiality purposes. Files should be maintained in a locked and if possible fireproof file cabinet.

14. SUBRECIPIENT agrees to make client files available for review by the Regional grantee upon request.

Treatment Plans
15. SUBRECIPIENT shall ensure that a treatment agreement, which includes the initial plan of action, is incorporated into a client/agency information sheet or record, and is dated and signed by the client and counselor. The record shall include the agency's definition of substance abuse counseling/treatment, general expectations of agency/counselor and client, grievance procedures, consequences of non-compliance with the plan, relevant re-entry requirements, and assurance of privacy and confidentiality.

16. SUBRECIPIENT shall ensure that a comprehensive treatment care plan is completed for each client within thirty (30) days of admission to the program. This plan shall include issues, goals, and objectives presented by the client as well as those identified in the individual's psycho-social history and evaluation, and shall be prioritized generally from the most important to the least. The comprehensive care plan shall be revised as clients meet goals, and as new goals arise and are identified.

17. SUBRECIPIENT shall ensure that the comprehensive treatment care plan includes but not be limited to:
   a. The service care goals and objectives for the period (which shall include but not be limited to the most important ones identified on the priority list);
   b. Action steps in connection with each service care goal, including time frames connected with each goal
   c. A good faith attempt to obtain the signature of the client and/or designated representative on the service care plan (which acknowledges the client's agreement with the treatment plan). This plan will be updated every Thirty (30) days, or more often as required by progress

18. SUBRECIPIENT shall ensure that each treatment plan is reviewed, accepted, and signed by a staff psychiatrist on a quarterly basis.

19. In the event that the client is hospitalized, SUBRECIPIENT shall ensure that, should the information be relevant to medical treatment, a copy of the client's psychosocial evaluation, care plan and a summary of the client's current social and medical status is provided to the hospital-based HIV Coordinator, if requested.

**Discharge/Non-compliance**

20. SUBRECIPIENT shall ensure that it moves a case to inactive status when the client chooses not to participate in counseling services for a period of thirty (30) days, when a client is non-compliant, or their behavior is contrary to the philosophy of the agency. The agency may keep a case open beyond the thirty (30) day period if it is the policy of the agency to do so.
21. SUBRECIPIENT shall make a reasonable, documented attempt to assure that an evaluation between the counselor and client occurs in a face-to-face interview, either when the case becomes inactive or at the closing of the case. The counselor must determine with the client whether the agreed upon treatment plans were effective. If a face-to-face interview is not possible, then a phone interview will be conducted. If no contact can be made, this fact shall be documented in the client chart.

22. SUBRECIPIENT shall ensure that a client will be made aware of their case status change through correspondence or other written documentation.

23. SUBRECIPIENT shall ensure that in a case where a client cannot be informed of his/her status change, that appropriate documentation regarding this fact shall be placed in the client record including the discharge summary.

24. SUBRECIPIENT shall ensure that an aftercare plan is developed within the final two weeks of the client’s outpatient substance abuse treatment program. This shall be noted on the client’s care plan.

25. SUBRECIPIENT shall ensure that a discharge summary is completed within one (1) week of the client’s discharge from the outpatient substance abuse facility.
Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds
Policy Clarification Notice (PCN) #16-02 (Revised 12/05/16)
Replaces Policy #10-02

Scope of Coverage: Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

Purpose of PCN
This policy clarification notice replaces the Health Resources and Services Administration (HRSA) PCN 10-02: Eligible Individuals & Allowable Uses of Funds for Discretely Defined Categories of Services regarding eligible individuals and the description of allowable service categories for Ryan White HIV/AIDS Program and program guidance for implementation.

Background
The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the “Uniform Guidance,” are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of the subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

The HIV/AIDS Bureau (HAB) has developed program policies that incorporate both HHS regulations and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S.
Government Accountability Office may assess and publicly report the extent to which a RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government.

**Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds**

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received...will not be utilized to make payments 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. At the individual client level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is aggressively and consistently pursued (e.g., Medicaid, CHIP, Medicare, other local or State-funded HIV/AIDS programs, and/or private sector funding, including private insurance).

In every instance, HAB expects that services supported with RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

RWHAP funds are intended to support only the HIV-related needs of eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with RWHAP funds and the intended client’s HIV status, or care-giving relationship to a person with HIV.

**Eligible Individuals:**

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1 See sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.
The principal intent of the RWHAP statute is to provide services to people living with HIV, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HAB expects all RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for RWHAP services in limited situations, but these services for affected individuals must always benefit people living with HIV. Funds awarded under the RWHAP may be used for services to individuals affected with HIV only in the circumstances described below.

a. The service has as its primary purpose enabling the affected individual to participate in the care of someone with HIV or AIDS. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for someone who is living with HIV.

b. The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a RWHAP client’s portion of a family health insurance policy premium to ensure continuity of insurance coverage for a low-income HIV-infected family member, or child care for children, while an infected parent secures medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV-infected family member.

Unallowable Costs:
RWHAP funds may not be used to make cash payments to intended clients of RWHAP-funded services. This prohibition includes cash incentives and cash intended as payment for RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,2 vouchers,

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2 Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the RWHAP are allowable as incentives for eligible program participants.
coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards. 3

Other unallowable costs include:
- Clothing
- Employment and Employment-Readiness Services
- Funeral and Burial Expenses
- Property Taxes

Allowable Costs:
The following service categories are allowable uses of RWHAP funds. The RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement.

Service Category Descriptions and Program Guidance
The following provides both a description of covered service categories and program guidance for RWHAP Part recipient implementation. These service category descriptions apply to the entire RWHAP. However, for some services, the RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a RWHAP Part would cover all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to care for seropositive individuals, retention in care, and the provision of HIV treatment. To be an allowable cost under the RWHAP, all services must relate to HIV diagnosis, care and support, and must adhere to established HIV clinical practice standards consistent with HHS treatment guidelines. In addition, all providers must be appropriately licensed and in compliance with state and local regulations. Recipients are required to work toward the development and adoption of service standards for all RWHAP-funded services.

3 General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.
RWHAP clients must meet income and other eligibility criteria as established by RWHAP Part A, B, C, or D recipients.

**RWHAP Core Medical Services**

AIDS Drug Assistance Program Treatments

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

**RWHAP Support Services**

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services
Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

**Effective Date**

This PCN is effective for RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non-competing continuations.

**Summary of Changes**

**August 18, 2016** – Updated Housing Service category by removing the prohibition on RWHAP Part C recipients to use RWHAP funds for this service.

**December 12, 2016** – 1) Updated Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals service category by including standalone dental insurance as an allowable cost; 2) Updated Substance Abuse Services (residential) service category by removing the prohibition on RWHAP Parts C and D recipients to use RWHAP funds for this service; 3) Updated Medical Transportation service category by providing clarification on provider transportation; 4) Updated AIDS Drug Assistance Program Treatments service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.
Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the RWHAP to provide FDA-approved medications to low-income clients with HIV disease who have no coverage or limited health care coverage. ADAPs may also use program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. RWHAP ADAP recipients must assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services to ensure that purchasing health insurance is cost effective in the aggregate.

Eligible ADAP clients must be living with HIV and meet income and other eligibility criteria as established by the state.

Program Guidance:
RWHAP Parts A, C and D recipients may contribute RWHAP funds to the Part B ADAP for the purchase of medication and/or health insurance for ADAP-eligible clients.

See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B (formerly Title II), AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services;
PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance; and
PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

Description:
AIDS Pharmaceutical Assistance services fall into two categories, based on RWHAP Part funding.

1. Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or subrecipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

RWHAP Part A or B recipients using the LPAP service category must establish the following:

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• Uniform benefits for all enrolled clients throughout the service area
• A recordkeeping system for distributed medications
• An LPAP advisory board
• A drug formulary approved by the local advisory committee/board
• A drug distribution system
• A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum of every six months
• Coordination with the state’s RWHAP Part B ADAP
  o A statement of need should specify restrictions of the state ADAP and the need for the LPAP
• Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program

2. Community Pharmaceutical Assistance Program is provided by a RWHAP Part C or D recipient for the provision of long-term medication assistance to eligible clients in the absence of any other resources. The medication assistance must be greater than 90 days.

RWHAP Part C or D recipients using this service category must establish the following:
• A financial eligibility criteria and determination process for this specific service category
• A drug formulary consisting of HIV primary care medications not otherwise available to the client
• Implementation in accordance with the requirements of the 340B Drug Pricing Program and the Prime Vendor Program

Program Guidance:
For LPAPs: Only RWHAP Part A grant award funds or Part B Base award funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

For Community Pharmaceutical Assistance: This service category should be used when RWHAP Part C or D funding is expended to routinely refill medications. RWHAP Part C or D recipients should use the Outpatient Ambulatory Health Services or Emergency Financial Assistance service for non-routine, short-term medication assistance.

See Ryan White HIV/AIDS Program Part A and B National Monitoring Standards
See also LPAP Policy Clarification Memo
See also AIDS Drug Assistance Program Treatments and Emergency Financial Assistance

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Early Intervention Services (EIS)

Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- RWHAP Parts A and B EIS services must include the following four components:
  - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected
    - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
    - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
  - Referral services to improve HIV care and treatment services at key points of entry
  - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
  - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- RWHAP Part C EIS services must include the following four components:
  - Counseling individuals with respect to HIV
  - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
    - Recipients must coordinate these testing services under Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
    - The HIV testing services supported by Part C EIS funds cannot supplant testing efforts covered by other sources
  - Referral and linkage to care of HIV-infected clients to Outpatient/Ambulatory Health Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
  - Other clinical and diagnostic services related to HIV diagnosis
**Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals**

*Description:*
Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

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

To use RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part recipients must ensure that clients are buying health coverage that, at a minimum, 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 outpatient/ambulatory health services.
- RWHAP Part recipients must assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services to ensure that purchasing health insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

To use RWHAP funds for standalone dental insurance premium assistance, an RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.
Program Guidance:

Traditionally, RWHAP Parts A and B recipients have supported health insurance premiums and cost sharing assistance. If a RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

See:

PCN 07-05: Program Part B ADAP Funds to Purchase Health Insurance;

PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance;

PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid; and

PCN 14-01: Revised 4/3/2015: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

Home and Community-Based Health Services

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

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

Program Guidance:

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

Home Health Care

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

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

HIV/AIDS BUREAU POLICY 16-02
• Other medical therapies

Program Guidance:
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Hospice Services
Description:
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:
• Mental health counseling
• Nursing care
• Palliative therapeutics
• Physician services
• Room and board

Program Guidance:
Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:
• Initial assessment of service needs
• Development of a comprehensive, individualized care plan
• Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
• Continuous client monitoring to assess the efficacy of the care plan
• Re-evaluation of the care plan at least every 6 months with adaptations as necessary

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• Ongoing assessment of the client’s and other key family members’ needs and personal support systems
• Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
• Client-specific advocacy and/or review of utilization of services

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

Program Guidance:
Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:
• Nutrition assessment and screening
• Dietary/nutritional evaluation
• Food and/or nutritional supplements per medical provider’s recommendation
• Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All services performed under this service category must be pursuant to a medical provider’s referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

See Food-Bank/Home Delivered Meals

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**Mental Health Services**

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

*Program Guidance:*
Mental Health Services are allowable only for HIV-infected clients.

See Psychosocial Support Services

**Oral Health Care**

*Description:*
Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

*Program Guidance:*
None at this time.

**Outpatient/Ambulatory Health Services**

*Description:*
Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

*Program Guidance:*
Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services.
category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

See Policy Notice 13-04: Clarifications Regarding Clients Eligibility for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program

See Early Intervention Services

**Substance Abuse Outpatient Care**

**Description:**

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

**Program Guidance:**

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific guidance.

See Substance Abuse Services (residential)

**RWHAP Legislation: Support Services**

**Child Care Services**

**Description:**

The RWHAP supports intermittent child care services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care

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Appendix B-1
• Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

*Program Guidance:*
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

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

*Program Guidance:*
Direct cash payments to clients are not permitted.

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

See AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, and other corresponding categories

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

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

*Program Guidance:*
Unallowable costs include household appliances, pet foods, and other non-essential products.
See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the RWHAP.

Health Education/Risk Reduction
Description:
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:
- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients’ partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.

See Early Intervention Services

Housing
Description:
Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

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

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

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

RWHAP Part A, B, C, and D recipients, subrecipients, and local decision making planning bodies are strongly encouraged to institute duration limits to housing services. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients and subrecipients consider using HUD’s definition as their standard.

Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.4

Housing services, as described here, replaces the guidance provided in PCN 11-01.

**Legal Services**
See Other Professional Services

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

*Program Guidance:*
Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

**Medical Transportation**
*Description:*
Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

*Program Guidance:*
Medical transportation may be provided through:
- Contracts with providers of transportation services

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4See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.
• Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
• Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
• Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
• Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

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

Non-Medical Case Management Services
Description:
Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:
• Initial assessment of service needs
• Development of a comprehensive, individualized care plan
• Continuous client monitoring to assess the efficacy of the care plan
• Re-evaluation of the care plan at least every 6 months with adaptations as necessary
• Ongoing assessment of the client’s and other key family members’ needs and personal support systems

Program Guidance:
Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

**Other Professional Services**

*Description:*

Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- **Legal services** provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills

- **Permanency planning** to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

- **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

*Program Guidance:*

Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

*See* [45 CFR § 75.459](#)

**Outreach Services**

*Description:*

Outreach Services include the provision of the following three activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services

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**HIV/AIDS BUREAU POLICY 16-02**

Appendix B-1
• Provision of additional information and education on health care coverage options
• Reengagement of people who know their status into Outpatient/Ambulatory Health Services

_Program Guidance:_
Outreach programs must be:
• Conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior
• Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness
• Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort
• Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection

Funds may not be used to pay for HIV counseling or testing under this service category.

See _Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services_. Outreach services cannot be delivered anonymously as personally identifiable information is needed from clients for program reporting.

See Early Intervention Services

**Permanency Planning**
See Other Professional Services

**Psychosocial Support Services**
_Description:_
Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:
• Bereavement counseling
• Caregiver/respite support (RWHAP Part D)
• Child abuse and neglect counseling
• HIV support groups
• Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
• Pastoral care/counseling services

_Program Guidance:_

**HIV/AIDS BUREAU POLICY 16-02**
Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals).

RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds may not be used for social/recreational activities or to pay for a client’s gym membership.

For RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under RWHAP Part D.

See Respite Care Services

**Rehabilitation Services**

*Description:*
Rehabilitation Services are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client’s quality of life and optimal capacity for self-care.

*Program Guidance:*
Examples of allowable services under this category are physical and occupational therapy.

**Referral for Health Care and Support Services**

*Description:*
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

*Program Guidance:*
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

**Respite Care**

*Description:*

**HIV/AIDS BUREAU POLICY 16-02**

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Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

Program Guidance:
Recreational and social activities are allowable program activities as part of a respite care service provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may not be used for off premise social/recreational activities or to pay for a client’s gym membership.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

See Psychosocial Support Services

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

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

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the RWHAP.

Acupuncture therapy may be allowable funded under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the RWHAP.
RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.
HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)

Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Frequently Asked Questions

GENERAL:
1. Are practitioners who provide RWHAP services required to have a professional license?

When licensure/certification is required by state and/or local regulations, providers must be appropriately licensed and in compliance with those regulations.

2. Do subrecipients have to adhere to the service category descriptions?

Yes, subrecipients must adhere to the service category descriptions. RWHAP recipients must ensure that subrecipients adhere to the service categories descriptions when developing contracts or memorandums of understanding and through their monitoring processes and procedures.

CORE MEDICAL SERVICES:
3. Which service categories can be used to purchase medications?

Purchasing of medications can be done through many service categories. To determine the appropriate category, review the program guidance under: AIDS Drug Assistance Program (ADAP) Treatments, Outpatient Ambulatory Health Services (OAHS), Emergency Financial Assistance (EFA), AIDS Pharmaceutical Assistance (i.e., Local Pharmaceutical Assistance Program (LPAP), Community Pharmaceutical Assistance), Substance Abuse Outpatient Care, Substance Abuse Services (residential), and/or Hospice Services.

4. During a medical care visit, there are immediate needs by the client to obtain a medication. Can a provider dispense this medication as part of that medical care visit and have the service categorized under Outpatient Ambulatory Health Services or EFA?

RWHAP recipients should not make the dispensing of medications a standard practice. When this does occur, on a rare occasion, the recipient should document such service under EFA. If EFA is not available (due to lack of contract or processes in place), the service can be documented under OAHS if the medication is dispensed as part of a medical visit and there is an immediate and urgent medical need.

5. As a direct medical care provider funded by Part C, which category should be used to capture the dispensing of medication?

Depending on the model of care, a direct provider of care could provide services under three different categories: AIDS Pharmaceutical Assistance (Community Pharmaceutical Assistance, Community Pharmaceutical Assistance, and/or Hospice Services).
Assistance), OAHS (prescription and management of prescription therapy), or EFA. Availability of pharmaceutical resources will influence which category is used.

6. Under OAHS, does prescription and management of medication include dispensing?

When the medications are not funded by any other source (such as ADAP or LPAP as part of AIDS Pharmaceutical Assistance), OAHS is an option if resources are available until such time that the client can be enrolled in other programs to pay for medications. The dispensing of medication should be in the context of a medical visit. This should be on a short term basis until recipients enroll clients in ADAP, AIDS Pharmaceutical Assistance or EFA.

7. What is the difference between a local pharmaceutical assistance program for indigent populations that is run and funded by a state or local government and the AIDS Pharmaceutical Assistance/LPAP service category described by HRSA/HAB?

HAB’s use of the term LPAP is intended to differentiate this service from the state ADAP. It is a supplemental means of providing medication assistance for people living with HIV (PLWH) where there are various limits on the state ADAP; it is created and supported by the RWHAP recipient, although, in some instances, the RWHAP-supported LPAP may also receive state or local funding. HAB recognizes that many governments fund and provide, with their own generated resources, more general pharmaceutical assistance to a wide range of indigent populations within their jurisdiction, some of which are called local pharmaceutical assistance programs. To the extent that such programs are available to PLWH, they should be utilized, but the term “LPAP” under RWHAP does not constitute a reference to such programs.

8. Can I provide targeted HIV testing and referral services under Early Intervention Services (EIS)?

Yes, in conjunction with the other required components of EIS. RWHAP Parts A and B EIS must include the following four components: targeted HIV testing, referral services, access and linkage to HIV care and treatment services, and health education/risk reduction related to HIV diagnosis. Part C EIS services must include the following four components: counseling individuals with respect to HIV, high risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency), referral and linkage to care of HIV-infected clients, and other clinical and diagnostic services related to HIV diagnosis.

9. I am a Part C recipient. Can I use the Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals service category?

Traditionally, RWHAP Parts A and B funding support health insurance premiums and cost-
sharing assistance. If a RWHAP Part C or D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective. Equitable is a systematic approach that is fair.

10. How are medical case management and non-medical case management services different?

Medical Case Management (MCM) services help clients improve health care outcomes. MCM providers should be able to analyze the care that a client receives to ensure that the client is obtaining the services necessary to improve his/her health outcomes. Non-Medical Case Management (NMCM) services provide guidance and assistance to clients to help them to access needed services (medical, social, community, legal, financial, and other needed services), but may not analyze the services to enhance their care toward improving their health outcomes.

Both MCM and NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans.

Both service categories include several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient.

11. How do I know which service category should be used for treatment adherence?

Treatment adherence services are provided conjointly with many service categories such as OAHS, MCM, or ADAP. As such, recipients may choose to record treatment adherence within the service category during which the adherence service was given. In addition, if treatment adherence services are provided as a stand-alone activity, it can be reported under Health Education/Risk Reduction.

12. Who are authorized to provide Home Health Care services to RWHAP clients?

Home health care services must be prescribed by a licensed medical provider and can be performed by licensed medical professionals, such as physicians, mid-level providers, nurses, and certified medical assistants. This does not include non-licensed, in-home care providers.

SUPPORT SERVICES:

13. If there is another professional service that clients need, can I include it under other professional services?
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include: legal services, permanency planning, and income tax preparation services. Recipients should work with their project officer to discuss other allowable professional services that may fall within this category.

14. Can I include vocational therapy under the rehabilitation services category?

Yes, this is an allowable activity, but a recipient should establish policies regarding the use of this service, and ensure it is cost effective.

15. How do recipients define the length of life expectancy an individual must have in order to receive hospice care?

Recipients have the flexibility to define life expectancy, but must establish that criterion and implement it consistently.

16. Can a RWHAP recipient support intermittent child care services for the children living in the house of HIV-infected clients?

Recipients may use funds to cover child care services for HIV-infected clients to enable their attendance at medical visits, related appointments, and/or RWHAP and HIV-related meetings, groups, or training sessions. Direct cash payments to clients are not permitted. Funds used for this service should be limited and carefully monitored.

17. Should EFA funds that are used for allowable services (food, housing, transportation, etc.) be accounted under the corresponding service category or the specific category of EFA?

The funds should be counted under EFA regardless of how the funds were used.

18. Is transitional housing an allowable service under the RWHAP?

Yes. Recipients and local decision making planning bodies are strongly encouraged to institute duration limits to provide transitional and emergency housing services. HAB recommends that recipients consider using the U.S. Department of Housing and Urban Development’s definition of transitional housing as 24 months.

19. Can linguistic services be used to pay for translating printed materials such as ADAP application?

Yes, this activity would facilitate discussion between the provider and client regarding their service needs through a language that is understood.
HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)

Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Housing Services Frequently Asked Questions

1. What service category should be used if the housing service is a one-time payment for a utility bill? Is a housing assessment required for this one-time payment?

The housing service category covers transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment that extends beyond a one-time service. If a RWHAP recipient makes a one-time payment for a client’s utility or housing bill, this should be categorized as emergency financial assistance. A housing assessment and individualized housing plan would not be required for a one-time housing payment provided under emergency financial assistance.

2. A client comes in to receive services and it is determined that their housing needs extend beyond a one-time payment. If the client’s housing needs were previously assessed, would that client need an additional assessment?

If a RWHAP client’s housing needs extend beyond a one-time payment, and there is a need for additional housing services, this service should be categorized as housing. Clients receiving housing services must have their housing needs assessed annually and an individualized written housing plan developed to determine if there is a need for new or additional housing services.

3. Can RWHAP funds be used for rental deposits?

No, RWHAP funds may not be used for rental deposits. Because rental deposits are typically returned to clients as cash, this would violate the prohibition on providing cash payments to clients. In some instances, deposits may be retained as payment (e.g., damage to the property). As such costs would additionally be unallowable, recipients cannot pay for a rental deposit using federal funds, program income generated from federal funds, or pharmaceutical rebates generated from federal funds.
Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Standalone Dental Insurance Frequently Asked Questions

1. Can recipients offer both standalone dental insurance premiums and/or cost sharing assistance under the service category Health Insurance Premiums and Cost Sharing Assistance and RWHAP Oral Health Care services in their program?

Recipients and subrecipients are able to provide both service categories within their programs as long as the standalone dental insurance premium and/or cost sharing assistance and Oral Health Care services are provided in compliance with the requirements for each described in PCN #16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds.

2. Can recipients/subrecipients use RWHAP funds to pay for oral health care services that exceed annual expenditure caps established by standalone dental insurance plans?

RWHAP recipients and subrecipients are in the best position to understand the unique needs of their client populations, determine which costs are cost-effective to pay, and ensure availability of the resources equitably for eligible clients. It is up to the recipient and subrecipient to identify which costs they will cover related to standalone dental insurance, which can include: premiums, deductibles, co-payments, and/or costs above the cap. The recipient or subrecipient must have policies and procedures in place to ensure these services are available to all eligible RWHAP clients.

3. Can ADAP funds or pharmaceutical rebates be used to purchase standalone dental insurance premiums and/or cost sharing assistance?

ADAP funds cannot be used to purchase standalone dental insurance premiums and cost sharing assistance because standalone dental insurance does not cover the cost of medications necessary in treatment for people living with HIV. See PCN #13-05 Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost Sharing Assistance for Private Health Insurance for requirements for ADAPs to pay for Health Insurance Premiums and Cost Sharing Assistance for Individuals.

However, as PCN #15-04 Utilization and Reporting of Pharmaceutical Rebates explains, “the RWHAP legislation requires that rebates collected on ADAP medication purchases be applied to the RWHAP Part B Program with a priority, but not a requirement, that the rebates be placed back into ADAP. These rebates must be used for the statutorily permitted purposes under the RWHAP Part B Program which are limited to core medical services including ADAP, support services, clinical quality management, and administrative expenses (including planning and evaluation) as part of a comprehensive system of care for low-income individuals living with
HIV.” Pharmaceutical rebates earned by the RWHAP Part B Program may be used to pay for standalone dental insurance premiums and/or cost sharing assistance.

4. When does the addition of standalone dental insurance to the Health Insurance Premiums and Cost Sharing Assistance for Low-Income Individuals service category take effect?

PCN #16-02 is in effect for all awards made on or after October 1, 2016, including competing continuations, noncompeting continuations, supplements, and new awards.
APPENDIX C

Checklist, Signature Page and Summary Sheet
APPENDIX C
PROPOSAL CHECKLIST

ORGANIZATION: _______________________________________

ATTACH THIS CHECKLIST TO THE FRONT OF THE ORIGINAL PROPOSAL.

SUBMIT AN ORIGINAL AND 9 COPIES OF THE FOLLOWING COMPONENTS IN THE ORDER LISTED.
IF THERE ARE ANY COMPONENTS YOU WILL NOT BE SUBMITTING, PLEASE MARK N/A:

_____ Cover sheet with appropriate signatures in blue ink on the original
_____ Proposal Summary Sheet
_____ Organizational Profile
_____ Cultural Competency
_____ Personnel (Include agency organizational chart, current resumes and job descriptions)
_____ Needs Assessment
_____ Description of the service(s) to be funded. (Include in the description for each service: Service Description, Goals, Objectives, Prior Program Experience, Personnel and Evaluation)
_____ Prevention Intervention Plan Spreadsheet
_____ Quality Management (QM) – Plan and Quality Improvement (QI) Projects
_____ Any other documentation referenced in the proposal
_____ Form B-1, Agency Revenue/Expense Form
_____ Form B-2, Indirect Cost Distribution Form (complete a form for each fiscal year)
_____ Form B-3, HIV Personnel Form
_____ Form B-4, Service Expense Form (complete this form for each service proposed)
_____ Form B-5, Narrative to Budget Form (complete this form for each service proposed)
_____ Form B-6, Project Revenue & Request Form (complete this form for each service proposed)
_____ Form B-7, Unit Cost Determination – Hours Form (complete this form for each service proposed)

In addition to the hard copies of the fiscal forms, please submit them in Excel format via email to Kevin Westgate, Fiscal Officer, at aidsntkw@ptd.net

IN ADDITION, SUBMIT THE FOLLOWING ITEMS:

_____ One copy of a list of current members of the organization’s Board of Directors
_____ One copy of the IRS determination letter of 501(c) status (if appropriate)
_____ One copy of the organization’s most recent audit
_____ One copy of the organization’s management letter
APPLICATION TO CONTRACT FOR AIDSNET FUNDED SERVICES

FISCAL YEARS 2018-2020

SUBMITTED BY: __________________________________________________________
Agency/Organization providing proposed Subgrant services

WE, THE UNDERSIGNED, SUBMIT THIS PROPOSAL FOR PROGRAM SUBRECIPIENT STATUS.

Board Representative

(Signature)

(Print Name)

(Title)

Agency Director

(Signature)

(Print Name)

(Title)
AIDSNET PROPOSAL SUMMARY SHEET
APPLICATION FOR PROGRAM SUBRECIPIENT STATUS, FISCAL YEARS 2018-2020

I. APPLICANT AGENCY/ORGANIZATION

AGENCY NAME: ____________________________________________________________

STREET ADDRESS: ____________________________________________ SUITE/FLOOR: ______

CITY: ______________________ STATE: _____ ZIP + 4 digits: ________________

AGENCY TELEPHONE: ___________________ FAX: _________________________

CONTACT PERSON: ___________________________ TITLE: ________________

CONTACT PERSON E-MAIL ADDRESS: _______________________________________

CONTACT PERSON TELEPHONE: __________________________________________

GEOGRAPHIC AREA OF SERVICE: _________________________________________

EMPLOYER FEDERAL TAX ID NO.: *

* A 9-digit number that usually begins with 22 or 23

II. DIRECT CARE SERVICE CATEGORIES:

_______ Home and Community-Based Health Services
_______ Medical Case Management
_______ Mental Health Services
_______ Non-Medical Case Management
_______ Oral Health Care Services
_______ Other Professional Services (Legal/Permanency Planning)
_______ Psychosocial Support Services
_______ Substance Abuse (outpatient)

FOR AGENCIES APPLYING FOR CASE MANAGEMENT (Medical or Non-Medical): Please select the additional services you are applying to have included in your grant agreement.

_______ Emergency Financial Assistance (utilities, short-term rent, hotel/motel, prescriptions)
_______ Food Bank, Home and Congregate Meals
_______ Health Education/Risk Reduction
_______ Health Insurance Premium & Cost Sharing Assistance
_______ Housing
_______ Medical Transportation Services
_______ Outpatient/Ambulatory Health Services
_______ Permanent Housing Placement
_______ Short-Term Rent Mortgage Utility
_______ Tenant-Based Rental Assistance
_______ Case Management (HOPWA)

PREVENTION INTERVENTIONS LISTED ON THE DOH GUIDANCE:

_______ ARTAS
_______ Healthy Relationships
Partnership for Health-Safer Sex

PREVENTION INTERVENTIONS PREVIOUSLY APPROVED BY THE DOH:
  ______ CLEAR
  ______ Personal Cognitive Counseling (PCC)
  ______ VOICES/VOCES

PREVENTION INTERVENTIONS REQUIRING DOH APPROVAL:

List proposed Intervention(s): ____________________________________________
APPENDIX D

Guidelines for Prevention Job Titles, Education and Experience
# APPENDIX D

## GUIDELINES FOR STANDARDIZED PREVENTION JOB TITLES, EDUCATION AND EXPERIENCE

<table>
<thead>
<tr>
<th>Job Title*</th>
<th>Minimum Education</th>
<th>Other Minimum Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention Services Manager</td>
<td>BS/BA degree in education or related field</td>
<td><strong>Minimum:</strong> Experience in health related prevention education; supervisory and management experience; <strong>Additional:</strong> Strong organization skills; non-profit experience a plus; willingness to work with diverse populations; participate in mandatory trainings in HIV fundamentals and DOH C&amp;T certification; effective communication skills and reliable transportation.</td>
</tr>
<tr>
<td>Prevention Education Specialist II</td>
<td>Bachelor's degree in public health, health education, social work, psychology, human service or related field; or comparable experience may be accepted</td>
<td>Willingness to work with diverse populations; certification or willingness to become certified in ARC HIV fundamentals &amp; Prevention Instruction and CDC HIV Prevention Counselor; bi-lingual; reliable transportation.</td>
</tr>
<tr>
<td>Prevention Education Specialist I</td>
<td>Associates degree; related experience in community outreach or health/education related field or comparable experience may be accepted</td>
<td>Willingness to work with diverse populations; participate in mandatory trainings in HIV fundamentals and DOH C&amp;T certification; bi-lingual; reliable transportation.</td>
</tr>
<tr>
<td>Prevention Educator</td>
<td>HS diploma or equivalent</td>
<td>Basic knowledge of HIV; experience in community outreach, health/education or related field desirable; willingness to work with diverse populations; take mandatory trainings in HIV fundamentals and DOH C&amp;T certification; bi-lingual; reliable transportation.</td>
</tr>
</tbody>
</table>

*unless constricted by established institutional titles*
APPENDIX E

Outcome-Based Objectives: Prevention
ARTAS

- 60% of ARTAS participants will successfully link to medical care on or before the end of the 5th session or 90 days, whichever comes first. Successful linkage is defined as confirmed attendance at one appointment with an HIV health care provider.  *(Number of ARTAS participants linked to care over the total number of participants for this quarter)*

- 50% of ARTAS participants, who successfully link to medical care, will be retained in care, as defined by attending at least two appointments with an HIV health care provider within 12 months of completing the intervention.  *(Number of linked ARTAS participants that attended at least 2 appointments 12 months after the intervention over the total number of participants for linked to care)*

Additional ARTAS Data to be tracked and reported quarterly (based on calendar year of 1/1/XX to 12/31/XX):

1. Total number of ARTAS participants that linked to medical care during the quarter.

<table>
<thead>
<tr>
<th># of clients</th>
<th>By Risk Category</th>
<th># of clients</th>
<th>By Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV+ MSM/IDU</td>
<td>HIV+ African Americans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ MSM</td>
<td>HIV+ Hispanics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ IDU</td>
<td>HIV+ clients of other/unknown race/ethnicity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ heterosexuals</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ Other or unknown risk</td>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

2. Of the participants listed in #1 above, how many were newly diagnosed participants that were linked to treatment adherence?

<table>
<thead>
<tr>
<th># of clients</th>
<th>By Risk Category</th>
<th># of clients</th>
<th>By Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV+ MSM/IDU</td>
<td>HIV+ African Americans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ MSM</td>
<td>HIV+ Hispanics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ IDU</td>
<td>HIV+ clients of other/unknown race/ethnicity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ heterosexuals</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ Other or unknown risk</td>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>
3. Of the participants listed in #1 above, how many were lost to care/follow-up that were re-engaged in treatment adherence?

<table>
<thead>
<tr>
<th># of clients</th>
<th>By Risk Category</th>
<th># of clients</th>
<th>By Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HIV+ MSM/IDU</td>
<td>HIV+ African Americans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ MSM</td>
<td>HIV+ Hispanics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ IDU</td>
<td>HIV+ clients of other/unknown race/ethnicity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ heterosexuals</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV+ Other or unknown risk</td>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

CLEAR

- 50% of CLEAR participants will complete the 5 required core skill sessions and identify both a life goal and at least one prevention goal. (Number of CLEAR participants that “completed the core” over the total number of participants for this quarter)
- 30% of CLEAR participants who identify a life goal and at least one prevention goal will complete all of the additional sessions under the corresponding domain. (Number of CLEAR participants that “completed the core” and additional domain sessions over the total number of participants who “completed the core” this quarter)

Healthy Relationships [HR]

- 60% of HR participants will complete the entire intervention, as defined by attending a minimum of 4 of the 5 sessions in a Healthy Relationships cycle. One of these sessions must be session 2, as required by the intervention guidelines. (Number of HR participants that completed the group over the total number of group participants for this quarter)
- 40% of HR participants who complete the intervention will report on an evaluation that the intervention helped them to feel more comfortable with disclosure. (Number of HR participants that completed the intervention and report that it helped over the total number of participants that completed the group for this quarter)

Partnership for Health – Safer Sex

- 100% of patients will be counseled to discuss safer sex with either the consequences or advantages frame messaging during the program year. (Number of patients that received PfH over the total number of patients seen this quarter)
- 90% of patients who practice safer sex with one partner or are abstinent will continue to practice safer sex. (Number of PfH participants seen this quarter that reported continuing to practice safer sex over the total number of PfH participants seen this quarter that previously reported practicing safer sex)
- 38% of patients with two or more partners will report a reduction in unprotected anal or vaginal sex and/or disclosure to partners. (Number of PfH participants seen this quarter that reported a reduction in unprotected/or disclosure over the total number of PfH participants seen this quarter that previously reported unprotected sex/non-disclosure)
Personal Cognitive Counseling [PCC]

• 30% of individuals screened and recruited for PCC will agree to participate in the intervention and complete the required questionnaire.  *(Number of PCC participants this quarter over the total number of individuals screened and recruited for this quarter)*

• 75% of PCC participants will identify at least one-step to decrease high-risk behavior(s) and commit to a risk reduction strategy. *(Number of PCC participants that identified a step and committed to a strategy over the total number of participants this quarter)*

VOICES/VOCES

• 75% of VOICES participants will, through the completion of a pre- and post-test, show that the intervention increased their knowledge. *(Number of Voices participants this quarter that report increased knowledge over the total number of participants this quarter)*
APPENDIX F

Performance Measures-Care Outcomes
## APPENDIX F

AIDSNET 2018-2019 Ryan White Part B Sub-recipient Care Outcomes  
(Required Performance Measures [PM] for DOH & Quality Management [QM] reporting)

### UNIVERSAL (ALL CASE MANAGEMENT AGENCIES)

#### PERFORMANCE MEASURE #1 (JHF2): MENTAL HEALTH HISTORY AND TREATMENT STATUS

<table>
<thead>
<tr>
<th>Service Category:</th>
<th>Case management (non-medical) and Medical case management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Percentage of clients with HIV infection who received mental health history and treatment status</td>
</tr>
<tr>
<td>Numerator:</td>
<td>Number of HIV clients who have their mental health history and treatment status documented at least once during the measurement year</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of clients who have at least one face-to-face case management visit during the measurement year</td>
</tr>
<tr>
<td>Patient Exclusions:</td>
<td>Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year</td>
</tr>
</tbody>
</table>
| Data Sources:     | 1. Client Files  
|                   | 2. CAREWare |

**Rationale:** Mental health problems can escalate quickly and significantly alter the lifestyle and health of a patient. Patients referred to mental health programs should be assessed within thirty days in order to address and alleviate the mental condition before related problems arise. Distressed or mentally unstable patients may be less likely to adhere to treatment plans and are at risk for poor judgment. Without counseling, patients are more likely to engage in risky sexual behaviors, are more likely to miss appointments, and are at risk for poor health related decisions. Suspected mental illnesses must be quickly addressed to ensure the patient is capable of properly caring for him/her and is not a danger to themselves or those around them.

#### PERFORMANCE MEASURE #2 (JHF3): SUBSTANCE ABUSE HISTORY AND TREATMENT

<table>
<thead>
<tr>
<th>Service Category:</th>
<th>Case management (non-medical) and Medical case management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Percentage of clients with HIV infection who have their substance abuse history and treatment status documented</td>
</tr>
<tr>
<td>Numerator:</td>
<td>Number of HIV clients who have their substance history and treatment status documented at least once during the measurement year</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of clients who have at least one face-to-face case management visit during the measurement year</td>
</tr>
<tr>
<td>Patient Exclusions:</td>
<td>Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year</td>
</tr>
</tbody>
</table>
| Data Sources:     | 1. Client Files  
|                   | 2. CAREWare |

**Rationale:** Substance abuse is a growing problem in HIV infected communities. Patients successfully completing substance abuse programs are in need of less acute medical care, have less frequent trips to emergency rooms, and are more likely to adhere to treatment plans and attend scheduled doctors’ appointments. Patients able to maintain recovery are more socially, financially, and medically stable. Immune function and overall wellness is increased after a decrease in substance abuse and use. Successful programs teach patients the skills needed to maintain and identify triggers related to addiction, and patients are expected to incorporate learned behaviors into everyday life.
PERFORMANCE MEASURE #3 (JHF4): DOCUMENTATION OF RETENTION IN CARE

<table>
<thead>
<tr>
<th>Service Category:</th>
<th>Addressing Unmet Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Percentage of clients with HIV infection whose records indicate retention in care</td>
</tr>
<tr>
<td>Numerator:</td>
<td>Number of clients whose records indicate</td>
</tr>
<tr>
<td></td>
<td>1. CD4 count performed within the measurement year; OR</td>
</tr>
<tr>
<td></td>
<td>2. Viral load test administered within the measurement year; OR</td>
</tr>
<tr>
<td></td>
<td>3. ARV therapy prescribed or discussed with a medical provider within the measurement year</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of HIV clients who have accessed services at least once during the measurement year</td>
</tr>
<tr>
<td>Patient Exclusions:</td>
<td>Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>1. Client Files</td>
</tr>
<tr>
<td></td>
<td>2. CAREWare</td>
</tr>
</tbody>
</table>

National Goals, Targets, or Benchmarks For Comparison: None available at this time

Rationale: All agencies (both medical and supportive service providers) must obtain documentation of when the most recent CD4 and/or viral load tests were performed and/or when the most recent prescription for ARV therapy was issued and maintain it on file as evidence that their clients are participating in care.

If a supportive service agency cannot obtain the documentation that confirms a client is participating in care, the supportive service agency cannot continue to provide supportive services for that client. Client self reporting is not acceptable; rather documentation should be obtained from medical providers.

Supportive services are designed to support a person’s ability to participate in care. Obtaining documentation related to the timing of CD4 counts, viral load tests and prescriptions of ARV therapy is one way to insure that services are provided as intended, while reducing the level of unmet need within the system.

CLINICAL PM (AAO & ASC ONLY)
(These measures are linked to an Outpatient/Ambulatory visit)

PERFORMANCE MEASURE #4 (HAB01): TWO PRIMARY CARE VISITS>= 3MOS APART

<table>
<thead>
<tr>
<th>Service Category:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.</td>
</tr>
<tr>
<td>Numerator:</td>
<td>No. of HIV-infected clients who had a medical visit with a provider with prescribing privileges in an HIV care setting two or more times at least 3 months apart during the measurement year.</td>
</tr>
<tr>
<td>Denominator:</td>
<td>No. of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.</td>
</tr>
<tr>
<td>Exclusions:</td>
<td></td>
</tr>
<tr>
<td>Data Sources:</td>
<td>1. Client files</td>
</tr>
<tr>
<td></td>
<td>2. CAREWare</td>
</tr>
</tbody>
</table>

National Goals, Targets, or Benchmarks For Comparison: None available at this time

Rationale:
## PERFORMANCE MEASURE #5 (HAB02): PERCENTAGE WITH >=2 CD4 COUNTS

<table>
<thead>
<tr>
<th>Definition:</th>
<th>No. of HIV-infected clients who had at least one medical visit with a provider with prescribing privileges in the measurement year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>No. who had at least 2 CD4 counts at least 3 months apart.</td>
</tr>
<tr>
<td>Denominator:</td>
<td>No. of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.</td>
</tr>
</tbody>
</table>

### Exclusions:

### Data Sources:

3. Client files  
4. CAREWare

### National Goals, Targets, or Benchmarks For Comparison: None available at this time

### Rationale:

PERFORMANCE MEASURE #6 (HAB03): PCP PROPHYLAXIS

<table>
<thead>
<tr>
<th>Service Category:</th>
<th>Prevention of PCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm who were prescribed PCP prophylaxis</td>
</tr>
<tr>
<td>Numerator:</td>
<td>Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm who were prescribed PCP prophylaxis</td>
</tr>
</tbody>
</table>
| Denominator: | Number of HIV-infected clients who:  
1. Had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and  
2. Had a CD4 T-cell count below 200 cells/mm |
| Patient Exclusions: | 1. Patients with CD4 T-cell counts below 200 cells/mm repeated within 3 months rose above 200 cells/mm  
2. Patients newly enrolled in care during last three months of the measurement year |
| Data Sources: | CAREWare |

### National Goals, Targets, or Benchmarks for Comparison: IHI Goal: 95%

### Rationale: Pneumocystis pneumonia (PCP) is the most common opportunistic infection in people with HIV. Without treatment, over 85% of people with HIV would eventually develop PCP. It is a major cause of mortality among persons with HIV infection, yet is almost entirely preventable and treatable. Measure reflects important aspect of care that significantly influences survival and mortality.
## APPENDIX F

AIDSNET 2018-2019 Ryan White Part B Sub-recipient Care Outcomes
(Required Performance Measures [PM] for DOH & Quality Management [QM] reporting)

### PERFORMANCE MEASURE #7 (HAB04): HAART

<table>
<thead>
<tr>
<th>Service Category</th>
<th>HIV Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Percentage of clients with AIDS who are prescribed HAART</td>
</tr>
<tr>
<td>Numerator:</td>
<td>Number of clients with AIDS who were prescribed a HAART regimen</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of clients who: &lt;br&gt;1. Have a diagnosis of AIDS (history of a CD4 T-cell count below 200 cells/mm or other AIDS-defining condition), and &lt;br&gt;2. Had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, and NP in the measurement year.</td>
</tr>
<tr>
<td>Patient Exclusions:</td>
<td>Patients newly enrolled in care during last three months of the measurement year</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>CAREWare</td>
</tr>
</tbody>
</table>

National Goals, Targets, or Benchmarks for Comparison: IHI Goal: 90%

Rationale: Randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating symptomatic patients and patients with CD4 T-cells <200 cells/mm. Measure reflects important aspect of care that significantly affects survival, mortality and hinders transmission.

### PERFORMANCE MEASURE #8 (HAB05): ARV THERAPY FOR PREGNANT WOMEN

<table>
<thead>
<tr>
<th>Service Category:</th>
<th>Prevention of Perinatal Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy</td>
</tr>
<tr>
<td>Numerator:</td>
<td>Number of HIV-infected pregnant women who were prescribed antiretroviral therapy during the 2nd and 3rd trimester</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year</td>
</tr>
<tr>
<td>Patient Exclusions:</td>
<td>1. Patients whose pregnancy is terminated &lt;br&gt;2. Pregnant patients who are in the 1st trimester and newly enrolled in care during last three months of the measurement year</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>CAREWare</td>
</tr>
</tbody>
</table>

National Goals, Targets, or Benchmarks for Comparison: None available at this time.

Rationale: Treatment recommendations for pregnant women infected with HIV-1 have been based on the belief that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus, or infant and unless these adverse effects outweigh the benefit to the woman. Antiretroviral therapy can reduce Perinatal HIV-1 transmission by nearly 70%. Measure reflects important aspect of care that significantly affects survival, mortality and hinders transmission.
## APPENDIX F

AIDSNET 2018-2019 Ryan White Part B Sub-recipient Care Outcomes
(Required Performance Measures [PM] for DOH & Quality Management [QM] reporting)

### PERFORMANCE MEASURE #9 (JHF1): VIRAL LOAD TESTING

<table>
<thead>
<tr>
<th>Service Category:</th>
<th>HIV Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition:</strong></td>
<td>Percentage of clients with HIV-infection who had a viral load test administered within 3 to 4 months of most recent medical visit</td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td>Number of HIV-infected clients who had a viral load test administered within 3 months of most recent medical visit</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, at least once in the measurement year</td>
</tr>
<tr>
<td><strong>Exclusions:</strong></td>
<td>Patients newly enrolled in care during last six months of the year</td>
</tr>
</tbody>
</table>
| **Data Sources:** | 5. Client files  
6. CAREWare |

**National Goals, Targets, or Benchmarks For Comparison:** None available at this time

**Rationale:** A viral load test is ordered when a patient is first diagnosed with HIV. The test result functions as a baseline measurement that shows how actively the virus is reproducing and whether treatment is immediately necessary. If the viral load measurement is high, it indicates that HIV is reproducing and that the disease will likely progress faster than if the viral load is low. Change in viral load is also a very important measurement. A rising count indicates an infection that is getting worse, while a falling count indicates improvement and suppression of the HIV infection.

---

### ORGANIZATIONAL (ALL CARE/PREVENTION PROVIDERS)

### PERFORMANCE MEASURE #10: ORGANIZATIONAL ASSESSMENT

<table>
<thead>
<tr>
<th>Service Category:</th>
<th>Quality Infrastructure and Activities</th>
</tr>
</thead>
</table>
| **Definition:**   | A.1. Are appropriate resources committed to support the HIV quality program?  
A.2. Does the HIV leadership support the HIV quality program?  
A.3. Does the HIV quality program have a comprehensive quality plan?  
B.1. Did the HIV program routinely measure the quality of care?  
C.1. Did the HIV program conduct quality projects to improve the quality of care?  
D.1. Is the staff routinely educated about quality?  
E.1. Is a process in place to evaluate the HIV quality program?  
F.1. Does the HIV program have an information system in place to track patient care and measure quality? |
| **Numerator:**    | None |
| **Denominator:**  | None |
| **Exclusions:**   | None |
| **Data Sources:** | 1. Quality Plan  
2. Interviews with leadership, staff, medical providers  
3. Organizational chart  
4. QM Committee minutes  
5. Other committee minutes  
6. Data Reports  
7. Team meeting minutes  
8. Education logs  
9. Training agendas and attendance records  
10. Evaluation tools  
11. Organizational documents, i.e., policies and procedure manuals, IT disaster recovery plans |

Appendix F
AIDSNET Care Outcomes 2018-2019 (Based on Part B Subgrantee Universal & Clinical PM Adopted 7/2009)
Page 5 of 6
APPENDIX F

AIDSNET 2018-2019 Ryan White Part B Sub-recipient Care Outcomes
(Required Performance Measures [PM] for DOH & Quality Management [QM] reporting)

<table>
<thead>
<tr>
<th>National Goals, Targets, or Benchmarks For Comparison: None available at this time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale: A formal quality of care program that embraces quality improvement (QI) philosophy should be developed and implemented as part of the HIV service delivery program. An effective HIV quality management program includes the following components:</td>
</tr>
<tr>
<td>• Adequate resources</td>
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<td>• Clear staff expectations related to quality</td>
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<tr>
<td>• Engagement of multidisciplinary team(s) and a QM Committee</td>
</tr>
<tr>
<td>• Commitment of leadership</td>
</tr>
<tr>
<td>• Quality management plan that is periodically reviewed and updated as needed</td>
</tr>
<tr>
<td>• Processes and systems in place to routinely collect and analyze data</td>
</tr>
<tr>
<td>The infrastructure of the quality program should be fully described in the quality plan, with a clear indication of responsibilities and accountability, and elaboration of processes for ongoing evaluation and assessment.</td>
</tr>
<tr>
<td>Performance measurement should include clearly defined indicators that address clinical, case management, and other services as prioritized by the program. A plan for follow-up of results should be outlined.</td>
</tr>
<tr>
<td>QI activities should be based on performance data results. Specific QM projects should be undertaken, which include action steps and a mechanism for integrating change into routine activities.</td>
</tr>
<tr>
<td>QI activities should be based on performance data results. Specific QI projects should be undertaken, which include action steps and a mechanism for integrating change into routine activities.</td>
</tr>
<tr>
<td>Staff should be actively involved in the HIV Quality Program and its QM activities. Participation in the quality program should be part of job expectations. Provisions should be made for ongoing education of staff about quality management.</td>
</tr>
</tbody>
</table>
APPENDIX G

Prevention Intervention Plan Spreadsheet
APPENDIX G

Instructions:
This spreadsheet is to be completed by the Agency/Applicant applying for state (11068) funding.
This EXCEL file contains two worksheets. The first contains codes and the second is the actual form to be completed.

<table>
<thead>
<tr>
<th>Activity/Intervention/Strategy - Column 7</th>
<th>Population to be served (by Risk Category) - Column 8</th>
<th>Code</th>
<th>By Race - Column 9</th>
<th>Code</th>
<th>Ethnicity - Column 10</th>
<th>Code</th>
<th>Gender - Column 11</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Anti-Retroviral Treatment and Access to Services (ARTAS)</td>
<td>HIV+ men who have sex with men/injection drug user</td>
<td>HIV+MSM</td>
<td>American Indian or Alaska Native</td>
<td>AI</td>
<td>AI</td>
<td>Male</td>
<td>M</td>
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<tr>
<td></td>
<td>HIV+ man who have sex with men</td>
<td>MSM</td>
<td>Asian</td>
<td>A</td>
<td>A</td>
<td>Female</td>
<td>F</td>
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<td>Partnership for Health (PfH)</td>
<td>HIV+ injection drug users</td>
<td>HIV+IDU</td>
<td>Black or African American</td>
<td>B</td>
<td>B</td>
<td>Transgender male to female</td>
<td>FM</td>
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</tr>
<tr>
<td>Other: specify*</td>
<td>HIV+ heterosexual</td>
<td>H</td>
<td>Native Hawaiian or Pacific Islander</td>
<td>PI</td>
<td>PI</td>
<td>Transgender female to male</td>
<td>FM</td>
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<tr>
<td>*must receive prior approval from PADOH</td>
<td>HIV+ clients with other/unknown behavioral risk factors</td>
<td>HIV+</td>
<td>White</td>
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<td>Unspecified</td>
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<td></td>
<td>Men who have sex with men/injection drug user</td>
<td>MSM</td>
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<td></td>
<td>Men who have sex with men</td>
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<td>Injection drug users</td>
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<td>High-risk heterosexual</td>
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<td></td>
<td>Clients with other/unknown behavioral risk factors</td>
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</table>
# Name of Activity/Intervention/Strategy

<table>
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<tr>
<th>Name of Activity/Intervention/Strategy</th>
<th>Target Population(s) to be Served</th>
<th>Race</th>
<th>Ethnicity</th>
<th>Gender</th>
<th>Service Area County/Counties</th>
<th>Service Area Zip Code(s)</th>
<th>Annual Budget</th>
<th># of Individuals to be served</th>
<th># of Sessions per budget period</th>
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</tbody>
</table>

# Name of Agency/Applicant:

*For Target Population, Race, Ethnicity, and Gender use the codes found in the “Instructions” Tab.

**PLEASE PRINT THIS COMPLETED SHEET OUT ON LEGAL SIZE PAPER.**
APPENDIX H

Fiscal Forms
### AGENCY REVENUE/EXPENSE FORM (B-1)

#### PART A

**TOTAL AGENCY REVENUE**

<table>
<thead>
<tr>
<th>(1) Source</th>
<th>(2) 7/1/18 to 6/30/19 Projected</th>
<th>(3) 7/1/19 to 6/30/20 Projected</th>
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<tbody>
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**TOTAL AGENCY REVENUE** 0 0

#### PART B

**TOTAL AGENCY EXPENSE**

<table>
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<th>Cost Categories</th>
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<th>(2) 7/1/19 to 6/30/20 Projected</th>
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<td>Advertising (Staff Recruitment)</td>
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<td>Resource Material/Subscriptions</td>
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<tr>
<td>Maintenance/Repairs</td>
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<td>Communications (Telephone, Internet, etc.)</td>
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<td>Copying/Printing</td>
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<tr>
<td>Equipment Lease &amp; Maintenance</td>
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<td>Insurance (Prof./Liability/Board/Fidelity)</td>
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<td>Meeting/Board Expenses</td>
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<td>Occupancy (Rent and Utilities)</td>
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<tr>
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<td>Professional Ed. Consultant/Group Facilitators</td>
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<td>Professional Fees (eg. Accounting/Audit/Legal)</td>
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<td>Travel Expense (Mileage, Lodging, etc.)</td>
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**TOTAL AGENCY EXPENSE** 0 0
## INDIRECT COST DISTRIBUTION FORM (B-2)

**AGENCY NAME:** 

**FISCAL YEAR:** 

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<th>(4) (Insert Program Name)</th>
<th>(5) (Insert Program Name)</th>
<th>(6) (Insert Program Name)</th>
<th>(7) (Insert Program Name)</th>
<th>(8) TOTAL 2-7</th>
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<td>Advertising (Staff Recruitment)</td>
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<td>Communications (Telephone, Internet, etc.)</td>
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<td>Office Supplies</td>
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<td>Other Consultants/Temporary Labor</td>
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<td>Professional Ed. Consultant/Group Facilitators</td>
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<td>Professional Fees (e.g. Accounting/Audit/Legal)</td>
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<td>Seminars/Conferences/Training</td>
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<td>Stipends/Products for Clients</td>
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<td>Travel Expense (Mileage, Lodging, etc.)</td>
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<td><strong>TOTALS</strong></td>
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</tbody>
</table>

Methodology for distribution

__________________________________________________________________________________

__________________________________________________________________________________

* This column is for all of the programs that are not included in this proposal.
<table>
<thead>
<tr>
<th>Title of Position</th>
<th>Employee Name</th>
<th>Fiscal Year 17/18 Annual Salary</th>
<th>Fiscal Year 18/19 Projected Annual Salary</th>
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<th>Fiscal Year 18/19 Total AIDSNET Funded Programs</th>
<th>Fiscal Year 19/20 Projected Annual Salary</th>
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<th>Fiscal Year 19/20 Total non AIDSNET Funded Programs</th>
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<th></th>
<th>Fiscal Year 19/20 Total non AIDSNET Funded Programs</th>
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| TOTAL |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

HIV/AIDS PERSONNEL FORM (B-3)
<table>
<thead>
<tr>
<th>Cost Categories</th>
<th>(1) 7/1/18-6/30/19 Projected Exps.</th>
<th>(2) 7/1/19-6/30/20 Projected Exps.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Salaries (Per Annum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Benefits and Taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Advertising (Staff Recruitment)</td>
<td></td>
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<tr>
<td>4 Resource Material/Subscriptions</td>
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<tr>
<td>5 Maintenance/Repairs</td>
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<td>6 Communications (Telephone, Internet, etc.)</td>
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<td>7 Copying/Printing</td>
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<td>8 Equipment Lease &amp; Maintenance</td>
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<tr>
<td>9 Insurance (Prof./Liability/Board/Fidelity)</td>
<td></td>
<td></td>
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<tr>
<td>10 Meeting/Board Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Occupancy (Rent, Utilities)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Office Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Other Consultants/Temporary Labor</td>
<td></td>
<td></td>
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<tr>
<td>17 Postage</td>
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<td></td>
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<tr>
<td>18 Professional Consultant/Group Facilitators</td>
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<tr>
<td>19 Professional Fees (e.g., Accounting/Legal)</td>
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<tr>
<td>20 Seminars/Conferences/Training</td>
<td></td>
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<tr>
<td>21 Stipends/Products for Clients</td>
<td></td>
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<tr>
<td>22 Travel Expense (Mileage, Lodging, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 TOTAL DIRECT COSTS</td>
<td>$0 $0</td>
<td></td>
</tr>
<tr>
<td>24 INDIRECT COSTS (from B-2)</td>
<td></td>
<td></td>
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<tr>
<td>25 10 % OF DIRECT COSTS (Line 23 x .10)</td>
<td>$0 $0</td>
<td></td>
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<tr>
<td>26 ALLOWABLE INDIRECT COSTS (lesser of lines 24 or 25)</td>
<td>$0 $0</td>
<td></td>
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<tr>
<td>27 GRAND TOTAL (lines 23 +26)</td>
<td>$0 $0</td>
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<tr>
<td>Cost Categories</td>
<td>(2) DESCRIPTION</td>
<td>(3) fy 2018-2019</td>
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<td>Salaries (Per Annum)</td>
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<td>Benefits and Taxes</td>
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<tr>
<td>Advertising (Staff Recruitment)</td>
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<td>Resource Material/Subscriptions</td>
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<td>Maintenance/Repairs</td>
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<td>Communications (Telephone, Internet, etc.)</td>
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<td>Equipment Lease &amp; Maintenance</td>
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<td>Insurance (Prof./Liability/Board/Fidelity)</td>
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<td>Meeting/Board Expenses</td>
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<tr>
<td>Stipends/Products for Clients</td>
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<tr>
<td>Travel Expense (Mileage, Lodging, etc.)</td>
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<tr>
<td><strong>Total Direct Cost</strong></td>
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</table>
### PROJECT REVENUE & REQUEST FORM (B-6)

**PART A**

<table>
<thead>
<tr>
<th>Source</th>
<th>7/1/17 to 6/30/18 Actual and Projected</th>
<th>7/1/18 to 6/30/19 Projected</th>
<th>7/1/19 to 6/30/20 Projected</th>
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**TOTAL:** $ - $ - $

### PART B

**REQUESTED AMOUNT FOR PROGRAM**

- **Fiscal year 2018-2019**
- **Fiscal year 2019-2020**

1. **TOTAL PROJECTED COST OF PROGRAM**
   - (from B-4 line 27, columns 1 (FY 18-19) & 2 (FY 19-20))
   - $0
   - $0

2. **TOTAL PROJECTED OTHER REVENUE**
   - (total columns 3 above (FY 18-19) & 4 above (FY 19-20))
   - $0
   - $0

3. **AMOUNT REQUESTED FROM AIDSNET**
   - (subtract line 2 from line 1)
   - $0
   - $0
### UNIT COST DETERMINATION- HOURS FORM (B-7)

<table>
<thead>
<tr>
<th></th>
<th>FY 18-19</th>
<th>FY 19-20</th>
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</thead>
<tbody>
<tr>
<td>(1) Number of Full Time Equivalents (Direct Service staff only)</td>
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<tr>
<td>(2) Number of Available Work Weeks (if less than 48 weeks, include a narrative explaining why)</td>
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<td>(3) Standard Workweek (e.g. 40 hours, 37.5 hours)</td>
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<tr>
<td>(4) Total Hours (Line 1 x Line 2 x Line 3)</td>
<td>0</td>
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<tr>
<td>(5) Percentage of Direct Services (if less than 60%, include a narrative explaining why)</td>
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<tr>
<td>(6) Total Direct Service Hours (units) Available (Line 5 x Line 4)</td>
<td>0</td>
<td>0</td>
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<tr>
<td>(7) Insert Total Cost of Program (Grand Total Columns 1 and 2 on Form B-4)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(8) Unit Cost (Line 7 / Line 6)</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>(9) Insert Total Requested from AIDSNET (Line 3, Part B on Form B-6 &quot;Project Revenue &amp; Request&quot;)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(10) Total Units Requested from AIDSNET (Line 9 / Line 8)</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>
APPENDIX I

Fiscal Forms Instructions
APPENDIX I

Instructions for 2018-2020 AIDSNET Rate Setting Process

Complete one of each of the following forms:

   B-1: Agency Revenue/Expense Form
   B-3: HIV/AIDS Personnel Form

Complete the following form for each fiscal year:

   B-2: Indirect Cost Distribution Form

Complete one set of the following forms for each service proposed:

   B-4: Service Expense Form
   B-5: Narrative to Budget Form
   B-6: Project Revenue & Request Form
   B-7: Unit Cost Determination – Hours Form

Complete the forms in chronological order. Some of the forms require information from a previous form.

Record all amounts in whole dollars.
INSTRUCTIONS FOR COMPLETING FORMS

B-1 Agency Revenue/Expense Form

Part A: Total Agency Revenue.


Column 2: Record the projected amount of revenue for next fiscal year (2018-19)

Column 3: Record the projected amount of revenue for following fiscal year (2019-20)

Part B: Total Agency Expense.

Column 1: Record the agency budget for fiscal year 2018-19

Column 2: Record the agency budget for fiscal year 2019-20

Note: Include a brief explanation if the revenue projected for 2018-19 does not equal the amount of expense projected for that fiscal year.

B-2 Indirect Cost Distribution Form (Prepare a separate form for each fiscal year)

Indirect costs are those expenses that are affiliated with running the agency and that are shared by more than one service. They support the entire agency rather than just one program. These costs include salaries and benefits of the agency director, divisional supervisors and/or administrative support personnel as well as occupancy, furniture and utilities. Indirect costs should be assigned to programs equitably using a consistent method of distribution. Examples of allocation methods are: gross salary expense of each program as compared to the total gross salaries for all programs; direct cost of each program as compared to total direct costs for all programs; square footage of the facility by program usage as compared to the total square footage for programmatic use; or sources of revenue for the program as compared to the total revenue for all programs.

Column 1: Record all indirect costs for the agency projected for the appropriate fiscal year.

Column 2: The total of all indirect costs allocated to services provided by the agency that are not being proposed in this RFP.

Columns 3-7: In the heading of each column list the name of each service being proposed. Record the amount in each cost category appropriated to the service listed.
Insert more columns if needed. Print on legal size paper, if necessary. Complete only column 1 if only one program is provided by the agency. The total from each program will be carried forward to the Indirect Cost line on the Service Expense Form (B-4) for that program.

**Column 8:** Enter the total of Columns 2 – 7. Each line of the total column should be the same amount as that line in column 1. The total column should equal column 1.

Record the methodology used for distribution of indirect costs on the lines at the bottom of the page.

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**B-3 HIV/AIDS Personnel Form**

**Column 1:** List the position titles for all program staff, whether or not reimbursement for their line item is being sought.

**Column 2:** List the name of the employee in each position, list “vacant” for unfilled positions.

**Column 3:** List the amount budgeted for each position in the 2017-18 fiscal year. If it will be a new position during the 2018-19 fiscal year, list as “new” in column 3.

**Column 4:** List the amounts proposed for each position for fiscal year 2018-19.

**Column 11:** List the amounts proposed for each position for fiscal year 2019-20.

**Columns 5 – 8 and 12 - 15:** List the direct cost portion of the total salary for each position proposed for each specific service in the 2018-19 and 2019-20 fiscal years. In the column heading, list the name of the service. (If more than four services are proposed in this RFP, please add columns as needed. Print on legal size paper if necessary).

Note: The total of each of these columns must match the total budgeted salary reported on Form B-4 for the corresponding service.

**Columns 9 and 16:** List the amount of the salary for each position that is included in the agency indirect costs.

**Columns 10 and 17:** List the amount of each position’s salary that is budgeted in programs not included in this RFP.

Note: The total of Columns 5 through 10 should always be equal to the amount in Column 4. The total of Columns 12 through 15 should always be equal to the amount in Column 11.
**B-4 Service Expense Form**

The purpose of this form is to report direct costs of providing the service proposed. Direct costs relate directly to the service. This includes salaries, benefits, travel and service-related training costs for employees who provide that service and supplies and materials used in the provision of the service. Expenses such as rent, telephone and postage can also be direct costs for some services if they can be directly and exclusively attributed to the provision of the service.

**Column 1:** Record projected direct cost expense for the service for Fiscal Year 2018-19. In row 24 “Indirect Costs from B-2”, record the amount in the “Total” row for the specific project column on form B-2, Indirect Cost Distribution. Calculate the allowed maximum 10% indirect costs by multiplying the total in line 23 by 0.1. Record the result in line 25 “10% of Direct Costs”. Enter the lesser of line 24 or 25 in line 26 “Allowable Indirect Costs”. The Grand Total is calculated by adding line 23 “Total Direct Costs” and line 26 “Allowable Indirect Costs”.

**Column 2:** Record projected direct cost expense for the service for Fiscal Year 2019-20. In row 24 “Indirect Costs from B-2”, record the amount in the “Total” row for the specific project column on form B-2, Indirect Cost Distribution. Calculate the allowed maximum 10% indirect costs by multiplying the total in line 23 by 0.1. Record the result in line 25 “10% of Direct Costs”. Enter the lesser of line 24 or 25 in line 26 “Allowable Indirect Costs”. The Grand Total is calculated by adding line 23 “Total Direct Costs” and line 26 “Allowable Indirect Costs”.

**B-5 Narrative to Budget Form**

The narrative is the line-by-line description of items listed in the service expense form (B-4). In the description column, Column 2, list the detail describing the nature of the expense proposed. For example, if benefits are a direct percentage of salaries, list the types of benefits provided plus the percentage used to calculate the total. In Columns 3 and 4 “Amount”, record the budgeted amount as listed on the same line of form B-4 Columns 4 and 5.

**B-6 Project Revenue & Request Form**

Part A (Proposed Service Revenue)

**Column 1:** List all funding sources (excluding AIDSNET) used since 2017-18 for the service and/or are anticipating using through 2019-20.
Column 2: Record projected revenue for the budgeted year 2018-19.

Column 3: Record projected revenue for the budgeted year 2019-20.

Part B (Requested Amount for Program)

Line 1: Enter the total projected cost of the program for fiscal year 2018-19 from Form B-4, Column 1, Line 27, and for fiscal year 2019-20 from Form B-4, Column 2, Line 27.

Line 2: Enter the total projected other revenue for fiscal year 2018-19 from Form B-6, Part A, Column 2, “Total” line, and for fiscal year 2019-20 from Form B-6, Part A, Column 3, “Total” line.

Line 3: Subtract the total projected other revenue from the projected cost of the program for each fiscal year. These are the amounts requested for each fiscal year from AIDSNET for that program.

B-7 Unit Cost Determination – Hours Form

Unit cost will be calculated for each service for each program for years 2018--19 and 2019-20.

Line 1: Report the number of Full Time Equivalents for the service being proposed.

To calculate Full Time Equivalents (FTE), list all of the employees who will be providing direct service to this program. Calculate the total hours worked on this program in a week collectively for the employees on the list. Divide the result by the number of hours in a standard workweek for your agency. The result is the total FTE to be used in line 1 of the Unit Cost Determination – Hours Form (B-7).

Line 2: Determine the number of weeks per year an FTE will be on the job (52 weeks minus vacation, personal, holiday and sick days). If the number is less than 44, attach a narrative explaining why.

Line 3: Record the number of paid hours an FTE works in a standard work week.

Line 4: Multiply lines 1, 2 and 3 to determine the total number of hours available per year.

Line 5: Determine the percentage of time spent in direct service provision. Direct service time does not include planning, travel, doing paperwork (unless it is being done with the client), meetings, trainings and supervision time. If this number is less than 60%, attach a narrative explaining why.
Line 6: Multiply the Percentage of Direct Service (Line 5) by the Total Hours (Line 4) to determine the total number of Direct Service Hours (units) available.

Line 7: Insert the total 2018-19 program costs from form B-4, Column 4, Line 27.

Line 8: Divide the Total Cost of Program (Line 7) by the Total Direct Service Hours (Line 6) to determine the unit cost.

Line 9: Enter the amount requested from AIDSNET for fiscal year 2018-19 from Form B-6, Part B, Line 3.

Line 10: Divide the amount requested from AIDSNET (Line 9) by the Unit Cost (Line 8) to determine total units requested.

In addition to the hard copies, submit all budget forms in Excel format by email to Kevin Westgate, Fiscal Officer, at aidsntkw@ptd.net
APPENDIX J

Policy Guidance on the Implementation of High Impact Prevention Activities
DATE:        April 10, 2015

SUBJECT:    Interim Policy Guidance on the Implementation of High Impact
            Prevention Activities

TO:         County/Municipal Health Departments and Ryan White Part B Regional
            Grantees

FROM:       Kenneth McGarvey, Director
            Division of HIV/AIDS
            Bureau of Communicable Diseases

Background Information:

In August 2010, the Department of Health (Department) distributed policy guidance on
the implementation of evidence-based HIV prevention interventions (EBI), at which time
grantees were informed that approved EBIs for implementation and funding through sub-
grants included, but were not limited to interventions disseminated by the Center for
Disease Control and Prevention’s (CDC) Diffusion of Effective Behavioral Interventions
(DEBI) Project.

The National HIV/AIDS Strategy, released by the White House in July 2010, called for a
shift in the HIV prevention approach in order to maximize the impact of prevention
efforts for those at greatest risk of HIV infection. In response, CDC and its partners are
pursuing a High Impact Prevention (HIP) approach, which encourages the use of a
combination of scientifically proven, cost-effective, and scalable interventions targeted to
the right populations in the right geographic areas.

Since that time, CDC engaged in an exhaustive process to determine which of the
interventions that were diffused as part of the DEBI Project provided the greatest benefit
in the most cost-effective way. As a result, CDC selected a number of interventions that
would continue to be supported as part of HIP, as well those that would not.

In addition to Behavioral Interventions, research has a led to a number of proven
approaches to reduce the risk of HIV infection, which includes: Biomedical
Interventions, Public Health Strategies, Structural Interventions and Social Marketing.
More information about CDC’s efforts in all of these key areas can be found at
https://www.effectiveinterventions.org


**Department Supported HIP Activities**

The Department implements HIP activities both directly and through grants/contracts. This Guidance serves to communicate the interventions and strategies that have been selected for support by the Department in future contracts/grants (including sub-grants/sub-contracts) utilizing Federal CDC HIV Prevention and State funds, effective July 1, 2015 for Ryan White Part B Grantees, and January 1, 2016 for County/Municipal Health Departments. It also serves to replace the August 2010 “Policy Guidance on the Implementation of Evidence-Based HIV Prevention Interventions; Priority Populations; and Incentives.”

**County/Municipal Health Departments (CMHD), excluding Philadelphia – CDC and State Funding**

The Department requires the CMHDs to implement the following HIP activities:

- **HIV Testing**
  - Routine HIV Testing in STD Clinics (stand-alone HIV testing clinics will no longer be supported)

- **Comprehensive Prevention with Positives**
  - Partner Services (PS) for newly identified HIV positive individuals (includes testing of partners)
  - Ongoing PS for previously diagnosed HIV positive individuals in cases where:
    - persons previously diagnosed are named as partners in the course of conducting PS with other index patients. These persons shall be interviewed to assess behavioral risk, provided partner services, and referred for prevention interventions, when indicated; and/or,
    - there is evidence of ongoing risk behavior among persons previously diagnosed with HIV (such as a new STD or injection drug use).
  - Coordination and collaboration with Ryan White Part B and C Grantees to ensure successful referral and linkage to HIV care, treatment, prevention services, and other medical and social services as needed, for persons testing HIV-positive or currently living with HIV/AIDS

- **Integrated HIV Surveillance and HIV Prevention Activities – investigative activities to gather information:**
  - to assist the Bureau of Epidemiology, HIV Surveillance Unit to document and complete HIV case reports; and,
  - to provide prevention/intervention activities to identified clients.
Ryan White Part B Grantees – State Funding

The Department requires that each Ryan White Part B Grantee shall implement and/or coordinate:

- Linkage coordination to ensure HIV positive individuals are engaged into HIV care, treatment, prevention, and other medical and social services. The Department’s required intervention for linkage coordination is ARTAS.
- Medical case management services that include navigation services.
- Activities/strategies for HIV positive individuals who have fallen out of care in order to re-engage them into care. **Specific activities/strategies must receive prior written approval from the Department.**

The Department will support the following recommended HIP activities for:

- People Living with HIV (PLWH)
  - Healthy Relationships
  - Partnership for Health-Safer Sex
  - Strategies/Interventions from CDC’s Compendium of Effective Behavioral Interventions (Compendium). These may be adapted for use with populations other than those for which they were originally intended (e.g. MSM or transgender persons). **Must receive prior written approval from Department.**

- Prevention for populations at high risk, with unknown HIV status (as identified by local HIV/AIDS epidemiologic data) with identified unmet HIV Prevention needs. Priority shall be given to strategies/interventions targeting African-American men who have sex with men (MSM).
  - Strategies/Interventions from CDC’s Compendium of Effective Behavioral Interventions (Compendium). These may be adapted for use with populations other than those for which they were originally intended (e.g. MSM or transgender persons). **Must receive prior written approval from Department.**
  - Other Strategies/Interventions with evidence of effectiveness will be considered on a case-by-case basis. **Must receive prior written approval from Department.**

As indicated above, prior written approval from the Department is necessary for Ryan White Part B Grantees that request to implement certain activities, strategies, and interventions. For those requests to be considered, the following information (at a minimum) must be provided to your assigned project officer**:

- The identified activity/intervention/strategy (include explanation of adaptation, if applicable).
- The target population to be served.
- A brief summary of how you determined the need for this intervention to include:
  - Identified geographic area to be served (zip code, or set of zip codes).
  - How/what epi data was utilized to determine the target population.
  - Why this specific intervention was selected.
- Anticipated annual budget for the intervention.
- The selected provider, including:
  - Current capacity of provider to implement the intervention
  - Anticipated capacity building and/or training needs identified
- Implementation Plan, and Monitoring & Evaluation Key Activities (must include smart objectives, including number of clients to be served) - Templates for most interventions are available at https://effectiveinterventions.cdc.gov

**A response from the Department for each request will be provided within two weeks of receipt.**

**Key Points for the selection/implementation of HIP activities:**

- **Condom Distribution must be incorporated into all activities/interventions.** Condoms are available at no cost, from the Department.
- When selecting a recommended HIP activity, please ensure that your agency has the appropriate capacity to deliver the strategies and interventions with fidelity (in a way that adheres to the procedures and content that determined its effectiveness). For example:
  - Agency budgets should take into consideration all necessary costs associated with implementing an intervention, such as travel costs for staff to attend training, training and implementation materials, etc.
  - In addition to the trainings specific to each strategy/intervention, please consider that some basic courses such as HIV/AIDS 101 and Cultural Competency are also a critical foundation for the successful implementation of any HIP activity.
  - The Department is committed to providing the necessary tools to facilitate the successful implementation of HIP activities. Please direct all requests for training/technical/capacity building assistance to Department’s HIV Training Program Administrator Marijane Salem-Noll at: masalemnol@pa.gov or 717-783-0572.

When implementing a strategy/intervention, a target population must be specifically identified, and be supported by local epidemiologic data. Please refer to the Department’s Integrated Epidemiologic Profile of HIV/AIDS In Pennsylvania, which can be found at: http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/E-H/HIV%20And%20AIDS%20Epidemiology/Documents/Epi-Profile-of-HIV-in-PA-2012-2013-1stEd-F.pdf

- When using incentives to enhance recruitment/retention into HIP activities, you must adhere to the following requirements:
  - Obtain prior written approval from the Department (detailed documentation of incentives in a Department approved budget constitutes prior written approval)
  - Develop/maintain a written procedure for use of incentives to include:
    - Clear guidelines for when and to whom incentives are to be provided, and under what circumstances
    - A tracking mechanism for the purchase/distribution of incentives
- Responsible parties for the purchase, handling and distribution of incentives, including security protocols.
  - The use of incentives that violate state or federal law is prohibited, including the purchase of alcohol.
  - Direct cash payments to recipients of services are prohibited.
  - Some examples of acceptable incentives includes but are not limited to:
    - Gift cards, bus tokens, certificates of appreciation, food and refreshments (non-alcoholic), clothing items, toiletries, etc.
  - Incentives may be provided to individuals on a one-time or periodic basis to encourage participation; however the value of each incentive must be reasonable and must not exceed a maximum of $50.00. No Grantee or employee of the Grantee is eligible to receive an incentive.

This updated Guidance reflects some of the changes being made within the Department’s HIV Program, to ensure the greatest impact for the clients we serve throughout the continuum of HIV Prevention and Care.

Please note that other than that which is listed above, HIV testing shall not be implemented through CMHD HIV Prevention, or Ryan White Part B Grants. Department-supported HIV testing, other than that which is listed above will be implemented through a variety of direct agreements with the Department (e.g. fee-for-service, letters of agreement) and will be engaged/supported based on a variety of factors, including but not limited to: an identified need for testing in the geographic area; epidemiologic data; a testing provider’s ability to reach persons/populations at high risk for HIV; past performance (if applicable); and the recommendation/support of the local health department (if applicable). Additionally, monitoring and evaluation of testing sites in a CMHD jurisdiction would be done in collaboration with the CMHD. If you or an agency in your jurisdiction has: identified unmet HIV testing needs; identified organizations that can provide targeted HIV testing to high risk population; or, questions regarding the implementation of HIV testing, please contact the Department’s HIV Testing Program Administrator Jonathan Steiner at: jsteiner@pa.gov or 717-783-0572.

If you have questions regarding this Guidance, please direct them to your Project Officer or to the Department’s HIV Prevention Program Manager, Jill Garland at jigarland@pa.gov or 717-547-3425. Thank you for your support.
APPENDIX K

Proposal Rating Criteria and Score Sheet
APPENDIX K
AIDSNET
PROPOSAL SCORE SHEET

Provider Name: _______________________________

Service: ____________________________________

Amount Requested: __________________________

Unit Cost: _________________________________

Programmatic Capacity (25 points) _______
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Administrative Capacity (25 points) _______
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Soundness of Approach (15 points) _______
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Appropriateness of Funding Requested (15 points) _______
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Priority of Activity and Population to be Served (10 points) _______
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Need for Support (10 points) _______

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Total Points _______

Additional Notes/Comments:
PROPOSAL RATING CRITERIA

Programmatic Capacity (25 points)
Applicable Proposal Sections –
  I: Organizational Profile
  II: Cultural Competency
  III: Personnel
  V: Description of Services to be funded – Service Description, Goals, Objectives, Evaluation, and Prior Program Experience, Personnel (program specific)
  VI: Prevention Intervention Plan Spreadsheet
  VIII: Quality Management

Programmatic Monitoring

Things to consider –
A. Does the organization have the administrative and programmatic components in place to perform the program effectively?
B. Is the program within the parameters of the overall mission of the agency?
C. Does the agency have the programmatic capacity and experience to provide this program? (Partially based on the results of prior programmatic monitoring, if applicable.)
D. Is there a coordinated effort to link with other service providers and community organizations to develop a comprehensive network of services?
E. Service Description
   i. Is there a logical connection between the proposed program and the need it is addressing (including the Federal and PA-DOH goal of ensuring greater access and fewer disparities with regard to minority and underserved populations)?
   ii. Does the program target specific populations?
   iii. Does the target population indicated address the need demonstrated?
   iv. Is the program duplicative of services being provided by other organizations in the community?
F. Goals
   i. Are there goals that describe the overall intent of the service? (They do not necessarily need to be measurable.)
   ii. Are the goals clearly stated and address the need as presented?
G. Objectives
   i. Are the objectives outcome-based?
   ii. Do the objectives clearly describe the desired outcome?
   iii. Are the objectives realistic, measurable and able to be evaluated?
   iv. Do the objectives meet or exceed the minimum standards listed in the RFP?
H. Evaluation
   Use these two types of evaluation as a guide when you assess each program
   i. Process Evaluation describes how the program operates, the services it delivers, and the functions it carries out. It addresses if the program was implemented and if providing services as it is intended. However, by additionally documenting the program's development and operation, process evaluation assesses reasons for successful or unsuccessful performance, and provides information for potential
replication. The foci include: Who did what? When was it done? Where was it done? How was it done?

ii. Outcome Evaluation is a method of determining how well a program achieved its objectives by measuring results. To ascertain how well a program achieved desired objectives, it is first important to have clearly defined objectives. Next, there must be a way to measure how well the objectives are being achieved. The third aspect of outcome-based evaluation is analyzing the measured results to determine how well the program performed. Utilizing the analysis, it can then be determined if corrective action should be taken to improve, terminate, or continue the program.

iii. Does the agency describe how it is going to measure outcomes?

iv. Does the agency describe how it is going to evaluate the effectiveness of the proposed services?

v. Does the agency describe how it will measure consumer satisfaction?

vi. Does the agency cite examples of actions it has taken to improve consumer satisfaction?

A. Prior Program Experience
   i. Has the agency had experience with providing this program; and, if so, have objectives been met and results documented?
   ii. If AIDSNET has previously funded the program, has there been good feedback from programmatic monitoring of the agency?

B. Personnel
   i. Is the supervision of direct service staff adequate to ensure performance of the program effectively?
   ii. Do the people who will be administrative and program staff have the appropriate level of certification, training and/or experience required?
   iii. Is the supervision of direct service staff adequate to ensure continuous oversight and effective program performance?

Administrative Capacity (25 points)
Applicable Proposal Sections –
I: Organizational Profile
III: Personnel
V: Description of Services to be funded – Evaluation and Personnel (supervision specific)
VIII: Quality Management
Board of Directors
Audit
Management Letter
Programmatic Monitoring
Fiscal Monitoring

Things to consider –
A. Does the organization have the administrative and programmatic components in place to perform the program effectively?
B. Is the program within the parameters of the overall mission of the agency?
C. Does the agency have the programmatic capacity and experience to provide this program? (Partially based on the results of prior programmatic monitoring, if applicable.)
D. Does the agency have the administrative capacity to maintain appropriate fiscal and programmatic records and monitor its programs?
E. Is there a coordinated effort to link with other service providers and community organizations to develop a comprehensive network of services?

**Soundness of Approach (15 points)**
Applicable Proposal Sections –
- I: Organizational Profile
- III: Personnel
- IV: Needs Assessment
- V: Description of Services to be funded – Objectives, Evaluation, and Prior Program Experience

Things to consider –
- A. Is there a coordinated effort to link with other service providers and community organizations to develop a comprehensive network of services?
- B. Is the need demonstrated effectively?
- C. Is the problem clearly identified, specific to an area to be served using needs assessment data that is relevant, correct and applicable?
- D. Is the need addressed relevant to the prioritization of care services and/or risk behavior services set forth in Tables 1 and 2 of the Request for Proposal?

**Appropriateness of Funding Requested (15 points)**
Applicable Proposal Sections –
- I: Organizational Profile
- V: Description of Services to be funded – Goals and Objectives
- VII: Fiscal Forms
- Audit
- Management Letter

Things to consider –
- A. Does the organization have the administrative and programmatic components in place to perform the program effectively?
- B. Are the expenses reported relevant to running the program?
- C. Are the expenses reported reasonable in comparison to similar programs from other agencies?

**Priority of Activity and Population to be Served (10 points)**
Applicable Proposal Sections –
- I: Organizational Profile
- II: Cultural Competency
- IV: Needs Assessment
- V: Description of Services to be funded – Service Description

*Prioritization of Care Services*
**Prioritization of Prevention Services**

Things to consider –

A. Does the agency address how its program will minimize the effect of clients’ language, cultural, educational, religious and social barriers on accessing services?

B. Does the agency have the capacity to provide services to the targeted populations while recognizing the role of culture in comprehensive and supportive prevention and care?

C. Is the problem clearly identified, specific to an area or population to be served using needs assessment data that is relevant, correct and applicable?

D. Is the need addressed relevant to the prioritization of care services and/or risk behavior services set forth in Tables 1 and 2 of the Request for Proposal?

**Need for Support (10 points)**

Applicable Proposal Sections –

I: Organizational Profile

VI: Fiscal Forms

Audit

Management Letter

Things to consider –

A. Are all required budget forms submitted, complete and mathematically correct?

B. Has the agency maximized the use of all potential sources of funds for the program prior to requesting the use of AIDSNET funds?

C. Has the agency documented a need for AIDSNET funds?
APPENDIX L

AIDSNET 2018-2020 RFP Process Applicant Survey
1. Please rate the CLARITY of the following sections of the Request for Proposals document.

<table>
<thead>
<tr>
<th>SECTION</th>
<th>CLEAR</th>
<th>SOMEWHAT CLEAR</th>
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<tr>
<td>General Information for Applicant</td>
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<tr>
<td>Appendix A – Definitions of Eligible Services</td>
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<tr>
<td>Appendix C – Checklist, Signature Page and Summary Page</td>
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<td>Appendix D – Guidelines for Prevention Job Titles, Education, Experience, etc.</td>
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<td>Appendix G – Prevention Intervention Plan Spreadsheet</td>
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<td>Appendix H – Fiscal Forms</td>
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2. If you have marked SOMEWHAT CLEAR or NOT CLEAR for any of the above sections, please indicate what we can do to make that segment(s) easier to understand:

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3. Please rate how HELPFUL the following sections were of the Request for Proposals document:

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4. If you have marked SOMEWHAT HELPFUL or NOT HELPFUL for any of the above sections, please indicate what we can do to make that section(s) helpful:

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5. Please indicate your level of satisfaction with each of the following areas:

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6. Please indicate any suggestions you have for improving the RFP process.

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