New Orleans EMA

Ryan White Part A

Service Eligibility Policies & Forms

FY2018

Office of Health Policy and AIDS Funding
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Updated from the Eligibility section of the New Orleans EMA Ryan White Part A Policy Manual

CLIENT ELIGIBILITY POLICY

Purpose:

The Ryan White Treatment Modernization Act helps meet the unmet health needs of people living with HIV (PLWH) by funding primary health care and supportive services that enhance access and improve retention in care. Part A funds support a comprehensive continuum of quality, community-based care for low-income individuals and families with HIV. All persons receiving Ryan White Part A services must be screened for residency, HIV status, and financial eligibility through an agency funded by Ryan White Part A. Agencies are responsible for intake/eligibility screening to ensure that Ryan White funds are used as **funds of last resort**, as specified by the Ryan White Treatment Modernization Act.

Policy:

Residency

Eligibility requires that a client is residing in one of the following eight parishes: Orleans, Jefferson, Plaquemine, St. Bernard, St. Charles, St. James, St. John the Baptist, or St. Tammany. If a client does not reside in one of the eight listed parishes, they are **NOT ELIGIBLE** for services funded by the New Orleans EMA. Evidence of residency must be provided. Acceptable documentation for residency include a Louisiana State ID or Louisiana Driver's License, confirmation in a residential program on a letterhead, official state documents (i.e. award letters) or other government issued documents, to name a few. Additional acceptable documents are listed in the Ryan White Client Eligibility Documentation Form. Self attestation may be used as a last resort for clients who do not have any of the documents listed.

Financial Eligibility

The client must meet financial eligibility requirements and their income may not exceed 500% of the federal poverty level. The client must provide documentation on each source of income reported. Acceptable documentation for income are recent check stubs, award letter for SSI or SSDI for the current calendar year, and most recent benefits summary statement for AFDC, or Food Stamps. Self attestation may be utilized after efforts to obtain all other supporting documents have been exhausted. If the client is married, all income information must also be presented for their spouse.

All income for the client and spouse is calculated together and multiplied by 12 to obtain an annual income for the client. Identify the number of persons living in the client's household. Refer to the Federal Poverty Guidelines website at https://aspe.hhs.gov/poverty-guidelines or review the Ryan White Eligible Documentation Checklist to determine the appropriate poverty level. Note the poverty level changes annually around January.

HIV Status

Eligibility requires that a client be diagnosed with HIV/AIDS. **Non-diagnosed (HIV affected individuals)** persons may be appropriate candidates for Ryan White services in limited situations. The services provided must always have an indirect benefit to a person living with HIV. Funds awarded under Part A of the Ryan White Treatment Extension Act may be used for services to individuals without HIV only in circumstances described below.

a. The primary purpose of the service is to enable affected individuals to participate in the care of someone living with HIV or AIDS. Examples include individual mental health counseling, caregiver training for in-home medical or support services, support groups, counseling, and practical support that assist with the stresses of caring for someone with HIV.

b. The service directly enables a PLWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of premiums for a family health insurance policy to ensure continuity of insurance coverage for a low-income family member living with HIV, or while a parent living with HIV secures medical care or support services.

c. The service promotes family stability in coping with the unique challenges posed by HIV. Examples include permanency planning for children with HIV and affected children of parents living with HIV, receiving psychosocial services focused on equipping affected family members to manage the stress associated with HIV, and short-term post-death bereavement counseling. Services to affected individuals that meet this criterion may not continue subsequent to the death of the family member with HIV beyond the period of short-term bereavement counseling and/or permanency planning.

The following forms must be in the client file for eligibility documentation along with supporting documents:

- Ryan White Client Eligibility Documentation Checklist
- Client Eligibility Review Verification Form (CERV)
- Self-Attestation for Eligibility (if applicable)

Effective: 3/1/2005

Revised: 3/24/2016

CLIENT ELIGIBILITY REVIEW VERIFICATION FORM (CERV)

Purpose:

The Client Eligibility Review Form (CERV) has been created for conducting Client Annual Reviews.

Policy:

It is the responsibility of each provider to avoid duplication of clients or services. This form must be completed for each client. The information included on the review form must be entered in CAREWare as it will be used for verification. Client eligibility must be verified every 6 months.

Procedure:

*** See section on Unique Record Number to develop a URN for each client***

- CERV must be completed during the following times:
    - Annually
    - During the 6 month eligibility review based on the client's anniversary date.
- CERV must be completed by agencies where clients receive services if one is not available from a referring agency.
- Each client's file must contain a copy of the CERV.
- A CERV must be shared to referred agencies as needed.
- To avoid duplication,
    - Ask client if they used another name or if there have been any changes in the last 12 months in the following: name, race, gender, SSN, birthdate
    - Search in LACAN/CAREWare prior to adding the client

Attachment:

- CERV Form

Effective: 3/01/2007

Revised: 3/31/2016

CLIENT ELIGIBILITY REVIEW VERIFICATION FORM for **AFFECTED Clients**

Purpose:
The Client Eligibility Review Form for Affected Clients (CERV-AF) has been created for conducting Client Annual Reviews for individuals who are HIV-negative, but provide support for the client living with HIV.

Policy:
This form must be completed for each client who is affected. The primary purpose is

a. to enable the affected individuals to participate in the care of someone with HIV
b. t o enable a PLWH to receive needed medical or support services
c. to promote family stability for coping with the unique challenges posed by HIV/AIDS

Services to affected individuals must meet these criteria and may not continue subsequent to the death of the individual with HIV.
A copy of the CERV-AF form follows. Client eligibility must be verified every 6 months. Affected clients can only access Part A services for the purposes of helping the PLWH stay in care or improve health outcomes.

Only psychosocial services can be utilized by affected clients.

Procedure:

*** See section on Unique Record Number to develop a URN for each client***

- CERV-AF must be completed during the following times:
  - Annually
  - During the 6 month eligibility review based on the client's anniversary date.
- CERV-AF must be completed by agencies where clients receive services if one is not available from a referring agency.
- Each affected client's file must also contain a copy of the CERV of the client living with HIV.
- CERV-AF must be shared to referred agencies as needed.
- To avoid duplication,
  - ask client if they used another name or if there have been any changes in the last 12 months in the following: name, race, gender, SSN, birthdate
  - search in LACAN/CAREWare prior to adding the client.

Attachment:

- CERV-AF Form

Effective: 1/01/2011

Revised: 3/24/2016

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AFFECTED CLIENT ONLY

CITY OF NEW ORLEANS – OFFICE OF HEALTH POLICY AND AIDS FUNDING RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT: CLIENT ELIGIBILITY AND REVIEW VERIFICATION (CERV-AF) FORM

The UIN is a 12 digit number consisting of both letters and numbers. The UIN is created using the following formula:	
1st digit: First letter of first name, if unavailable, enter '9' 2nd digit: Third letter of first name, if unavailable, enter '9' 3rd digit: First letter of last name, if unavailable, enter '9' 4th digit: Third letter of last name, if unavailable, enter '9' 5th & 6th digits: Month of birth (01 to 12) 7th & 8th digits: Day of birth (01 to 31)	9th & 10th digits: Year of birth (00 to 99), do not use century 11th digit: Gender (Male: 1, Female: 2, Transgender: 3, Unknown: 4) 12th digit: Race/Ethnicity (White/Non Hispanic: 1, Black or African American/Non Hispanic: 2, Hispanic/Latino (a): 3, Asian: 4, Native Hawaiian/Pacific Islander: 5, American Indian or Alaskan Native: 6, Two or more races: 7, Unknown/Unreported: 8

DATE ________________

Affected clients are HIV-negative individuals who provide support for a client living with HIV.

URN: ______________________**(Automatically generated for the Affected client)**

Person Completing Initial CERV: ____________________________ **Agency:**____________________________

Client:	**Program:**
☒ Affected; Infected Client UIN: ______________________	☐ Ryan White Part A
☒ HIV-negative (affected only)	☐ MAI – (Minority AIDS Initiative)

DEMOGRAPHICS

In the last 12 months, have there been any changes in: name, race, gender, SSN, birthdate? ☐Yes ☐ No

Last Name	**First Name**
Middle Name	**Birth date (mm/dd/yyyy)**
	/ /
Preferred name:	

Gender

☐ Male	☐ Transgender: MtF
☐ Female	☐ Transgender unknown
☐ Transgender: FtM	☐ Refused to report

Sex at Birth ☐ Male ☐ Female

Race
- ☐ White
- ☐ Black / African American
- ☐ Two or More Races
- ☐ Native Hawaiian/ Other Pacific Islander
  - ☐ Native Hawaiian
  - ☐ Guamanian or Chamorro
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ American Indian /Alaskan Native
- ☐ Asian
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Other

Ethnicity: ☐ Non-Hispanic ☐ Hispanic → ☐ Mexican, Mexican American, Chicano/a ☐ Other Hispanic Latino/a, or Spanish Origin ☐ Puerto Rican ☐ Cuban

Address	**Apt#:**	**County (Parish)**		**Age Category**	
City		☐ Orleans	☐ Jefferson	☐ Infant (< 2 y)	☐ Adult (25 – 44)
State	**Zip**	☐ St. Bernard	☐ Plaquemines	☐ Children (2 – 12)	☐ Adult (45 – 64)
Cell Phone: ( ) -		☐ St. Charles	☐ St. James	☐ Youth (13 – 24)	☐ Adult (>65)
Home Phone: ( ) -		☐ St. Tammany	☐ St. John the Baptist		

Email address:

Calling/contact instructions: ☐ Do not leave a message ☐ *67 ☐ Other:

CLIENT CERTIFICATION AND CONSENT (Please initial next to each line below.)

_______ I understand that I have the right and freedom to select the service provider of my choice.
_______ I certify that the intake worker has informed me of all existing Ryan White Part A service providers.
_______ I understand that application to available third party payor is required in order to receive Ryan White Part A services.
_______ I certify that the information I have provided to document eligibility is true and accurate.
_______ I have been informed that all Ryan White Part A agencies to which I may be referred have a grievance policy and I may request a copy of grievance policy.
_______ I have been informed of my rights and responsibilities as a Ryan White client receiving services.
_______ I certify that I have been advised to have an emergency evacuation plan in the event of a mass departure.
_______ I authorize my information to be released or received to/from the Ryan White Part A Grantee, Ryan White agencies, U.S. Department of Health and Human Services (HRSA), Louisiana Office of Public Health, STD/HIV Program and other agencies for the purpose of programmatic reporting, coordinating care or services, and/or health monitoring. I understand that this information may be faxed, mailed or shared through a network database system, including the Louisiana CAREWare Access Network system, or CAREWare to said agencies.
_______ I consent to being contacted two years beyond the expiration date of this form for the purposes of health improvement, health monitoring and/or re-engagement in care or services.
_______ I understand I can revoke this consent at any time prior to the receipt of these services.

______________________________	______________________________
Printed Name of Client or Guardian/Legal Representative	Relationship to Client
______________________________	______________________________
Signature of Client or Guardian/Legal Representative	Date of Signature

Agency Representative (Print) ____

Agency Representative Signature ____**Date** ________/ ________/ ___________

SELF ATTESTATION FOR ELIGIBILITY FORM

Purpose:

The Self Attestation for Eligibility Form was created for determining client eligibility for residency and income verification when no other documentation is available.

Policy:

This form must be completed for clients who do not have the documents listed in the Ryan White Client Documentation Checklist to support residential and financial eligibility. Client eligibility must be verified every six (6) months. Self attestation can only be used once per grant cycle or per year.

Procedure:

- Self attestation must be completed during the following times:
  - Annually
  - During the 6 month eligibility review.
- Self attestation must be completed by agencies where clients receive services if one is not available from a referring agency.
- A completed Self Attestation for Eligibility Form must be in the client's file.

Attachment:

- Self attestation for Eligibility Form

Effective: 3/01/2016

Revised: 2/20/2017

Self-Attestation for Eligibility

This form shall be used for eligibility for Ryan White services only in the absence of other documentation as it pertains to no income or cash only income and/or proof of local residency. Completed form must be included in the client's file and can only be used once per grant year.

____

First Name   Middle Name   Last Name   Date of Birth

Agency: ___________________________ Agency Representative: ___________________________

RESIDENCY VERIFICATION

Please describe your current living arrangements:

☐ I am married and live with my spouse who supports me;
☐ I am married but do not live with my spouse and spouse provides no financial support;
☐ My rent and/or utilities are subsidized by a housing program;
☐ I live with a family member;
☐ I live with a friend;
☐ I live in a residential facility;
☐ I live in a homeless shelter/I am homeless.
☐ Other ____

Please state the reason you do not have identification or identification with your current address:

☐ Recently moved to the New Orleans EMA   ☐ Homeless   ☐ Living with friends/family temporarily

☐ Other:____

My identification card does not include my current address. I currently reside at the following address:

______________________________, ____________________, Louisiana ____________
Street address   City   zip code

INCOME VERIFICATION

Please initial next to the statement that best describes you.

_______**I certify that I am currently not employed and have no source of income. I do not receive any type of benefits including, but not limited to, unemployment, retirement, Social Security Income, or Social Security Disability Income.**

_______**I certify that I am paid in cash and this is my only source of income. I am employed on an (check one) ☐ hourly ☐ weekly ☐ monthly basis. I earn $_____________each (check one) ☐ hour ☐ week ☐ month.**
Please describe the work for which you are paid and reasons why your income would change (seasonal work, etc.)

____

____

By signing below (please initial next to each statement),
_____ I agree that the statements above are accurate.
_____ I agree that I will notify the program if there is any change in my income or address.
_____ I understand that this information will be used to allow me to receive Ryan White services.
_____ I understand that this information may be shared with a provider of a service to which I am referred.

______________________________________   ______________________________________
Client signature   *Date*   *Program representative signature*   *Date*

Update: 2/18/17

FILE CLOSURE POLICY

Purpose:

This policy is to give guidance on how to address the nonresponsive client, designating a time limit to close a client's file, and inform Providers when additional contact attempts with a client is no longer billable to Ryan White. This policy is meant to ensure that Providers have sustainable contact with their clients, and to ensure Ryan White dollars are utilized effectively.

Policy:

A Provider has 9 months and at least 3 contact attempts to bring a client back into care. Additional contact attempts can be made, not limited to, via phone, letter, or email per agency's policy. A client's file should be closed if no contact has been made after 9 months from their last face-to-face visit. Any continuation of contact attempts beyond this point is no longer billable to Ryan White Part A. A new CERV must be completed if the client desires to resume services.

Effective: 12/1/17