PALM BEACH COUNTY
RYAN WHITE HIV/AIDS PROGRAM MANUAL

Community Services Department
Board of County Commissioners Palm Beach County

Helping People Build Better Communities!

Effective Date: March 1, 2021

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Section I: Overview of Ryan White Part A Program

Ch 1. Statement of Purpose

The Palm Beach County Ryan White HIV/AIDS Program (PBC RWHAP) has developed this Program Manual to ensure adherence to local and federal policies and standards. The Program Manual serves as a reference to support service delivery within the HIV Coordinated Services Network system of care, and is inclusive of program, fiscal, and service specific guidelines. The Program Manual is reviewed annually, with updates released prior to the beginning of the grant year (GY). Program Manual updates within the GY are communicated through PBC RWHAP clarification notices, and will be included in the Program Manual the following year.

Ch 2. Authority/Oversight

HRSA HAB Policy Clarification Notices
HRSA HAB Universal, Program and Fiscal Monitoring Standards (2013)
HRSA Part A Manual (2013)
Palm Beach County Community Services Department (Recipient)
Palm Beach County HIV Care Council (local Planning Council)
Ryan White HIV/AIDS Treatment Extension Act

Referencing: Specific Authority 381.0011(13) FS.
Law Implemented 381.001(1), 381.003(1)(c), 381.0011 (5) FS, History-New1-23-07.
Amended 10-27-08

Ch 3. Ryan White HIV/AIDS Program (RWHAP) Part A Description

The United States Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 to improve quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV. The legislation has been reauthorized four times since its inception, in 1996, 2000, 2006, and 2009. The Ryan White Treatment Extension Act expired on September 30, 2013, but funding has been extended through the appropriations bill. Federal funding delivers HIV/AIDS care to over 500,000 people each year nationally, and approximately 3,500 persons in Palm Beach County. The RWHAP is the payer of last resort, with program clients receiving services when there are no other available sources of payment for care and treatment, public or private.

The Health Resources & Services Administration (HRSA) RWHAP provides core medical and support services to low-income persons with HIV/AIDS, based on availability, accessibility and funding of the program. As the Recipient of RWHAP Part A funding, Palm Beach County Board of County Commissioners (BCC) designates administration of the program to the Community Services Department (CSD), in concert with Palm Beach County HIV CARE Council (HIV CARE Council).

The Ryan White HIV/AIDS Treatment Extension Act of 2009 guiding principles include:

- Revise care systems to meet emerging needs. The Ryan White programs through local planning and decision making with broad community involvement, determine how to best meet the HIV/AIDS care needs. Programs assess the demographics of new HIV/AIDS

cases and revise care systems to ensure capacity to meet the needs of emerging communities and populations. Populations traditionally underserved, including persons living with HIV (PWH) who know their HIV status but are not in care, are a priority. Outreach and Early Intervention Services (EIS) work to ensure linkages are made to primary health and supportive services.

- Ensure access to quality HIV/AIDS care. Ryan White programs shall use quality management programs to ensure that available treatments are accessible and delivered according to established HIV related treatment guidelines.
- Coordinate services with other health care delivery systems. The Ryan White program, as payer of last resort, may fill gaps in care. This occurs through the coordination across federal/state/local programs in order to maximize efficient use of resources, enhance systems of care, and ensure coverage of HIV/AIDS related services within managed care plans.
- Evaluate the impact of funds and make needed improvements. Federal policy and funding decisions are increasingly determined by outcomes. Documentation demonstrating the impact of Ryan White funds on improving access to quality care/treatment along with areas of continued need are a priority. Programs must have a quality assurance and evaluation mechanisms that assess the effects of Ryan White resources on health outcomes of clients.

Structure

The Palm Beach County Board of County Commissioners (BCC) is the Recipient of the Ryan White Part A & MAI funding from the U.S. Department of Health and Human Services (HHS), Health Resource Services Administration (HRSA), HIV/AIDS Bureau (HAB) as an Eligible Metropolitan Area (EMA). The BCC delegates grant management and administration to the Community Services Department (CSD), Ryan White HIV/AIDS Program (RWHAP). This responsibility includes managing and monitoring each project, program, sub-award, function, or activity supported by the grant award.

PBC RWHAP organization chart (Appendix G) and Recipient staff contact information:

Program/Quality Management:

Casey Messer, DHSc, PA-C, AAHIVS
Program Manager, Ryan White
810 Datura Street
West Palm Beach, FL 33401
Phone: (561) 355-4730
E-Fax: (561) 242-7609
Email: cmesser@pbcgov.org

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Quality Management Clinician, Ryan White Program
810 Datura Street
West Palm Beach, FL 33401
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Juliane Tran, MPH
Quality Management Clinician, Ryan White Program
810 Datura Street
West Palm Beach, FL. 33401
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Shirley Lanier
Health Planner II, Ryan White Program
810 Datura Street
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Shoshana Ringer, M.Ed.
Ryan White Quality Management Coordinator
810 Datura Street
West Palm Beach, FL 33401
Phone: (561) 355-4788
E-Fax: (561) 242-7321
Email: sringer@pbcgov.org

Fiscal:
Maria L. Corona, MBA, CIA
Financial Analyst II
810 Datura Street
West Palm Beach, FL 33401
Phone: (561) 355-4796
Fax: (561) 355-3863
Email: mcorona@pbcgov.org

Tyshon Grimsley
Fiscal Specialist III
810 Datura Street
West Palm Beach, FL 33401
Phone: (561) 355-4708
Email: tgrimsle@pbcgov.org

Grant Compliance/Contract:
Anna Balla
Grant Compliance Specialist II
810 Datura Street
West Palm beach, FL 33401
Phone: (561) 355-4665
E-Fax: (561) 242-7172
Email: aballa@pbcgov.org

The BCC appoints members of the Palm Beach County HIV CARE Council (HIV CARE Council). The HIV CARE Council is charged with planning for the HIV Coordinated Services Network. This includes priority setting, resource allocation, integrated/comprehensive planning, assessing unmet need, special studies as needed, and administrative assessment. The HIV CARE Council has several standing committees, displayed below. The HIV CARE Council Manual can be found at http://discover.pbcgov.org/carecouncil/PDF/Member%20Services/manual.pdf.

The HIV CARE Council is a collaborative and balanced body made up of persons with HIV, members of affected communities, service providers, and community leaders whose legislative responsibilities shall be to plan, develop, monitor, evaluate and advocate for a medical and support services system for individuals and families affected by HIV/AIDS.

The current officials for 2020-2021 are:

CC Chair – Kim Enright
CC Vice Chair – Felisha Douglas-Bowman
CC Secretary – Eileen Perry
CC Treasurer – Vacant

The current committee chairs for 2020-2021 are:

Community Awareness Chair – Mary Jane Reynolds
Membership Chair – Eileen Perry
Planning Chair – Lysette Perez
Priorities & Allocations Chair – Vacant
Quality Management & Evaluation (QMEC) Chair – Lilia Perez
LGBTQ Health Equity Chair – Kim Enright
Local Pharmaceutical Assistance Program (LPAP) Chair – Felisha Douglas-Bowman

For more information about the HIV CARE Council, contact the HIV CARE Council Coordinator, Neeta Mahani, by phone 561-355-4820 or by email nmahani@pbcgov.org

Ch 4. PBC RWHAP Sub-recipients (2021-2022)

AIDS Healthcare Foundation (AHF)

AIDS Pharmaceutical Assistance, Early Intervention Services (EIS), Medical Case Management, including Treatment Adherence, Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Emergency Financial Assistance/Emergency Medication, Food Bank/Nutritional Supplements, Medical Transportation, Non-Medical Case Management

Location(s): 1. 200 Congress Park Drive, Delray Beach, FL 33445
2. 1411 North Flagler Drive, West Palm Beach, FL 33401
Phone: 1. (561) 279-0991
2. (561) 284-8182
Fax: 1. (561) 279-0539

Program Contact: Kristen Harrington
Email: Kristen.Harrington@ahf.org
Phone: (561) 350-2196

Fiscal Contact: Brad Mester
Email: Brad.Mester@ahf.org
Phone: (954) 522-3132

Quality Management Contact: Kristen Harrington
Email: Kristen.Harrington@ahf.org
Phone: (561) 350-2196

Compass, Inc.

Early Intervention Services (EIS), Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Mental Health Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Housing, Medical Transportation, Non-Medical Case Management

Location(s): 201 N. Dixie Highway, Lake Worth, FL 33460
Phone: (561) 533-9699
Fax: (561) 318-6671

Program Contact: Lysette Pérez
Email: lysette@compassglcc.com
Phone: (561)533-9699 ext. 4007

Fiscal Contact: Julie Seaver or Crista Mockenhaupt
Email: julie@compassglcc.com or Crista@compassglcc.com
Phone: (561)533-9699 ext. 4038

Quality Management Contact: Neka Mackay or Lysette Pérez
Email: neka@compassglcc.com or lysette@compassglcc.com
Phone: (561)533-9699 ext. 4003 or 4007

Florida Department of Health, Palm Beach County

Early Intervention Services (EIS), Oral Health Care

Appointment Line: (561) 625-5180
Location(s):

1. 851 Avenue P, Riviera Beach, FL 33404
   Northeast Health Center, (561) 803-7300
   Dental Clinic
2. 1250 Southwinds Dr, Lantana, FL 33462
   Lantana/Lake Worth Health Center, (561) 547-6800
   Maternity, Family Planning, STD Clinic, PrEP
3. 225 S. Congress Avenue, Delray Beach, FL 33445
   Delray Beach Health Center, (561) 274-3100
   STD Clinic, PrEP, Maternity, Family Planning
4. 345 S. Congress Avenue, Delray Beach, FL 33445
   Delray Beach Health Center, (561) 274-3100
   IDC
5. 38754 State Road 80, Belle Glade, FL 33430
   C.L. Brumback Health Center, (561) 983-9220
   IDC, STD Clinic, PrEP, Maternity, Family Planning
6. 1150 45th Street, West Palm Beach, FL 33407
   West Palm Beach Health Center, (561) 514-5300
   IDC, STD Clinic, PrEP, Maternity, Family Planning
7. 5985 10th Ave, Greenacres, FL 33463
   WIC Greenacres Center, (561) 357-6000
   WIC

Program Contact: Robert Scott
Email: Robert.Scott@flhealth.gov
Phone: (561) 804-7947

Fiscal Contact: Liliana Vasquez
Email: Liliana.Vasquez@flhealth.gov
Phone: (561) 530-6885

Quality Management Contact: Kathryn Mathieu
Email: Kathryn.Mathieu@flhealth.gov
Phone: (561) 514-5322

FoundCare, Inc.

Early Intervention Services (EIS), Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Food Bank/Home Delivered Meals, Medical Transportation, Non-Medical Case Management, Psychosocial Support Counseling (MAI only)

Location(s):
(1) 2330 S. Congress Avenue, Palm Springs, FL 33406
(2) 1901 South Congress Ave Suite 100 Boynton Beach, FL 33426
(3) 840 US Highway 1 North Palm Beach FL 33408
(4) 1500 NW Ave. L Suite A, Belle Glade, FL 33430

Phone:
(1) (561) 472-2466 (Palm Springs)
(2) (561) 274-6400 (Boynton Beach)
(3) (561) 776-8300 (North Palm Beach)
(4) (561) 996-7059 (Belle Glade)

Fax: (1) (561) 304-0472
(2) (561) 274-3912
(3) (561) 776-0727
(4) (561) 996-1567

Program Contact: Tiffany Coutee
Email: tcoutee@foundcare.org
Phone: (561) 472-2466 X111

Fiscal Contact: Hannah Burson
Email: hburson@foundcare.org
Phone: (561) 472-9160 X211

Quality Management Contact: Tiffany Coutee
Email: tcoutee@foundcare.org
Phone: (561) 472-2466 X111

Legal Aid Society of Palm Beach County
Legal Services, Non-Medical Case Management

Location(s): 423 Fern Street, Suite 200, West Palm Beach, FL 33401
Phone: (561)655-8944
Fax: (561)655-5269

Program Contact: Sandra Powery Moses
Email: smoses@legalaidpbc.org
Phone: (561)822-9821 and (561)383-1530

Fiscal Contact: Shane Ramsaroop
Email: sramsaroop@legalaidpbc.org
Phone: (561)822-9765

Quality Management Contact: Laura Rivera
Email: lrivera@legalaidpbc.org
Phone: (561)721-6096

Midway Specialty Care Center

Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Non-Medical Case Management

Location(s): 1515 North Flagler Drive, Suite 200, West Palm Beach, FL 33401
Phone: (561) 249-2279
Fax: (561) 720-2970

Program Contact: Jenn Kuretski, DNP, APRN, FNP-C, AAHIVS
Email: jkuretski@midwaycare.org
Phone: (561) 249-2279

Fiscal Contact: Kathyrn Hayden
Email: khayden@midwaycare.org
Phone: (772) 742-9276

Quality Management Contact: Geoff Downie
Email: gdownie@midwaycare.org
Phone: (954) 495-7141

Monarch Health Services, Inc.

Early Intervention Services (EIS)

Location(s): 2580 Metrocentre Blvd., Ste 1
Phone: (561) 523-4589
Fax: (561) 491-2602

Program Contact: Stephanie Thomas
Email: sthomas@monarchealth.org
Phone: (786)449-9683

Fiscal Contact: Stephanie Thomas
Email: sthomas@monarchealth.org
Phone: (786)449-9683

Quality Management Contact: Stephanie Thomas
Email: sthomas@monarchealth.org
Phone: (786)449-9683

The Poverello Center, Inc.

Food Bank/Home Delivered Meals

Location(s): Grocery and Gift Card Home Deliveries throughout Palm Beach County, Administrative Offices at 2056 N Dixie Hwy, Wilton Manors, FL 33305

Program Contact: Shanel Pamphile
Email: spamphile@poverello.org for intake: intake@poverello.org
Phone: (954) 361-9242

Fiscal Contact: Jose Castillo
Email: jcastillo@poverello.org
Phone: (954) 256-8134

Quality Management Contact: Santiago Barney
Email: sbarney@poverello.org
Phone: (954) 449-6357

Treasure Coast Health Council, Inc. d/b/a Health Council of Southeast Florida
Early Intervention Services (EIS), Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Specialty Outpatient Medical Care, Medical Transportation, Non-Medical Case Management, Psychosocial Support Counseling (MAI only)

Location(s): 600 Sand Tree Drive, Suite 101, Palm Beach Gardens, FL 33403
Phone: (561) 844-4220
Fax: (561) 844-3310

Program Contact: Anil Pandya, COO
Email: apandya@hcsef.org
Phone: Extension 2400

Fiscal Contact: Anne Costello, CFO
Email: acostello@hcsef.org
Phone: Extension 2000

Quality Management Contact: Tanya Lacey, Quality Manager
Email: apandya@hcsef.org
Phone: Extension 2400

(Appendix H- PBC RWHAP Subrecipient Service Matrix)

Section II: Universal Guidelines-Program

Ch 1. Continuous Quality Improvement

Purpose
To establish continuous quality improvement standards for Sub-recipients providing any service through PBC RWHAP.

Policy
Sub-recipients shall participate in quality management activities, as required by the Recipient.

Procedure
Sub-recipient shall designate a Quality Management representative.
The designated Quality Management representative shall

a) Participate in the HIV CARE Council Quality Management and Evaluation Committee
b) Lead Sub-recipient continuous quality improvement projects and author Sub-recipient's quality management plan; and
c) Ensure accurate collection and reporting of Sub-recipient data.

National Monitoring Standards

Quality Management		
Standard	**Performance Measure/Method**	**Provider/Sub-Recipient Responsibility**
Implementation of a Clinical Quality Management (CQM) Program to: • Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent HHS Guidelines for the treatment of HIV/AIDS and related opportunistic infections • Develop strategies for ensuring that services are consistent with the guidelines for improvement in the access to and quality of HIV health services CQM program to include: • A Quality Management Plan • Quality expectations for providers and services • A method to report and track expected outcomes • Monitoring of provider compliance with HHS Guidelines and the EMA's approved Standards of Care	• Documentation that the West Palm Beach EMA has in place a Clinical Quality Management Program that includes, at a minimum: o A Quality Management Plan o Quality expectations for providers and services o A method to report and track expected outcomes o Monitoring of provider compliance with HHS Guidelines and the EMA's approved service category definition for each funded service • Review of CQM program to ensure that both the grantee and providers are carrying out necessary CQM activities and reporting CQM performance data	• Participate in quality management activities as contractually required; at a minimum: o Compliance with relevant service category definitions and EMA/TGA standards of care o Collection and reporting of data for use in measuring performance

Ch 2. Access to Care

Purpose
To establish access to care standards for Sub-recipients providing any service through PBC RWHAP.

Policy
Sub-recipient shall ensure access to care standards are met.

Procedure
Sub-recipient must demonstrate access to care standards are met through documentation/methods outlined in National Monitoring Standards.

National Monitoring Standards

Access to Care		
Standard	**Performance Measure/ Method**	**Provider/Sub-Recipient Responsibility**
1. Structured and ongoing efforts to obtain input from clients in the design and delivery of services	· Documentation of Consumer Advisory Board and public meetings – minutes and/ or · Documentation of existence and appropriateness of a suggestion box or other client input mechanism and/or · Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted at least annually	· Maintain file of materials documenting Consumer Advisory Board (CAB) membership and meetings, including minutes · Maintain visible suggestion box or other client input mechanism · Regularly implement client satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented
2. Provision of services regardless of an individual's ability to pay for the service	Subgrantee billing and collection policies and procedures do not: · Deny services for non- payment · Deny payment for inability to produce income documentation · Require full payment prior to service · Include any other procedure that denies services for non-payment	· Have billing, collection, co- pay, and schedule of charges and limitation of charges policies that do not act as a barrier to providing services regardless of the client's ability to pay · Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of complaint review and decision reached
3. Provision of services regardless of the current or past health condition of the individual to be served	· Documentation of eligibility determination and provider policies to ensure that they do not: · Permit denial of services due to pre-existing conditions · Permit denial of services due to non-HIV-related conditions (primary care) · Provide any other barrier to care due to a person's past or present health condition	· Maintain files of eligibility determination and clinical policies · Maintain file of individuals refused services

4. Provision of services in a setting accessible to low-income individuals with HIV disease	· A facility that is accessible, · Policies and procedures that provide, by referral or vouchers, transportation if facility is not accessible to public transportation policies that may act as a barrier to care for low- income individuals	· Comply with Americans with Disabilities Act (ADA) requirements · Ensure that the facility is accessible by public transportation or provide for transportation assistance
5. Outreach to inform low-income individuals of the availability of HIV-related services and how to access them	Availability of informational materials about subgrantee services and eligibility requirements such as: · Newsletters · Brochures · Posters · Community Bulletins · Any other types of promotional materials	· Maintain file documenting subgrantee activities for the promotion of HIV services to low-income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements

Ch 3. Client Eligibility Determination

Purpose
To establish client eligibility determination standards for Sub-recipients providing any service through PBC RWHAP.

Policy
The RWHAP legislation requires that individuals receiving services through HRSA RWHAP must:

a) Have a diagnosis of HIV;
b) Be low-income, defined as at or below 400% Federal Poverty Level (FPL); AND
c) Be a resident of Palm Beach County.

By statute, HRSA RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payment source. Sub-recipients must make reasonable efforts to secure non-RWHAP funds for services, prior to utilizing PBC RWHAP-funded services. Sub-recipients are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage and/or other private health insurance). PBC RWHAP is the payer of last resort and will provide services not covered, or partially covered, by public or private health insurance plans.

Additional caps/limitations for specific service categories may be implemented to meet program goals under principles of health equity. When setting priorities and allocating funds, the HIV CARE Council may optionally limit certain services more precisely. Further information can be found within each service category guideline and summarized on the Caps/Limitations Table (formerly known as the Eligibility Table)

HRSA Policy Clarification Notices: PCN#13-01, PCN#13-02, PCN#13-03, PCN#13-04, PCN#13-05

Procedures
Sub-recipients providing PBC RWHAP services must certify and document client eligibility prior to, or simultaneously with, services being rendered. Sub-recipients are required to make a determination of client eligibility/ineligibility within 24 hours of receiving all required documentation.

<u>Initial Eligibility Certification Documentation</u>

Required Eligibility Documentation

a) Proof of HIV diagnosis; AND
b) Proof of Palm Beach County residency; AND
c) Proof of income at or below 400% FPL.

Required HIV Coordinated Services Network (CSN) Enrollment Documentation

- Authorization to Use and Disclose Protected Health Information
- Notice of Privacy Practices

- Client Rights and Responsibilities
- Grievance Policy
- Verification of enrollment and/or screening for other third-party insurance programs or payer sources

Required Client Profile Documentation
- Eligibility Assessment
- Notice of Eligibility Determination

Eligibility Recertification Documentation
Sub-recipients must recertify and document client ongoing eligibility to receive PBC RWHAP services at least every six (6) months OR at any time within the eligibility period when changes may affect a client's eligibility status, including:
- Client is no longer a resident of Palm Beach County
- Client income exceeds 400% FPL

Semi-Annual Recertification

Once every twelve (12) months, Sub-recipients may accept client self-attestation as verification for ongoing eligibility to receive PBC RWHAP services.

Required Eligibility Documentation
- Proof of Palm Beach County residency
- Proof of income at or below 400% FPL

Required Coordinated Services Network (CSN) Enrollment Documentation
- Verification of enrollment and/or screening for other third-party insurance programs or payer sources

Required Client Profile Documentation
- Eligibility Assessment
- Notice of Eligibility Determination

Annual Recertification

At least once every twelve (12) months, Sub-recipients must collect documentation verifying ongoing eligibility to receive PBC RWHAP services. *Note: Self-Attestation Form is not an acceptable verification document for annual recertification. Self-Attestation may only be utilized to recertify client eligibility once in any twelve (12) month period.*

Required Eligibility Documentation
- Proof of Palm Beach County residency
- Proof of income at or below 400% FPL

Required Coordinated Services Network (CSN) Enrollment Documentation
- Authorization to Use and Disclose Protected Health Information
- Notice of Privacy Practices

- Client Rights and Responsibilities
- Grievance Policy
- Verification of enrollment and/or screening for other third-party insurance programs or payer sources

Required Client Profile Documentation

- Eligibility Assessment
- Notice of Eligibility Determination

Rapid Eligibility Determination

For both initial/annual and semi-annual recertification procedures, eligibility determinations may be performed simultaneously with testing and treatment. Sub-recipients assume the risk that PBC RWHAP funds utilized for clients ultimately determined to be ineligible will not be reimbursed by the recipient, and Sub-recipient must identify an alternate payment source for the services rendered. All funded service categories may be provided on a time-limited basis, not to exceed 30 days. Sub-recipients may determine if and which services they are willing to provide to clients during this time-limited rapid eligibility determination period.

PBC RWHAP Client Eligibility Determination & Recertification Required Documentation Table (Appendix A)

PBC RWHAP Six-Month Self-Attestation Eligibility Form (Appendix B)

Allowable Documentation List is in (Appendix C)

Eligibility Status Notification

1. The applicant shall be provided written Notice of Eligibility (NOE) determination identifying the service categories for which they are eligible.
2. The applicant will be ineligible for all service categories not listed on the NOE and shall be provided reason for ineligibility.

Additional Information

1. Clients with access to local, state or federal programs that deliver the same type of services provided through HRSA RWHAP must utilize services through those programs since PBC RWHAP is payer of last resort. This requirement does not preclude an individual from receiving allowable services not provided or available by other local, state or federal programs, or pending a determination of eligibility from other local, state or federal programs.

2. PBC RWHAP eligibility shall only be determined by PBC RWHAP Recipient/Sub-recipients. PBC RWHAP will allow an active, current (less than 6 months old) Notice of Eligibility from a RW HIV/AIDS Program Part A or Part B/ADAP within the state of Florida as acceptable source documentation for PBC RWHAP eligibility so long as the NOE contains sufficient information from which an eligibility determination can be made (current address, income/household size/FPL, 3rd party payer source, etc.). If the information contained in the NOE is insufficient (i.e. address outside of PBC), additional documentation must be provided.

National Monitoring Standards

Client Eligibility Determination		
Standard	**Performance Measure/Method**	**Provider/Sub-Recipient Responsibility**
1. Eligibility determination and reassessment of clients to determine eligibility as specified by the jurisdiction or ADAP: · Eligibility determination of clients to determine eligibility for Ryan White services within a predetermined timeframe · Reassessment of clients at least every 6 months to determine continued eligibility	· Documentation of eligibility determination required in client records, with copies of documents (e.g., proof of HIV status, proof of residence, proof of income eligibility based on the income limit established by the EMA, TGA, State/territory jurisdiction or ADAP (for Part A can be established by the grantee or the planning council), proof of insurance, uninsured or underinsured, using approved documentation as required by the jurisdiction · Eligibility Determination and enrollment forms for other third party payers such as Medicaid and Medicare · Eligibility policy and procedures on file · Documentation that all staff involved in eligibility determination has participated in required training · Subgrantee client data reports are consistent with eligibility requirements specified by funder. · Documentation of reassessment of client's eligibility status at least every six months · Training provided by the Grantee/contractor to ensure understanding of the policy and procedures	· Develop and maintain client records that contain documentation of client's eligibility determination, including the following: Initial Eligibility Determination & Once a year/12 Month Period Recertification Documentation Requirements: · HIV/AIDS diagnosis (at initial determination) · Proof of residence · Low income (Note: for ADAP supplemental, low income is defined as not more than 200% of the Federal Poverty Level) · Uninsured or underinsured status (Insurance verification as proof) · Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare · For underinsured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare · Proof of compliance with eligibility determination as defined by the jurisdiction or ADAP Recertification (minimum of every six months) documentation requirements:

			· Proof of residence · Low-income documentation · Uninsured or underinsured status (Insurance verification as proof) · Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare **Note:** At six-month recertification, one of the following is acceptable: *full application and documentation, self-attestation of no change or self- attestation of change with documentation.* · Proof of compliance with eligibility determination as defined by the jurisdiction or ADAP · Document that the process and timelines for establishing initial client eligibility, assessment, and recertification takes place at a minimum every six months. · Document that all staff involved in eligibility determination have participated in required training · Subgrantee client data reports are consistent with eligibility requirements specified by funder, which demonstrates eligible clients are receiving allowable services [See Program Monitoring section for a list of allowable services.]

2. Ensure military veterans with Department of Veterans Affairs (VA) benefits are deemed eligible for Ryan White services	· Documentation that eligibility determination policies and procedures do not consider VA health benefits as the veteran's primary insurance and deny access to Ryan White services citing "payer of last resort"	· Ensure that policies and procedures classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the "payer of last resort" requirement

Ch 4. Suspending Client Relationships

Purpose
To establish guidelines for suspending client relationships with Sub-recipients providing any service through PBC RWHAP.

Policy
Sub-recipients are not required to provide PBC RWHAP services to prospective or current clients when doing so threatens the physical, mental, or emotional well-being of Sub-recipient staff, the public, or the client themselves.

Procedure
A prospective or current PBC RWHAP client relationship with a Sub-recipient may be suspended voluntarily, or involuntarily for violations of Sub-recipient policies and procedures that govern code of conduct, rights and responsibilities, or for actions that are deemed threatening to the well-being of Sub-recipient staff, the public, or the client themselves. Client behavior warranting suspension may include, but is not limited to, threats or acts of violence, verbal abuse and harassment, criminal activity, and destruction or theft of property.

Sub-recipients are encouraged to assess if client behavior can be attributed to medical or mental health diagnoses, and attempt to provide appropriate services that may support a change in client behaviors when possible. Progressive interventions such as verbal warning, written warning, and counseling/education should be utilized and documented prior to suspending client relationships.

Client relationship suspensions may be for a defined period of time or indefinite, and must be documented in the client record. Client must be notified of suspension in writing; including information related to reason for suspension, length of time of suspension, procedures and conditions of re-establishing the relationship, resources/referrals to needed services from other service providers, and a copy of the sub-recipient grievance policy.

In all cases of client relationship suspensions, the Ryan White Part A Program Manager must be notified by the Sub-recipient via email and provided a copy of written client notification. Clients have the right to grieve the suspension in accordance with Sub-recipient grievance policy and procedures.

Ch 5 Service Referrals

Purpose
To establish service referral standards for Sub-recipients providing any service through PBC RWHAP.

Policy
Sub-recipient shall obtain written referral and linkage agreements with key points of entry. Referrals shall be managed in the RWHAP data management information system. Sub-recipients shall acknowledge referrals regardless of current funding availability.

Procedure
All referrals must be processed and tracked through the RWHAP client data management information system. For internal referrals to Ryan White sub-recipients, the agency and needed service must be selected. For external referrals outside the HIV CSN, select or enter the agency and service needed.

Regardless of funding availability for service, referrals are encouraged to be submitted. Referral reports are used in planning, the priorities and allocations process, as well as grant applications to demonstrate unmet need.

Referrals created in the client data management system are open for 30 days. After 30 days, if there is no acknowledgement, a new referral must be submitted.

National Monitoring Standards

Service Referrals		
Standard	**Performance Measure/Method**	**Provider/Sub-Recipient Responsibility**
2. **Referral relationships with key points of entry:** Requirement that Part A service providers maintain appropriate referral relationships with entities that constitute key points of entry Key points of entry defined in legislation: • Emergency rooms • Substance abuse and mental health treatment programs • Detoxification centers • Detention facilities • Clinics regarding sexually transmitted disease • Homeless shelters • HIV disease counseling and testing sites Additional points of entry include: • Public health departments • Health care points of entry specified by eligible areas • Federally Qualified Health Centers • Entities such as Ryan White Part B, C , D, and F grantees	Documentation that written referral relationships exist between Part A service providers and key points of entry	• Establish written referral relationships with specified points of entry • Document referrals from these points of entry

Ch 6. Minority AIDS Initiative Services (MAI)

Purpose
To establish Minority AIDS Initiative service standards for Sub-recipients providing any service through PBC RWHAP.

Policy
MAI funds are designated to reduce the HIV-related health disparities and improve the health outcomes for disproportionately impacted, HIV+ minority populations, such as Black/African Americans, Black Haitians, and Hispanics. MAI funding shall be used to address health disparities and health inequalities among minority communities. As instructed by HRSA, MAI funds are to be used to deliver services designed to address the unique barriers and challenges faced by hard to reach disproportionately impacted minorities within the EMA.

The overarching goal of the MAI is to improve health outcomes by preventing transmission or slowing disease progression for disproportionately impacted communities, such as: a. getting persons with HIV into care at an earlier stage in their illness; b. assuring access to treatments that are consistent with established standards of care; and c. helping individuals to remain in care.

MAI funded services must be consistent with the epidemiologic data and the needs of the community, and be culturally appropriate. MAI funded services shall use population-tailored, innovative approaches or interventions that differ from the usual service methodologies and that specifically address the unique needs of prioritized sub-groups.

MAI funding may be allocated to any HRSA defined service. MAI funded services are determined by the HIV CARE Council on an annual basis.

Organizations funded to provide MAI services must also meet the following criteria:

1. Are located in or near to the prioritized community they are intending to serve.
2. Have a documented history of providing services to the prioritized communities.
3. Have documented linkages to the prioritized populations, so that they can help close the gap in access to service for highly impacted minority communities.
4. Provide services in a manner that is culturally and linguistically appropriate.
5. Demonstrate understanding of the importance of cross-cultural, language appropriate communications, and general health literacy issues in an integrated approach to develop the skills and abilities needed by HRSA-funded providers and staff to effectively deliver the best quality health care to the diverse populations they serve.

Procedure
Sub-recipients must provide specific and population-tailored services, including prioritized activities to improve HIV-related health outcomes, reduce existing racial and ethnic health disparities, and increase equity in the HIV care continuum. Sub-recipient must be able to describe how these activities address the unique needs of the prioritized MAI populations. Sub-recipients must clearly specify the prioritized population/s to be served within the client data management information system.

The following data shall be tracked and maintained for each priority population served under the initiative:

- Funding amount expended
- Number of clients served
- Units of service overall and by race/ethnicity and WICY (women, infants, children and youth)
- Client level outcomes (HRSA/HAB measures or local metrics)

National Monitoring Standards

Minority AIDS Initiative		
Standard	**Performance Measure/Method**	**Provider/Sub-Recipient Responsibility**
1. Reporting a. Submission of an Annual Plan 60 days after the budget start date or as specified in the Notice of Award that details: • The actual award amount • Anticipated number of unduplicated clients who will receive each service • Anticipated units of service • Planned client-level outcomes for each minority population served under the Minority AIDS Initiative (MAI) b. Submission of an Annual Report due January 31 of the year following completion of the MAI fiscal year	Documentation that the grantee has submitted an MAI Annual Plan 60 days after the budget start date that contains required elements and meets HRSA/HAB reporting requirements	• Establish and maintain a system that tracks and reports the following for MAI services: o Dollars expended o Number of clients served o Units of service overall and by race and ethnicity, women, infants, children, youth o Client-level outcomes

Ch 7 Sub-recipient Monitoring

Purpose
To establish monitoring standards for Sub-recipients providing any service through PBC RWHAP.

Policy
Sub-recipients, including their sub-contractors, shall be monitored annually by the Recipient to ensure compliance with all applicable HRSA standards.

Procedure
The Sub-recipient shall participate in an annual monitoring site visit, using the *Ryan White Part A Comprehensive Monitoring Tool* to assess compliance with the HRSA National Monitoring Standards (April 2013). Recipient may conduct unannounced site visits when deemed appropriate.

Sub-recipients shall provide all requested documentation including, but not limited to, applicable files, policy manuals, records, etc. Interviews with staff members and clients may also be requested.

The Sub-recipient shall commit to annual monitoring dates at the beginning of the contract period.

A comprehensive monitoring report will be emailed to the authorizing official whose signature is on the contract.

Findings shall be addressed through a Corrective Action Plan (CAP). Failure of Sub-recipient to resolve issues identified through the monitoring process may result in contract penalties, suspension, termination or more rigorous future monitoring.

Sub-recipient shall establish policies and procedures to ensure compliance with federal and programmatic requirements.

National Monitoring Standards

Sub-recipient Monitoring		
Standard	**Performance Measure/Method**	**Provider/Sub-Recipient Responsibility**
1. Any grantee or subgrantee or individual receiving federal funding is required to monitor for compliance with federal requirements and programmatic expectations	· Development and consistent implementation of policies and procedures that establish uniform administrative requirements governing the monitoring of awards	· Participate in and provide all material necessary to carry out monitoring activities. · Monitor any service contractors for compliance with federal and programmatic requirements
2. Monitoring activities expected to include annual site visits of all Provider/Sub grantee.Note: Annual Site Visit Exemption requests may be submitted through EHB prior approval Note: Code of Federal Regulations (45 CFR 74.51; 92.40 and 215.51) states that the HHS awarding	· Review of the following program monitoring documents and actions: o Policies and procedures o Tools, protocols, or methodologies o Reports o Corrective site action plans o Progress on meeting goals of corrective action plans	· Establish policies and procedures to ensure compliance with federal and programmatic requirements · Submit auditable reports · Provide the grantee access to financial documentation

agency will prescribe the frequency of monitoring activities		
3. Performance of fiscal monitoring activities to ensure Ryan White funds are only used for approved purposes	· Review of the following fiscal monitoring documents and actions: o Fiscal monitoring policy and procedures o Fiscal monitoring tool or protocol o Fiscal monitoring reports o Fiscal monitoring corrective action plans o Compliance with goals of corrective action plans	Have documented evidence that federal funds have been used for allowable services and comply with Federal and Ryan White requirements
4. Salary Limit: HRSA funds may not be used to pay the salary of an individual at a rate in excess of $197,300. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts for substantive work under a HRSA grant or cooperative agreement.	· Identification and description of individual employee salary expenditures to ensure that salaries are within the HRSA Salary Limit. · Determine whether individual staff receives additional HRSA income through other subawards or subcontracts.	· Monitor staff salaries to determine whether the salary limit is being exceeded. · Monitor prorated salaries to ensure that the salary when calculated at 100% does not exceed the HRSA Salary Limit. · Monitor staff salaries to determine that the salary limit is not exceeded when the aggregate salary funding from other federal sources including all parts of Ryan White do not exceed the limitation. · Review payroll reports, payroll allocation journals and employee contracts.
5. Salary Limit Fringe Benefits: If an individual is under the salary cap limitation, fringe is applied as usual. If an individual is over the salary cap limitation, fringe is calculated on the adjusted base salary.	· Identification of individual employee fringe benefit allocation.	· Monitor to ensure that when an employee salary exceeds the salary limit, the fringe benefit contribution is limited to the percentage of the maximum allowable salary.
6. Corrective actions taken when subgrantee outcomes do not meet program objectives and grantee expectations, which may include: · Improved oversight · Redistribution of funds · A "corrective action" letter · Sponsored technical assistance	· Review corrective action plans · Review resolution of issues identified in corrective action plan · Policies that describe actions to be taken when issues are not resolved in a timely manner	Prepare and submit: · Timely and detailed response to monitoring findings · Timely progress reports on implementation of corrective action plan

Ch 8. Client Grievances

Purpose
To establish client grievance standards for Sub-recipients providing any service through PBC RWHAP.

Policy
The Sub-recipient shall establish a grievance policy for PBC RWHAP clients. The grievance policy must outline steps in the grievance process, including appeals and escalation, and provide the right to appeal to the Recipient's office after exhausting Sub-recipient's process.

Procedure
Sub-recipient grievance policy must be provided to clients upon enrollment, and/or prior to providing services.

Sub-recipient must track all grievances filed by clients and provide summary, including resolution, to Recipient upon request.

PBC RWHAP Monitoring Standards

Client Grievances		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Client grievance policy outlining steps in the grievance process, including appeals and escalation.	Documentation of client grievance policy Grievance policy provided to client upon enrollment, and/or prior to providing services Tracking of all Sub-recipient grievances filed by clients with associated resolutions.	Establish client grievance policy Demonstrate grievance policy provided to clients upon enrollment, and/or prior to providing services Provide summary of all grievances filed by clients, including resolutions, to Recipient upon request

Ch 9. Client Data Management Information System Access & Reporting

Purpose
To establish client data management information system standards for Sub-recipients providing any service through PBC RWHAP.

Policy
The PBC RWHAP client data management information system is Groupware Technologies, Inc. (GTI) Provide Enterprise (PE) Care Management Software.

Sub-recipients must report all service delivery information using the client data management information system.

Sub-recipients requesting discontinued access for a User must submit a User Deletion Request through the data management system. If the User is separated from the organization, the request shall be submitted no later than one (1) business day following separation of the User.

It is prohibited to enter fraudulent records into the system. Additionally, unauthorized use, destruction, stealing and/or alteration of data are prohibited. Incidents of fraud and/or misuse shall be reported immediately followed by submission of the Community Services PBC RWHAP Incident Notification Form (Appendix D) to the Ryan White Program Manager.

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) continues to improve health outcomes through data utilization. National RWHAP client-level data is collected through the Ryan White HIV/AIDS Services Report (RSR). The RSR dataset is HAB's primary source of annual, client-level data collected from its nearly 2,000 funded grant recipients and Sub-recipients.

Client-level RSR data have been used to assess the numbers and types of clients receiving services and their HIV outcomes. As such, the Recipient and Sub-recipients are required to submit to HRSA an annual RSR, which draws from information from the client data management information system.

Sub-recipients shall submit all required reports by the deadline, ensuring the data and subsequent analyses are accurate.

Procedures
Sub-recipients shall:

- Follow instructions detailed in the Provide Enterprise Palm Beach HIV/AIDS Care Network CARE User Guide;
- Ensure all client data management information system users have signed the Provide Enterprise User Confidentiality Agreement (Appendix E) ;
- Document all service delivery information in client data management information system before submitting request for reimbursement. Service-specific information requirements can be found within the Core Medical and Support Service sections.
- Secure data according to all local, state, and federal regulations;
- Establish a policy that addresses protection of data;

- Report any suspected data compromises to the RWHAP Recipient immediately, but no later than one (1) business day.
- Submit the Ryan White HIV/AIDS Program Service Report RSR by the established deadline.

National Monitoring Standards

Data Reporting Requirements		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Submission of the **Ryan White HIV/AIDS Program Services Report (RSR),** which includes three components: the Grantee Report, the Service Provider Report, and the Client Report		
Submission of the on-line service providers report	Documentation that all service providers have submitted their sections of the online service providers report	• Report all the Ryan White Services offered to clients during the funding year • Submit both interim and final reports by the specified deadlines
Submission of the on-line client report	Documentation that all service providers have submitted their sections of the online client report	• Maintain client-level data on each client served, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received, and the client's Unique Client Identifier • Submit this report online as an electronic file upload using the standard format • Submit both interim and final reports by the specified deadlines
Submission of standard reports as required in circulars as well as program- specific reports as outlined in the Notice of Award.	Records that contain and adequately identify the source of information pertaining to: · Federal award revenue, expenses, obligations, unobligated balances, assets, outlays, program income, interest · Client level data · Aggregate data on services provided; clients served, client demographics, and selected financial information	Ensure: · Submission of timely subgrantee reports · File documentation or data containing analysis of required reports to determine accuracy and any reconciliation with existing financial or programmatic data. Example: Test program income final FFR with calendar year RDR. · Submission of periodic financial reports that document the expenditure of Ryan White funds, positive and negative spending variances, and how funds have been reallocated to other line-items or

		service categories
WICY – Women, Infants, Children, and Youth: Amounts set aside for women, infants, children, and youth to be determined based on each of these population's relative percentage of the total number of persons living with AIDS in the EMA/TGA Waiver available if grantee can document that funds sufficient to meet the needs of these population groups are being provided through other federal or state programs	• Documentation that the amount of Part A funding spent on services for women, infants, children, and youth is at least equal to the proportion each of these populations represents of the entire population of persons living with AIDS in the EMA or TGA • If a waiver is requested, documentation that the service needs of one or more of these populations are already met through funding from another federal or state program	Track and report to the grantee the amount and percentage of Part A funds expended for services to each priority population

Ch 10. Service Eligibility Override Request

Purpose
To establish service eligibility override request standards for Sub-recipients providing any service through PBC RWHAP

Policy
Sub-recipient may submit a service eligibility override to request Recipient review of client service eligibility determination made by PBC RWHAP client data management information system.

Service eligibility override requests shall not be used to request an exception to PBC RWHAP eligibility policies.

Service eligibility override requests shall only be submitted in instances where a client has an alternative payer source that does not provide coverage for the needed service (underinsured).

Service eligibility override requests shall be approved or rejected at the discretion of the Recipient.

Procedure
Sub-recipient shall submit a service eligibility override request through the PBC RWHAP client data management information system.

Sub-recipient shall include client-specific documentation to demonstrate that client has exhausted all alternative payer sources. (e.g. Summary of Benefits, Insurance Denial Letter, etc.)

Sub-recipient may resubmit service eligibility override requests that are rejected based on lack of supporting documentation once necessary supporting documentation is obtained.

Section III: Universal Guidelines-Fiscal

Ch 1. Allowable & Unallowable/Prohibited Uses of Funds

Purpose
To establish standards for the use of RWHAP funds by Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
Sub-recipients shall only make use of RWHAP funds to support the following:

- Core Medical Services
- Support Services that are needed by individuals with HIV/AIDS to achieve medical outcomes related to their HIV/AIDS-related clinical status
- Clinical Quality Management
- Administrative activities

Sub-recipients must comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and with any cancellation of unobligated funds.

Sub-recipients shall comply with legislative requirements for RWHAP to participate in Medicaid and be certified to receive Medicaid payments or be able to document efforts under way to obtain such certification.

Limitations for RWHAP funds include the following:

- Aggregated sub-recipient administrative expenses total not more than 10% of Part A service dollars
- Appropriate sub-recipient assignment of Ryan White Part A administrative expenses, with administrative costs to include:
  · Usual and recognized overhead activities, including rent, utilities, and facility costs (mortgage/property taxes are unallowable).
  · Costs of management oversight of specific programs funded under this title, including program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; computer hardware/ software not directly related to patient care
- Only first line supervisors responsible for oversight of direct patient care are allowable as Direct costs (PCN 15-01)

Procedures
Sub-recipients shall:

- Use RWHAP funds in accordance with established federal regulations and limitations.
- Sub-recipients shall bill and document for only allowable services.
- Prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses, quality management, program income, and expenses by service category.
- Inform the Recipient of any projected under-expenditures greater than 10% in any service category on a monthly basis.

- By June 30th provide status of 1st quarter expenditures, if 20% of expenditures have not been spent, agency is subject to 10% sweep of funds. Agency must submit Cash Flow Commitment Statement along with Statement of Cash Flows, Statement of Activities and Statement of Financial Position.
- By September 30th provide status of 2nd quarter expenditures, if 40% of expenditures have not been spent, agency is subject to 50% sweep of funds. Agency must submit Cash Flow Commitment Statement along with Statement of Cash Flows, Statement of Activities and Statement of Financial Position.
- By November 1st agency to provide projection of unspent/unobligated funds for end of grant year.
- By December 30th, provide status of 3rd quarter expenditures, if 75% of expenditures have not been spent, agency is subject to sweeps of 100% of remaining unspent funds. Agency must submit Cash Flow Commitment Statement along with Statement of Cash Flows, Statement of Activities and Statement of Financial Position.
- Provide annual audit within nine (9) months of fiscal year end.
- Provide copies of all grant audits and monitoring reports from other agencies by first day of monitoring by the County.
- Provide Final invoice by March 31st and label "Final Invoice".
- Provide Final closeout report and Financial Reconciliation Statement no later than 30 days from end of contract.

Program National Monitoring Standards

Allowable Uses of Part A Service Funds & Prohibitions of Certain Activities and Additional Requirements		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
Allowable Uses of Part A Service Funds		
1. Use of Part A funds only to support: • Core medical services • Support services that are needed by individuals with HIV/AIDS to achieve medical outcomes related to their HIV/AIDS-related clinical status • Clinical quality management • Administrative activities (including Planning Council support)	RFP, contracts, MOU/LOA, and/or statements of work language that describes and defines Part A services within the range of activities and uses of funds allowed under the legislation and defined in HRSA HAB Policy Notices including core medical and support services, clinical quality management and administration (including Planning Council support)	• Provide the services described in the RFP, contracts, MOU/LOA, and/or statements of work Bill only for allowable activities • Maintain in files, and share with the grantee on request, documentation that only allowable activities are being billed to the Part A grant
Administration		
Prohibitions on Promotion of Certain Activities and Additional Requirements		

1. **Drug Use and Sexual Activity:** Ryan White funds cannot be used to support AIDS programs or materials designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual	• Signed contracts, grantee and subgrantee assurances, and/or certifications that define and specifically forbid the use of Ryan White funds for unallowable activities • Grantee review of subgrantee budget and expenditures to ensure that they do not include any unallowable costs or activities	• Maintain a file with signed subgrant agreement, assurances, and/or certifications that specify unallowable activities • Ensure that budgets and expenditures do not include unallowable activities • Ensure that expenditures do not include unallowable activities • Provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs or activities
2. **Purchase of Vehicles without Approval:** No use of Ryan White funds by grantees or subgrantees for the purchase of vehicles without written approval of HRSA Grants Management Officer (GMO)	• Implementation of measure/method, grantee responsibility and provider/subgrantee responsibility actions specified in G.1 above • Where vehicles were purchased, review of files for written permission from GMO	• Carry out subgrantee actions specified in G.1 above • If vehicle purchase is needed, seek grantee assistance in obtaining written GMO approval and maintain document in file
3. **Broad Scope Awareness Activities:** No use of Ryan White funds for broad scope awareness activities about HIV services that target the general public	• Implementation of actions specified in G.1 above • Review of program plans, budgets, and budget narratives for marketing, promotions and advertising efforts, to determine whether they are appropriately targeted to geographic areas and/or disproportionately affected populations rather than targeting the general public	• Carry out subgrantee actions specified in G.1 above • Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities
4. **Lobbying Activities:** prohibition on the use of Ryan White funds for influencing or attempting to influence members of Congress and other Federal personnel	• Implementation of actions specified in G.1 above • Review of lobbying certification and disclosure forms for both the grantee and subgrantees Note: Forms can be obtained from the CFR website: http://www.hhs.gov/forms/PHS-5161-1.pdf http://ecfr.gpoAccess.gov	• Carry out subgrantee actions specified in G.1 above • Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds

5. **Direct Cash Payments:** No use of Ryan White program funds to make direct payments of cash to service recipients	• Implementation of activities described in the "Performance Measure/Method, Grantee Responsibility and Provider/Subgrantee Responsibility" sections in G.1 above • Review of Standards of Care and other policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance premiums, medical or medication co-pays and deductibles, food and nutrition) • Review of expenditures by subgrantees to ensure that no cash payments were made to individuals	• Carry out subgrantee actions specified in G.1 above • Maintain documentation that all provider staff have been informed of policies that forbid use of Ryan White funds for cash payments to service recipients
6. **Employment and Employment-Readiness Services:** prohibition on the use of Ryan White program funds to support employment, vocational, or employment-readiness services	Implementation of measure/method, grantee responsibility and provider/subgrantee responsibility actions specified in G.1 above	Carry out subgrantee actions specified in G.1 above
7. **Maintenance of Privately Owned Vehicle:** No use of Ryan White funds for direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees ***Note:*** This restriction does not apply to vehicles operated by organizations for program purposes	• Implementation of actions specified in G.1 above • Documentation that Ryan White funds are not being used for direct maintenance expenses or any other costs associated with privately owned vehicles, such as lease or loan payments, insurance, or license and registration fees – except for vehicles operated by organizations for program purposes	Carry out subgrantee actions specified in G.1 above
8. **Syringe Services**: No use of Ryan White funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug	Implementation of measure/method, grantee responsibility and provider/subgrantee responsibility actions specified in G.1 above Documentation that Ryan White funds are not being used for programs related to sterile needles or syringe exchange for injection drug use.	Carry out subgrantee actions specified in G.1 above

9. **Additional Prohibitions:** No use of Ryan White Funds for the following activities or to purchase these items: • Clothing • Funeral, burial, cremation or related expenses • Local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied) • Household appliances • Pet foods or other non- essential products • Off-premise social/recreational activities or payments for a client's gym membership • Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility • Pre-exposure prophylaxis	• Implementation of measure/method, grantee responsibility and provider/subgrantee responsibility actions specified in G.1 above • Review and monitoring of grantee and subgrantee activities and expenditures to ensure that Ryan White funds are not being used for any of the prohibited activities	Carry out subgrantee actions specified in G.1 above
3. **Expenditure and Use of Funds** a. Compliance with statutory requirements regarding the timeframe for obligation and expenditure of funds, and with any cancellation of unobligated funds	Documentation that grantee has complied with statutory requirements regarding the timeframe for obligation and expenditure of funds, and with any cancellation of unobligated funds	• Inform the grantee of any expected under-expenditures as soon as identified
f. Compliance with legislative requirements regarding the Medicaid status of providers: funded providers of Medicaid-reimbursable services must be participating in Medicaid and certified to receive Medicaid payments or able to document efforts under way to obtain such certification.	Documentation that funded providers providing Medicaid- reimbursable services either: • Are participating in Medicaid, certified to receive Medicaid payments, and using Medicaid funds whenever possible to cover services to people living with HIV disease • Are actively working to obtain such certification Documentation that funded providers providing Medicaid- reimbursable services either: • Are participating in Medicaid, certified to receive Medicaid payments, and using Medicaid funds whenever possible to cover services to people living with HIV disease • Are actively working to obtain such certification	• Maintain on file documentation of Medicaid Status and that the provider is able to receive Medicaid payments • Document efforts and timeline for certification if in process of obtaining certification

Fiscal National Monitoring Standards

Limitation on Uses of Part A Funding & Unallowable Costs		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
***Section A:* Limitation on Uses of Part A funding**		

4. Aggregated subgrantee administrative expenses total not more than 10% of Part A service dollars	· Review of subgrantee budgets to ensure proper designation and categorization of administrative costs · Calculation of the administrative costs for each subgrantee · Calculation of the total amount of administrative expenses across all subgrantees to ensure that the aggregate administrative costs do not exceed 10%	Prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses
5. Appropriate subgrantee assignment of Ryan White Part A administrative expenses, with administrative costs to include: · Usual and recognized overhead activities, including rent, utilities, and facility costs · Costs of management oversight of specific programs funded under this title, including program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; computer hardware/ software not directly related to patient care	Review of subgrantee administrative budgets and expenses to ensure that all expenses are allowable	· Prepare project budget that meets administrative cost guidelines · Provide expense reports that track administrative expenses with sufficient detail to permit review of administrative cost elements
6. Inclusion of Indirect costs (capped at 10%) only where the grantee has a certified HHS-negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certificate of Indirect Costs, which has been reviewed by the HRSA/HAB Project Officer ***Note*:** To obtain an indirect cost rate through HHS's Division of Cost Allocation (DCA),visit their website at: http://rates.psc.gov/	For grantee wishing to include an indirect rate, documentation of a current Certificate of Cost Allocation Plan or Certificate of Indirect Costs that is HHS- negotiated, signed by an individual at a level no lower than chief financial officer of the governmental unit that submits the proposal or component covered by the proposal, and reviewed by the HRSA/HAB Project Officer	· If using indirect cost as part or all of its 10% administration costs, obtain and keep on file a federally approved HHS-negotiated Certificate of Cost Allocation Plan or Certificate of Indirect Costs · Submit a current copy of the Certificate to the grantee
8. Expenditure of not less than 75% of service dollars on core medical services, unless a waiver has been obtained from HRSA (Service dollars are those grant funds remaining after removal of administrative and clinical quality management funds)	· Review of budgeted allocations and actual program expenses to verify that the grantee has met or exceeded the required 75% expenditure on HRSA-defined core medical services	Report to the grantee expenses by service category
9. Total expenditures for support services limited to no more than 25% of service dollars. Support services are those services, subject to approval of the Secretary of Health and Human Services, that are needed for individuals with HIV/AIDS to achieve their medical outcomes.	· Documentation that support services are being used to help achieve positive medical outcomes for clients · Documentation that aggregated support service expenses do not exceed 25% of service funds	· Report to the grantee expenses by service category · Document that support service funds are contributing to positive medical outcomes for clients
***Section B:* Unallowable Costs**		

1. The grantee shall provide to all Part A subgrantees definitions of unallowable costs	· Signed contracts, grantee and subgrantee assurances, and/or certifications that define and specifically forbid the use of Ryan White funds for unallowable expenses Note: Unallowable costs are listed in the Universal Monitoring Standards · Grantee review of subgrantee budgets and expenditures to ensure that they do not include any unallowable costs	· Maintain a file with signed subgrant agreement, assurances, and/or certifications that specify unallowable costs · Ensure that budgets do not include unallowable costs · Ensure that expenditures do not include unallowable costs · Provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs
2. No use of Part A funds to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility (other than minor remodeling)	Implementation of actions specified in B.1 above	Carry out subgrantee actions specified in B.1 above
3. No cash payments to service recipients Note: A cash payment is the use of some form of currency (paper or coins). Gift cards have an expiration date; therefore, they are not considered to be cash payments.	· Implementation of actions specified in B.1. above · Review of policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance premiums, medical or medication co-pays and deductibles, food and nutrition) · Review of expenditures by subgrantees to ensure that no cash payments were made to individuals	· Carry out subgrantee actions specified in B.1. above · Maintain documentation of policies that prohibit use of Ryan White funds for cash payments to service recipients
4. No use of Part A funds to develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual	Implementation of actions specified in B.1 above	Carry out subgrantee actions specified in B.1 above
5. No use of Part A funds for the purchase of vehicles without written Grants Management Officer (GMO) approval	· Implementation of actions specified in B.1. above · Where vehicles were purchased, review of files for written permission from GMO	· Carry out subgrantee actions specified in B.1 above · If vehicle purchase is needed, seek grantee assistance in obtaining written GMO approval and maintain document in file
6. No use of Part A funds for: · Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.) · Broad-scope awareness activities about HIV services that target the general public	· Implementation of actions specified in B.1. above · Review of program plans, budgets, and budget narratives for marketing, promotions and advertising efforts, to determine whether they are appropriately targeted to geographic areas and/or disproportionately affected populations rather than targeting the general public	· Carry out subgrantee actions specified in B.1. above · Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities

7. No use of Part A funds for outreach activities that have HIV prevention education as their exclusive purpose	· Implementation of actions specified in B.1. above · Review of program plans, budgets, and budget narratives for outreach activities that have HIV prevention education as their exclusive purpose	· Carry out subgrantee actions specified in B.1. above · Provide a detailed program plan of outreach activities that demonstrates how the outreach goes beyond HIV prevention education to include testing and early entry into care
8. No use of Part A funds for influencing or attempting to influence members of Congress and other Federal personnel	· Implementation of actions specified in B.1. above · Review of lobbying certification and disclosure forms for both the grantee and subgrantees Note: Forms can be obtained from the CFR website: http://ecfr.gpoAccess.gov	· Carry out subgrantee actions specified in B.1 above · Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds
9. No use of Part A funds for foreign travel	Implementation of actions specified in B.1 above · Review of program plans, budgets, and budget narratives for foreign travel	· Carry out subgrantee actions specified in B.1 above · Maintain a file documenting all travel expenses paid by Part A funds
***Section I:* Matching or Cost-Sharing Funds**		
1. Grantees required to report to HRSA/HAB information regarding the portion of program costs that are not borne by the federal government Grantees expected to ensure that non-federal contributions: · Are verifiable in grantee records · Are not used as matching for another federal program · Are necessary for program objectives and outcomes · Are allowable · Are not part of another federal award contribution (unless authorized) · Are part of the approved budget · Are part of unrecovered indirect cost (if applicable) · Are apportioned in accordance with appropriate federal cost principles · Include volunteer	· Review grantee annual comprehensive budget · Review all grantee in-kind and other contributions to Ryan White program · Review grantee documentation of other contributed services or expenses	Where subgrantee on behalf of the grantee provides matching or cost sharing funds, follow the same verification process as the grantee

services, if used, that are an integral and necessary part of the program, with volunteer time allocated value similar to amounts paid for similar work in the grantee organization · Value services of contractors at the employees' regular rate of pay plus reasonable, allowable and allocable fringe benefits · Assign value to donated supplies that are reasonable and do not exceed the fair market value · Value donated equipment, buildings, and land differently according to the purpose of the award · Value donated property in accordance with the usual accounting policies of the recipient (not to exceed fair market value)		

Ch 2. Program Income from Third Party Source/Fees for Services Performed

Purpose
To establish standards for program income from third party source/fees for services performed by Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
Sub-recipients shall adhere to federal requirements and maximize program income from third party sources.

Procedure
Sub-recipients shall:

- Document policies and procedures, including staff training, on meeting the requirement that Ryan White be the payer of last resort.
- Require that each client be screened for insurance coverage and eligibility for third party programs, and assist client to apply for such coverage, with documentation of this in client records.
- Establish and maintain medical practice management systems for billing.
- Document and maintain file information on agency Medicaid status and that the provider is able to receive Medicaid payments.
- Maintain file of contracts with Medicaid insurance companies. If no Medicaid certification, document current efforts to obtain such certification. If certification is not feasible, request a waiver where appropriate.
- Bill, track, and report to the Recipient all program income billed and obtained.
- Report expenses from third-party payer collections, and adjustment reports or by the application of a revenue allocation formula.
- Report to the Recipient in detail, use of Program Income in RWHAP.

Fiscal National Monitoring Standards

Income from Fees for Services Performed		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
***Section C:* Income from Fees for Services Performed**		
1. Use of Part A and other funding sources to maximize program income from third party sources and ensure that Ryan White is the payer of last resort. Third party funding sources include: · Medicaid · State Children's Health Insurance Programs (SCHIP) · Medicare (including the Part D prescription drug benefit) and · Private insurance	· Information in client records that includes proof of screening for insurance coverage · Documentation of policies and consistent implementation of efforts to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance or other programs · Documentation of procedures for coordination of benefits by grantee and subgrantees	· Have policies and staff training on the requirement that Ryan White be the payer of last resort and how that requirement is met · Require that each client be screened for insurance coverage and eligibility for third party programs, and helped to apply for such coverage, with documentation of this in client records · Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third party payer is not available · Establish and maintain medical practice management systems for billing
2. Ensure billing and collection from third party payers, including Medicare and Medicaid, so that payer of last resort requirements are met	· Inclusion in subgrant agreements of language that requires billing and collection of third party funds · Review of the following subgrantee systems and procedures: o Billing and collection policies and procedures o Electronic or manual system to bill third party payers o Accounts receivable system for tracking charges and payments for third party payers	Establish and consistently implement: · Billing and collection policies and procedures · Billing and collection process and/or electronic system · Documentation of accounts receivable
3. Ensure subgrantee participation in Medicaid and certification to receive Medicaid payments.	· Review of subgrantee's/ provider's individual or group Medicaid number · If subgrantee is not currently certified to receive Medicaid payments, documentation of efforts under way to obtain documentation and expected timing	· Document and maintain file information on grantee or individual provider agency Medicaid status · Maintain file of contracts with Medicaid insurance companies · If no Medicaid certification, document current efforts to obtain such certification · If certification is not feasible, request a waiver where appropriate
4. Ensure billing, tracking, and reporting of program income by grantee and subgrantees	· Review of subgrantee billing, tracking, and reporting of program income, · Review of program income	Bill, track, and report to the grantee all program billed and obtained

	reported by the grantee in the FFR and annual reports	
5. Ensure service provider retention of program income derived from Ryan White-funded services and use of such funds in one or more of the following ways: · Funds added to resources committed to the project or program, and used to further eligible project or program objectives · Funds used to cover program costs ***Note:*** Program income funds are not subject to the federal limitations on administration (10%), quality management (5%), or core medical services (75% minimum). For example, all program income can be spent on administration of the Part A program, however HRSA does encourage funds be used for services.	· Review of grantee and subgrantee systems for tracking and reporting program income generated by Ryan White-funded services · Review of expenditure reports from subgrantees regarding collection and use of program income · Monitoring of medical practice management system to obtain reports of total program income derived from Ryan White Part A activities	· Document billing and collection of program income. · Report program income documented by charges, collections, and adjustment reports or by the application of a revenue allocation formula

Ch 3. Program Income from RWHAP Client Fees and Use of Program Income

Purpose
To establish standards for program income from RWHAP client fees and use of program income by Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
The Sub-recipient shall:

- Develop and implement a program income policy as defined in PCN 15-03.
- Charge clients for RWHAP Part A services based on established sliding fee schedule.
- Document each instance where a client is asked to pay, as well as instances where a client is unable to pay.
- Not refuse services for non-payment.
- Ensure that the accounting system for tracking patient charges and payments discontinues charges once the client has reached their annual cap.
- Uses the 'additive' alternative whereby program income must be used for the purposes for which the award was made, and may only be used for allowable costs under the award. For RWHAP allowable costs are limited to core medical and support services, clinical quality management, and administrative expenses (including planning and evaluation) as part of a comprehensive system of care for low-income people with HIV and AIDS.
- Document and track all payments received in accordance with its program income policy, and report to the Recipient annually at the close of the grant year and when status update is requested during monitoring activities. Such revenue must be deposited into the account of the program that generated it, and must be used for the sole purpose to grow or benefit that program.

Procedure
The Sub-recipient shall establish, document and have available for Recipient review:

- Program Income Policy
- Schedule of charges
- Fees charged by the Sub-recipient and the payments made to that Sub-recipient by clients and/or source of generated income
- Process for obtaining and documenting client charges and other generated income

Sub-recipient charges shall:

- Be publicly posted (schedule of charges or sliding fee scale).
- Not be imposed on clients with income below 100% of the Federal Poverty Level (FPL). This shall be reflected in all Sub-recipient program income policy.
- Be for clients with incomes greater than 100% FPL as determined by the schedule of charges.
- Note annual limitations on the amount of charge for RWHAP services are based on the percent of the client's annual income as follows:
  - 5% for clients with incomes between 100% and 200% of FPL
  - 7% for clients with incomes between 201% and 300% of FPL
  - 10% for clients with incomes greater than 301% of FPL

Sub-recipients shall:

- Determine clients' eligibility for established fees and caps.
- Track RWHAP charges or medical expenses inclusive of enrollment fees, deductibles, co-payments, etc.
- Develop a process for alerting the billing system when the client has reached the cap and shall not be further charged for the remainder of the year.
- Ensure Sub-recipient staff are following the established program income policy.

Sub-recipients shall not:

- Deny services for non-payment
- Deny services for inability to produce income documentation
- Require full payment prior to service
- Include any other procedure that denies services for non-payment

Fiscal National Monitoring Standards

Imposition & Assessment of Client Charges		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
***Section D:* Imposition & Assessment of Client Charges**		
1. Ensure grantee and subgrantee policies and procedures require a publicly posted schedule of charges (e.g. sliding fee scale) to clients for services, which may include a documented decision to impose only a nominal charge ***Note:*** This expectation applies to grantees that also serve as direct service providers	Review of subgrantee policies and procedures, to determine: · Existence of a provider policy for a schedule of charges. A publically posted schedule of charges based on current Federal Poverty Level (FPL) including cap on charges · Client eligibility for imposition of charges based on the schedule. · Track client charges made and payments received · How accounting systems are used for tracking charges, payments, and adjustments	Establish, document, and have available for review: · policy for a schedule of charges Current schedule of charges · Client eligibility determination in client records · Fees charged by the provider and the payments made to that provider by clients · Process for obtaining, and documenting client charges and payments through an accounting system, manual or electronic
2. No charges imposed on clients with incomes below 100% of the Federal Poverty Level (FPL)	Review of provider policy for schedule of charges to ensure clients with incomes below 100% of the FPL are not charged for services	Document that: · policy for schedule of charges does not allow clients below 100% of FPL to be charged for services · Personnel are aware of and consistently following the policy for schedule of charges Policy for schedule of charges must be publically posted

3. Charges to clients with incomes greater than 100% of poverty are determined by the schedule of charges. Annual limitation on amounts of charge (i.e. caps on charges) for Ryan White services are based on the percent of client's annual income, as follows: · 5% for clients with incomes between 100% and 200% of FPL · 7% for clients with incomes between 200% and 300% of FPL · 10% for clients with incomes greater than 300% of FPL	· Review of policy for schedule of charges and cap on charges · Review of accounting system for tracking patient charges and payments · Review of charges and payments to ensure that charges are discontinued once the client has reached his/her annual cap.	Establish and maintain a schedule of charges t policy that includes a cap on charges and the following: · responsibility for client eligibility determination to establish individual fees and caps · Tracking of Part A charges or medical expenses inclusive of enrollment fees, deductibles, co-payments, etc. · A process for alerting the billing system that the client has reached the cap and should not be further charged for the remainder of the year · Personnel are aware of and consistently following the policy for schedule of charges and cap on charges.

Ch 4. Financial Management & Fiscal Procedural Requirements

Purpose
To establish standards for financial management & fiscal procedural requirements for Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
Sub-recipients' financial management shall**:**

- Comply with established requirements in the Code of Federal Regulations (CFR) all applicable federal and local statutes and regulations governing contract award and performance.

Sub-recipients' fiscal policies and procedures shall:

- Maintain policies and procedures for handling revenues from the Ryan White grant, including program income.
- Comply with the right of the Recipient to inspect and review records and documents that detail the programmatic and financial activities and the use of Ryan White funds, including payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds.
- Document employee time and effort.
- Ensure adequate reporting, reconciliation, and tracking of program expenditures.
- Coordinate fiscal activities with program activities.
- Have an organizational and communications chart for the fiscal department.

Procedure
Sub-recipients provide Recipient access to the following evidence of financial management:

- Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports.
- All financial policies and procedures, including billing and collection policies and purchasing and procurement policies, and accounts payable systems and policies.
- Ensure adequate fiscal systems to generate needed budgets and expenditure reports with line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services.

Fiscal National Monitoring Standards

Financial Management & Fiscal Procedures		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
***Section E:* Financial Management**		
1. Compliance by grantee with all the established requirements in the Code of Federal Regulations (CFR) for (a) state and local governments; and (b) non-profit organizations, hospitals, commercial organizations and institutions of higher education. Included are for: · Payments for services · Program income · Revision of budget and program plans · Non-federal audits · Property standards, including insurance coverage, equipment, supplies, and other expendable property · Procurement standards, including recipient responsibilities, codes of conduct, competition, procurement procedures, cost and price analysis, and procurement records. · Reports and records, including monitoring and reporting, program performance, financial reports, and retention and access requirements · Termination and enforcement and closeout procedures	· Review of grantee and subgrantee accounting systems to verify that they are sufficient and have the flexibility to operate the federal grant program and meet federal requirements · Review of the grantee's systems to ensure capacity to meet requirements with regard to: o Payment of subgrantee contractor invoices o Allocation of expenses of subgrantees among multiple funding sources · Review of grantee and subgrantee: o Financial operations policies and procedures o Purchasing and procurement policies and procedures o Financial reports · Review of subgrantee contract and correspondence files · Review of grantee's process for reallocation of funds by service category and subgrantee · Review of grantee's FFR trial worksheets and documentation	Provide grantee personnel access to: · Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports of the subgrantee · All financial policies and procedures, including billing and collection policies and purchasing and procurement policies · Accounts payable systems and policies
2. Comprehensive grantee and subgrantee budgets and reports with sufficient detail to account for Ryan White funds by service category, subgrantee, administrative costs, and (75/25 rule) core medical and support services rules, and to delineate between multiple funding sources and show program income	Review of: · Accounting policies and procedures · Grantee and subgrantee budgets · Accounting system used to record expenditures using the specified allocation methodology · Reports generated from the accounting system to determine if the detail and timeliness are sufficient to manage a Ryan White program	Ensure adequacy of agency fiscal systems to generate needed budgets and expenditure reports, including: · Accounting policies and procedures · Budgets · Accounting system and reports

3. Line-item grantee and subgrantee budgets that include at least four category columns: · Administrative · Clinical Quality Management (CQM) · HIV Services · MAI	· Review of grantee line-item budget and narrative for inclusion of required forms, categories, and level of detail to assess the funding to be used for administration, CQM, and direct provision of services and the budget's relation to the scope of services · Review of grantee's administrative budget and narrative for inclusion of sufficient Planning Council support funds to cover reasonable and necessary costs associated with carrying out legislatively mandated functions · Review of subgrantee line- item budget to ensure inclusion of required information and level of detail to ensure allowable use of funds and its relation to the proposed scope of services	Submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services
4. Revisions to approved budget of federal funds that involve significant modifications of project costs made by the grantee only after approval from the HRSA/HAB Grants Management Officer (GMO) ***Note:*** A significant modification occurs under a grant where the federal share exceeds $100,000, when cumulative transfers among direct cost budget categories for the current budget period exceed 25% of the total approved budget (inclusive of direct and indirect costs and federal funds and required matching or cost sharing) for that budget period or $250,000, whichever is less. Even if a grantee's proposed re-budgeting of costs fall below the significant re-budgeting threshold identified above, grantees are still required to request prior approval, if some or all of the re- budgeting reflects either of the following: · A change in scope · A proposed purchase of a unit of equipment exceeding $25,000 (if not included in the approved application)	· Comparison of grantee's current operating budget to the budget approved by the Project Officer · Documentation of written GMO approval of any budget modifications that exceeds the required threshold	Document all requests for and approvals of budget revisions

6. Provider subgrant agreements and other contracts meet all applicable federal and local statutes and regulations governing subgrant/contract award and performance Major areas for compliance: a. Follow state law and procedures when awarding and administering subgrants (whether on a cost reimbursement or fixed amount basis) b. Ensure that every subgrant includes any clauses required by federal statute and executive orders and their implementing regulations c. Ensure that subgrant agreements specify requirements imposed upon subgrantees by federal statute and regulation d. Ensure appropriate retention of and access to records e. Ensure that any advances of grant funds to subgrantees substantially conform to the standards of timing and amount that apply to cash advances by federal agencies	Develop and review Part A subcontract agreements and contracts to ensure compliance with local and federal requirements	· Establish policies and procedures to ensure compliance with subgrant provisions · Document and report on compliance as specified by the grantee
Section K: **Fiscal Procedures**		
1. Grantee and subgrantee policies and procedures in place for handling revenues from the Ryan White grant, including program income	· Review policies and procedures related to the handling of cash or Ryan White grantee or subgrantee revenue · Sample accounting entries to verify that cash and grant revenue is being recorded appropriately	· Establish policies and procedures for handling Ryan White revenue including program income · Prepare a detailed chart of accounts and general ledger that provide for the tracking of Part A revenue · Make the policies and process available for grantee review upon request
2. Advances of federal funds not to exceed 30 days and to be limited to the actual, immediate cash requirements of the program ***Note:*** Grantee permitted to draw down 1/12 of funds, but at the end of each month must do a reconciliation to actual expenses	· Review grantee's advance policy to assure it does not allow advances of federal funds for more than 30 days · Review subgrantee agreements for allowable advances · Review payments to subgrantees and payment management system draw- downs	Document reconciliation of advances to actual expenses
3. Right of the awarding agency to inspect and review records and documents that detail the programmatic and financial activities of grantees and subgrantees in the use of Ryan White funds	Review subgrantee agreements to ensure that language is included that guarantees access to records and documents as required to oversee the performance of the Ryan White subgrantee	Have in place policies and procedures that allow the grantee as funding agency prompt and full access to financial, program, and management records and documents as needed for program and fiscal monitoring and oversight

4. Awarding agency to have access to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds	Use of primary source documentation for review: · A sample of grantee and subgrantee payroll records · Grantee and subgrantee documentation that verifies that payroll taxes have been paid · Grantee and subgrantee accounts payable process, including a sampling of actual paid invoices with back-up documentation	· Maintain file documentation of payroll records and accounts payable, and hard-copy expenditures data · Make such documentation available to the grantee on request
5. Awarding agency not to withhold payments for proper charges incurred by grantee unless the grantee or subgrantee has failed to comply with grant award conditions or is indebted to the United States; grantee not to withhold subgrantee payments unless subgrantee has failed to comply with grant award conditions	Review the timing of payments to subgrantee through sampling that tracks accounts payable process from date invoices are received to date checks are deposited	· Provide timely, properly documented invoices · Comply with contract conditions
6. Awarding agency to make payment within 30 days after receipt of a billing, unless the billing is improperly presented or lacks documentation	· Review grantee payable records · Review subgrantee invoices, submission dates, and bank deposits of Part A payments · Review grantee policies on how to avoid payment delays of more than 30 days to subgrantees	· Submit invoices on time monthly, with complete documentation · Maintain data documenting reimbursement period, including monthly bank reconciliation reports and receivables aging report
7. Employee time and effort to be documented, with charges for the salaries and wages of hourly employees to: · Be supported by documented payrolls approved by the responsible official · Reflect the distribution of activity of each employee · Be supported by records indicating the total number of hours worked each day	Review documentation of employee time and effort, through: · Review of payroll records for specified employees · Documentation of allocation of payroll between funding sources if applicable	· Maintain payroll records for specified employees · Establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources · Make payroll records and allocation methodology available to grantee upon request
9. Grantee and subgrantee fiscal staff are responsible for: · Ensuring adequate reporting, reconciliation, and tracking of program expenditures · Coordinating fiscal activities with program activities (*For example, the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income)* · *Having an organizational and communications chart for the fiscal department*	· Review qualifications of program and fiscal staff · Review program and fiscal staff plan and full-time equivalents (FTEs) to determine if there are sufficient personnel to perform the duties required of the Ryan White grantee · Review grantee organizational chart	· Review the following: o Program and fiscal staff resumes and job descriptions o Staffing Plan and grantee budget and budget justification o Subgrantee organizational chart · Provide information to the grantee upon request

Ch 5. Property Standards

Purpose
To establish property standards for Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
Sub-recipients shall:

- Track and report on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part A funds and having a useful life of more than one year, and an acquisition cost of $5,000 or more per unit (Lower limits may be established, consistent with Recipient policies).
- Implement adequate safeguards for all capital assets that assure that they are used solely for authorized purposes.
- Real property, equipment, intangible property, and debt instruments acquired or improved with federal funds held in trust by Sub-recipient with title of the property vested in the Sub-recipient but with the federal government retaining a reversionary interest.

Procedure

Sub-recipients shall:

- Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source.
- Make the list and schedule available to the Recipient upon request.
- Establish policies and procedures that acknowledge the reversionary interest of the federal government over property improved or purchased with federal dollars.
- Maintain file documentation of these policies and procedures for Recipient review.
- Develop and maintain a current, complete, and accurate supply and medication inventory list and make the list available to the Recipient upon request.

Fiscal National Monitoring Standards

Property Standards		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
***Section F:* Property Standards**		
1. Grantee and subgrantee tracking of and reporting on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part A funds and having: · A useful life of more than one year, and · An acquisition cost of $5,000 or more per unit (Lower limits may be established, consistent with recipient policies)	Review to determine that the grantee and each subgrantee has a current, complete, and accurate: · Inventory list of capital assets purchased with Ryan White funds · Depreciation schedule that can be used to determine when federal reversionary interest has expired	· Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source · Make the list and schedule available to the grantee upon request

2. Implementation of adequate safeguards for all capital assets that assure that they are used solely for authorized purposes	· Review grantee and subgrantee inventory lists of assets purchased with Ryan White funds · During monitoring, ensure that assets are available and appropriately registered · Review depreciation schedule for capital assets for completeness and accuracy	Carry out the actions specified in F.1 above
3. Real property, equipment, intangible property, and debt instruments acquired or improved with federal funds held in trust by grantee and subgrantees, with title of the property vested in the grantee or subgrantee but with the federal government retaining a reversionary interest	· Implementation of actions specified in F.1. above · Review to ensure grantee and subgrantee policies that: o Acknowledge the reversionary interest of the federal government over property purchased with federal funds o Establish that such property may not be encumbered or disposed of without HRSA/HAB approval	· Carry out the actions specified in F.1. above · Establish policies and procedures that acknowledge the reversionary interest of the federal government over property improved or purchased with federal dollars · Maintain file documentation of these policies and procedures for grantee review
4. Assurance by grantee and subgrantees that: · Title of federally-owned property remains vested in the federal government · If the HHS awarding agency has no further need for the property, it will be declared excess and reported to the General Services Administration	Implementation of actions specified in F.1 above	Carry out the actions specified in F.1 above
5. Title to supplies to be vested in the recipient upon acquisition, with the provision that if there is a residual inventory of unused supplies exceeding $5,000 in total aggregate value upon termination or completion of the program and the supplies are not needed for any other federally-sponsored program, the recipient shall: · Retain the supplies for use on non-federally sponsored activities or sell them · Compensate the federal government for its share contributed to purchase of supplies	Review to ensure the existence of an inventory list of supplies including medications purchased with local drug assistance or ADAP funds	· Develop and maintain a current, complete, and accurate supply and medication inventory list · Make the list available to the grantee upon request

Ch 6. Cost Principles

Purpose
To establish cost principle standards for Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
Sub-recipients shall ensure cost principles by:

- Ensuring services are cost based and relate to Ryan White administrative, quality management, and programmatic costs in accordance with standards cited under OMB Circulars or the Code of Federal Regulations.
- Ensuring cost for services to be reasonable, not exceeding costs that would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs.
- Maintain written procedures for determining the reasonableness of costs, the process for allocations, and the policies for allowable costs, in accordance with the provisions of applicable Federal cost principles and the terms and conditions of the award.
- Calculate unit costs based on an evaluation of reasonable cost of services; financial data must relate to performance data and include development of unit cost information whenever practical.
- Ensure the unit cost of a service shall not exceed the actual cost of providing the service, shall only include expenses that are allowable under Ryan White requirements, and the calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided.

Procedure
Sub-recipients shall:

- Ensure that budgets and expenses conform to federal cost principles.
- Ensure fiscal staff familiarity with applicable federal regulations.

Fiscal National Monitoring Standards

Cost Principles		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
***Section G:* Cost Principles**		
1. Payments made to subgrantees for services need to be cost based and relate to Ryan White administrative, quality management, and programmatic costs in accordance with standards cited under OMB Circulars or the Code of Federal Regulations	Review grantee and subgrantee budgets and expenditure reports to determine whether use of funds is consistent with OMB and CFR cost principles	· Ensure that budgets and expenses conform to federal cost principles · Ensure fiscal staff familiarity with applicable federal regulations

2. Payments made for services to be reasonable, not exceeding costs that would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs	· Review subgrantee budgets and expenditure reports to determine costs and identify cost components · When applicable, review unit cost calculations for reasonableness · Review fiscal and productivity reports to determine whether costs are reasonable when compared to level of service provided	· Make available to the grantee very detailed information on the allocation and costing of expenses for services provided · Calculate unit costs based on historical data · Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis
3. Written grantee and subgrantee procedures for determining the reasonableness of costs, the process for allocations, and the policies for allowable costs, in accordance with the provisions of applicable Federal cost principles and the terms and conditions of the award Costs are considered to be reasonable when they do not exceed what would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs	· Review policies and procedures that specify allowable expenditures for administrative costs and programmatic costs · Ensure reasonableness of charges to the Part A program	· Have in place policies and procedures to determine allowable and reasonable costs · Have in place reasonable methodologies for allocating costs among different funding sources and Ryan White categories · Make available policies, procedures, and calculations to the grantee on request
4. Calculate unit costs by grantees and subgrantees based on an evaluation of reasonable cost of services; financial data must relate to performance data and include development of unit cost information whenever practical ***Note:*** When using unit costs for the purpose of establishing fee-for-service charges, the GAAP† definition can be used. Under GAAP, donated materials and services, depreciation of capital improvement, administration, and facility costs are allowed when determining cost. · If unit cost is the method of reimbursement, it can be derived by adding direct program costs and allowable administrative costs, capped at 10%, and dividing by number of units of service to be delivered.	· Review unit cost methodology for subgrantee and provider services. · Review budgets to calculate allowable administrative and program costs for each service.	Have in place systems that can provide expenses and client utilization data in sufficient detail to determine reasonableness of unit costs

5. Requirements to be met in determining the unit cost of a service: · Unit cost not to exceed the actual cost of providing the service · Unit cost to include only expenses that are allowable under Ryan White requirements · Calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided	· Review methodology used for calculating unit costs of services provided · Review budgets to calculate allowable administrative and program costs for each service	· Have in place systems that can provide expenses and client utilization data in sufficient detail to calculate unit cost · Have unit cost calculations available for grantee review

Ch 7. Auditing Requirements

Purpose
To establish auditing requirement standards for Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
Sub-recipients shall:

- Adhere to the audit requirements contained in the Single Audit Act Amendments of 1996 (31 USC 7501–7507) and revised OMB Circular A-133, with A- 133 audits required for all Sub-recipients receiving more than $500,000 per year in federal grants.
- Based on criteria established by the Recipient, small Sub-recipients (i.e. receive less than $500,000 per year in federal grants) may be subject to audit as a major program (i.e. a program that receives more than $500,000 in aggregate federal funding) pursuant to OMB Circular 1-133, Section .215 c).
- Select an auditor based on Audit Committee for Board of Directors (if non-profit) policy and process.
- Provide audited financial statements to verify financial stability of organization.
- Provide A-133 audits to include statements of conformance with financial requirements and other federal expectations.
- Note reportable conditions from the audit and provide a resolution.

Procedure

Sub-recipients shall:

- Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds).
- Request a management letter from the auditor.
- Submit the audit and management letter to the Recipient on a timely basis within nine (9) months of agency's fiscal year end.

Fiscal National Monitoring Standards

Auditing Requirements		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
***Section H:* Auditing Requirements**		
1. Recipients and sub- recipients of Ryan White funds that are institutions of higher education or other non- profit organizations (including hospitals) are subject to the audit requirements contained in the Single Audit Act Amendments of 1996 (31 USC 7501–7507) and revised OMB Circular A-133, with A- 133 audits required for all grantees and subgrantees receiving more than $500,000 per year in federal grants	· Review requirements for subgrantee audits · Review most recent audit (which may be an A-133 audit) to assure it includes: o List of federal grantees to ensure that the Ryan White grant is included o Programmatic income and expense reports to assess if the Ryan White grant is included · Review audit management letter if one exists · Review all programmatic income and expense reports for payer of last resort verification by auditor	· Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds) · Request a management letter from the auditor · Submit the audit and management letter to the grantee · Prepare and provide auditor with income and expense reports that include payer of last resort verification
2. Based on criteria established by the grantee, subgrantees or Sub-recipients of Ryan White funds that are small programs (i.e. receive less than $500,000 per year in federal grants) may be subject to audit as a major program (i.e. a program that receives more than $500,000 in aggregate federal funding) pursuant to OMB Circular 1-133, Section .215 c).	· Review requirements for "small program" subgrantee audits · Review most recent audit (which may be an A-133 audit) to determine if it includes: o List of federal grantees and determine if the Ryan White grant is included o Programmatic income and expense reports to assess if the Ryan White grant is included · Review audit management letter Review all programmatic income and expense reports for payer of last resort verification by auditor	· Prepare and provide auditor with financial and other documents required to conduct a major program audit (e.g. income and expense reports that include payer of last resort verification, timesheets, general ledger, etc.) · Comply with contract audit requirements on a timely basis
3. Selection of auditor to be based on Audit Committee for Board of Directors (if non-profit) policy and process	Review subgrantee financial policies and procedures related to audits and selection of an auditor	· Have in place financial policies and procedures that guide selection of an auditor · Make the policies and procedures available to grantee on request
4. Review of audited financial statements to verify financial stability of organization	Review Statement of Financial Position/Balance Sheet, Statement of Activities/Income and Expense Report, Cash Flow Statement, and Notes included in audit to determine organization's financial stability	· Comply with contract audit requirements on a timely basis · Provide audit to grantee on a timely basis
5. A-133 audits to include statements of conformance with financial requirements and other federal expectations	Review statements of internal controls and federal compliance in A-133 audits	· Comply with contract audit requirements on a timely basis · Provide audit to grantee on a timely basis

6. Grantees and subgrantees expected to note reportable conditions from the audit and provide a resolution.	· Review of reportable conditions · Determination of whether they are significant and whether they have been resolved · Development of action plan to address reportable conditions that have not been resolved	· Comply with contract audit requirements on a timely basis · Provide grantee the agency response to any reportable conditions

Ch 8. Reallocation and Unobligated Balance

Purpose
To establish reallocation and unobligated balance standards for Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
Sub-recipient shall demonstrate its ability to expend funds efficiently, and submit an estimation of unobligated balance projecting expenditures through grant year end to Recipient by November 1st.

Procedure
The Sub-recipient shall provide the following to the Recipient:

- Monthly Reimbursement Requests for each service category of expenditure by the 25th of the month following expenditures
- Variance in expenditures
- Timely reporting of unspent funds by the 15th of the month following expenditures and on a quarterly basis at the end of the 1st, 2nd and 3rd quarter ending by the 30th of the following month, position vacancies, etc.
- Final Invoice due by March 31st and marked "Final Invoice".

The Sub-recipient shall:

- Establish and implement a process for tracking unspent Part A funds and provide accurate and timely reporting to the Recipient
- Carry out monthly monitoring of expenses to detect and implement cost- saving strategies

Fiscal National Monitoring Standards

Unobligated Balances		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
***Section L:* Unobligated Balances**		
1. EMA/TGA demonstration of its ability to expend fund efficiently by expending 95% of its formula funds in any grant year Note: EMA/TGA must submit an estimation of unobligated balance 60 days prior to the end of the grant period – by December 31 of every calendar year.	· Review grantee and subgrantee budgets · Review grantee accounting and financial reports that document the year-to-date and year-end spending of grantee and subgrantee obligated funds, including separate accounting for formula and supplemental funds · Calculation of unspent funds and potential unspent funds to determine estimated unobligated balance	· Report monthly expenditures to date to the grantee Inform the grantee of variance in expenditures.

2. EMA/TGA annual unobligated balance for formula dollars of no more than 5% reported to HRSA/HAB in grantee's Federal Financial Report (FFR)	Determination of the breakdown of the unobligated balance in the FFR by Formula, Supplemental, and Carryover · Submission of the final annual FFR no later than the July 30 after the closing of the grant year, without exception	· Provide timely reporting of unspent funds, position vacancies, etc. to the grantee · Establish and implement a process for tracking unspent Part A funds and providing accurate and timely reporting to the grantee · Be an active participant in the re-allocation process by informing the grantee on a timely basis of funds not spent or funds spent too quickly
3. EMA/TGA recognition of consequences of unobligated balances and evidence of plans to avoid a reduction of services, if any of the following penalties is applied: a. Future year award is offset by the amount of the unobligated balance less any approved carry over b. Future year award is reduced by amount of unobligated balance less the amount of approved carry over c.The grantee is not eligible for a future year supplemental award	· Review EMA/TGA compliance with any cancellation of unobligated funds · Review EMA/TGA grantee and subgrantee budgets and implementation of plans on how not to reduce services in a penalty year	· Report any unspent funds to the grantee · Carry out monthly monitoring of expenses to detect and implement cost- saving strategies

Ch 9. Anti-Kickback Statute

Purpose
To establish anti-kickback statute standards for Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
Sub-recipients shall demonstrate structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement). Sub-recipients and their employees (as individuals or entities) are prohibited from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.

Procedure
Sub-recipients shall:

- Maintain and review file documentation of:
  - Corporate Compliance Plan (required by CMS if providing Medicare- or Medicaid- reimbursable services)
  - File documentations of any employee or Board Member violation of the Code of Ethics or Standards of Conduct
  - Documentation of any complaint of violation of the Code of Ethics or Standards of Conduct and its resolution

Universal National Monitoring Standards

Anti-Kickback Statute		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
1. Demonstrated structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program	Employee Code of Ethics including: · Conflict of Interest · Prohibition on use of property, information or position without approval or to advance personal interest · Fair dealing – engaged in fair and open competition · Confidentiality · Protection and use of company assets · Compliance with laws, rules, and regulations · Timely and truthful disclosure of significant accounting deficiencies · Timely and truthful disclosure of non- compliance	· Maintain and review file documentation of: o Corporate Compliance Plan (required by CMS if providing Medicare- or Medicaid- reimbursable services) o Personnel Policies o Code of Ethics or Standards of Conduct o Bylaws and Board policies o File documentations of any employee or Board Member violation of the Code of Ethics or Standards of Conduct o Documentation of any complaint of violation of the Code of Ethics or Standards of Conduct and its resolution · For not-for-profit contractors/grantee organizations, ensure documentation of subgrantee

		Bylaws, Board Code of Ethics, and business conduct practices
2. Prohibition of employees (as individuals or entities), from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	· Any documentation required by the Compliance Plan or employee conduct standards that prohibits employees from receiving payments in kind or cash from suppliers and contractors of goods or services	· Have adequate policies and procedures to discourage soliciting cash or in-kind payments for: o Awarding contracts o Referring clients o Purchasing goods or services and/or o Submitting fraudulent billings · Have employee policies that discourage: o The hiring of persons who have a criminal record relating to or are currently being investigated for Medicaid/Medicare fraud. o Large signing bonuses

Ch 10. Grant Accountability and Stewardship of Funds

Purpose
To establish grant fund stewardship standards for Sub-recipients providing RWHAP Part A services in Palm Beach County.

Policy
Sub-recipients shall:

- Ensure proper stewardship of all grant funds including compliance with programmatic requirements.

Procedure

Sub-recipients shall:

- Meet contracted programmatic and fiscal requirements

Universal National Monitoring Standards

Recipient Accountability		
Standard	**Performance Measure/ Method**	**Provider/Sub-recipient Responsibility**
1. Proper stewardship of all grant funds including compliance with programmatic requirements	Policies, procedures, and contracts that require: · Timely submission of detailed fiscal reports by funding source, with expenses allocated by service category · Timely submission of programmatic reports · Documentation of method used to track unobligated balances and carryover funds · A documented reallocation process · Report of total number of funded subgrantees · A-133 or single audit · Auditor management letter	Meet contracted programmatic and fiscal requirements, including: · Provide financial reports that specify expenditures by service category and use of Ryan White funds as specified by the grantee · Develop financial and subgrantee Policies and Procedures Manual that meet federal and Ryan White program requirements · Closely monitor any subcontractors · Commission an independent audit; for those meeting thresholds, an audit that meet A-133 requirements · Respond to audit requests initiated by the grantee
2. Grantee accountability for the expenditure of funds it shares with lead agencies (usually health departments), subgrantees, and/or consortia	· A copy of each contract · Fiscal, program site visit reports and action plans · Audit reports · Documented reports that track funds by formula, supplemental, service categories · Documented reports that track unobligated balance and carryover funds	Establish and implement: · Fiscal and general policies and procedures that include compliance with federal and Ryan White programmatic requirements. · Flexible fiscal reporting systems that allow the tracking of unobligated balances and carryover funds and detail service reporting of funding sources

	· Documented reallocation process · Report of total number of funded subgrantees · Grantee A-133 or single audit conducted annually and made available to the state every two years · Auditor management letter	· Timely submission of independent audits (A-133 audits if required) to grantee
3. Business management systems that meet the requirements of the Office of Management and Budget code of federal regulations, programmatic expectations outlined in the grantee assurances and the Notice of Grant Award	· Review of subgrantee contracts · Fiscal and program site visit reports and action plans · Policies and Procedures that outline compliance with federal and Ryan White programmatic requirements · Independent audits · Auditor management letter	Ensure that the following are in place: documented policies and procedures and fiscal/programmatic reports that provide effective control over and accountability for all funds in accordance with federal and Ryan White programmatic requirements
4. Responsibility for activities that are supported under the Ryan White Program as outlined by Office of Management and Budget, Code of Federal Regulations, HHS Grant Policy Statement Program Assurances, and Notice of Grant Award (NOA)	Desk audits of budgets, applications, yearly expenses, programmatic reports; audit reports or on-site review when assessing compliance with fiscal and programmatic requirements	Ensure fiscal and programmatic policies and procedures are in place that comply with federal and Ryan White program requirements

Ch 11. Sub-recipient Fiscal Monitoring

Purpose
To establish standards for the Sub-recipients fiscal monitoring.

Policy
As a condition for receiving PBC RWHAP funds, Sub-recipient agencies and contractors agree to being fiscally monitored each grant year to ensure fiscal compliance with related federal statutes, HRSA program rules and regulations, PBC RWHAP award document, state statutes, local and department rules and regulations and agencies' PBC RWHAP contract.

Procedure
PBC RWHAP primarily utilizes four monitoring tools in complying with the Sub-recipient fiscal monitoring responsibilities. These tools include annual financial statement analysis, financial risk assessments, management inquiries, and onsite fiscal compliance reviews. All PBC RWHAP Sub- recipients, regardless of amount, are included in the onsite review. Onsite reviews include review of fiscal policies and procedures for compliance with funding source requirements, substantive testing of the organization's primary transaction cycles (revenue, disbursements, and payroll) and inquiry with management.

Major areas of review include:

- Fiscal requirements related to specific contract conditions
- Applicable Federal and State rules and regulations
- Appropriate chart of accounts, general ledger, and financial reporting
- Accurate and complete property management records for all capital assets and related depreciation
- Adequacy of required minimum accounting records for all major transaction cycles (revenue, general disbursements, and payroll)
- Verification that internal controls are operating as expected
- Payroll expense and personnel records include required documentation related to time, program, rate, and eligibility to work in the United States
- Verification of compliance with payroll taxing authorities
- Inclusion of required topics in written financial policies and procedures

Sub-recipient accounting practices are measured against PBC RWHAP documents, all applicable Federal and State rules and regulations as well as the following authoritative accounting pronouncements:

- Generally Accepted Accounting Principles
- Generally Accepted Auditing Standards
- Applicable AICPA Industry Audit and Accounting Guides
- OMB Circular 2 CRF Part 200 and 45 CFR Part 75
- Government Auditing Standards
- Contract specific attachments and special conditions

PBC RWHAP review the following of each Sub-recipient:

- Written fiscal policies and procedures for such elements as internal controls, accounts payable, purchasing, and reimbursements for travel and other expenses

- Documentation of expenditures to enable the award recipient to determine:
    - Whether the Sub-recipient reconciles budgeted expenditures to actual expenditures
    - Whether costs are allowable, reasonable, and allocable
    - Whether expenses are supported by clear, complete, and detailed documentation
    - Whether the Sub-recipient has followed the rules about limiting funds to support direct medical, dental, mental health, or legal services
- Single Audit Report (if applicable), conducted annually by an independent accounting firm in compliance with 45 CFR Part 75.500–521; or other audit, review, financial statements, or corrective action plan for any fiscal or other audit findings
- Records of employee time and effort, including:
    - Assurances that employees are tracking actual time spent on PBC RWHAP services rather than just reporting budgeted hours per day
    - Allocations of operating and/or other costs for employees who are not funded 100 percent by this program
- System for Award Management (SAM) registration for all Sub-recipients to ensure they have an active account with accurate information and are eligible to receive federal funding
- Timeliness of fiscal reporting
- Adherence to the federal record retention policy

Section IV: Core Medical Services Guidelines

Ch 1. Local- AIDS Pharmaceutical Assistance Program (LPAP)

Purpose
To establish service standards for Sub-recipients providing Local AIDS Pharmaceutical Assistance Program services through PBC RWHAP.

Policy
Description:
The Local Pharmaceutical Assistance Program (LPAP) is a supplemental means of providing ongoing medication assistance when Florida RWHAP ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

Sub-recipients must adhere to the following guidelines:

- Provide uniform benefits for all enrolled clients throughout the service area
- Establish and maintain a recordkeeping system for distributed medications
- Participate in the LPAP committee
- Utilize the drug formulary that is approved by the LPAP Committee
- Establish and maintain a drug distribution system
- Screening for alternative medication payer sources, including but not limited to Patient Assistance Programs (PAP), rebate/discount programs, Health Care District, and Florida RWHAP ADAP prior to dispensing.
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:
LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

Medications may be added to the LPAP formulary by request to the Ryan White Program Manager. LPAP formulary additions must be approved by the PBC HIV CARE Council LPAP Committee.

Procedure
Unit of Service Description
1 unit= 1 prescription

Service Specific Criteria & Required Documentation
Referral documentation
Letter of Medical Necessity for Chronic Opioid Medication (Appendix F)

Caps/Limitations
Medications dispensed must not be included on the ADAP formulary

National Monitoring Standards

Local AIDS Pharmaceutical Assistance Program		
Standard	**Performance Measure/Method**	**Provider/ Sub-Recipient Responsibility**
Implementation of a LPAP for the provision of HIV/AIDS medications using a drug distribution system shall: • Provide uniform benefits for all enrolled clients throughout the service area • Establish and maintain a recordkeeping system for distributed medications • Participate in the LPAP committee • Utilize the drug formulary that is approved by the LPAP Committee • Establish and maintain a drug distribution system • Screen for alternative medication payer sources, including but not limited to Patient Assistance Programs (PAP), rebate/discount programs, Healthcare District, and Florida RWHAP ADAP prior to dispensing. • Implement in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program) • Not dispense medications as: A result or component of a primary medical visit; A single occurrence of short duration (an emergency); Vouchers to clients on an emergency basis. • Be consistent with the most current HIV/AIDS Treatment Guidelines • Coordinate with the Florida ADAP	Documentation that the LPAP's drug distribution system: • Provides uniform benefits for all enrolled clients throughout the service area • Establishes and maintains a recordkeeping system for distributed medications • Participates in the LPAP committee • Utilizes the drug formulary that is approved by the LPAP Committee • Establishes and maintain a drug distribution system • Screens for alternative medication payer sources, including but not limited to Patient Assistance Programs (PAP), rebate/discount programs, Healthcare District, and Florida RWHAP ADAP prior to dispensing. • Implements in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program) • Documents that the LPAP is not dispensing medications as: A result or component of a primary medical visit; A single occurrence of short duration (an emergency) without arrangements for longer term access to medication; Vouchers to clients on a single occurrence without arrangements for longer-term access to medications. • Documents that the LPAP is: Consistent with the most current HIV/AIDS Treatment Guidelines; and Coordinated with the Florida ADAP.	Provide to the Recipient upon request, documentation that the LPAP meets HRSA/HAB requirements • Maintain documentation, and make available to the Recipient on request, proof of client LPAP eligibility that includes HIV status, residency, medical necessity, and low-income status • Provide reports to the Recipient of number of individuals served and the medications provided

Local Pharmacy Assistance Program- Local Standard		
Standard	**Performance Measure/Method**	**Provider/Sub-Recipient Responsibility**
Implementation of a LPAP for the provision of HIV/AIDS medications using a drug distribution system shall: • Provide uniform benefits for all enrolled clients throughout the service area • Establish and maintain a recordkeeping system for distributed medications • Participate in the LPAP committee • Utilize the drug formulary that is approved by the LPAP Committee • Establish and maintain a drug distribution system • Screen for alternative medication payer sources, including but not limited to Patient Assistance Programs (PAP), rebate/discount programs, Healthcare District, and Florida RWHAP ADAP prior to dispensing. • Implement in accordance with requirements of the HRSA 340B Drug Pricing	Documentation that the LPAP's drug distribution system: • Provides uniform benefits for all enrolled clients throughout the service area • Establishes and maintains a recordkeeping system for distributed medications • Participates in the LPAP committee • Utilizes the drug formulary that is approved by the LPAP Committee • Establishes and maintain a drug distribution system • Screens for alternative medication payer sources, including but not limited to Patient Assistance Programs (PAP), rebate/discount programs, Healthcare District, and Florida RWHAP ADAP prior to dispensing. • Implements in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program) • Documents that the LPAP is not dispensing medications as: A result or component of a primary medical visit; A single occurrence of short duration (an emergency) without arrangements for longer term access to	• Dispensing of a medication to a client on an ongoing basis, requiring more than a thirty (30) day supply during any 12-month period. • A client must apply, and be denied access to the medication from all other medication assistance programs for which the client may be eligible (ADAP, pharmaceutical manufacturer patient assistance program, etc.). • Medications dispensed must not be included on the ADAP formulary. Clients needing emergency access to medications included on the ADAP formulary shall utilize Emergency Financial Services. • Medications dispensed shall be included on the most recently published Florida Medicaid PDL Preferred Drug List.* • Medications defined by Florida Medicaid PDL as “Clinical PA Required”, “Cystic Fib Diag Auto PA”, or “Requires Med Cert 3” shall require submission and approval of an override request prior to dispensing. • Any ongoing medication needs not specified in this service standard shall require submission and approval of an override request prior to dispensing. Override requests shall not be submitted as exception to policy (e.g. medication is included on the ADAP formulary). *Florida Medicaid PDL https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

Program (including the Prime Vendor Program) • Not dispense medications as: A result or component of a primary medical visit; A single occurrence of short duration (an emergency); Vouchers to clients on an emergency basis. • Be consistent with the most current HIV/AIDS Treatment Guidelines • Coordinate with the Florida ADAP	medication; Vouchers to clients on a single occurrence without arrangements for longer-term access to medications. • Documents that the LPAP is: Consistent with the most current HIV/AIDS Treatment Guidelines; and Coordinated with the Florida ADAP.	

Ch 2. Early Intervention Services (EIS)

Purpose
To establish service standards for Sub-recipients providing Early Intervention Services through PBC RWHAP.

Policy
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. Sub-recipients shall 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 living with HIV
    - 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

***Further information can be found in the PBC RWHAP Supplemental Guide.**

Procedure

Unit of Service Description
1 unit=15 minutes of service

Service Specific Criteria & Required Documentation
Client is not required to meet PBC RWHAP eligibility criteria to receive EIS services

Caps/Limitations
None

National Monitoring Standards

Early Intervention Services		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of: • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable clients to navigate the HIV system of care All four components must be present, but Part A funds are to be used for HIV testing only as necessary to supplement, not to supplant, existing funding	Documentation that: • Part A funds are used for HIV testing only where existing federal, state, and local funds are not adequate, and Ryan White funds will supplement and not supplant existing funds for testing • Individuals who test positive are referred for and linked to health care and supportive services • Health education and literacy training is provided that enables clients to navigate the HIV system • EIS is provided at or in coordination with documented key points of entry • EIS services are coordinated with HIV prevention efforts and programs	• Establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who test positive • Document provision of all four required EIS service components, with Part A or other funding • Document and report on numbers of HIV tests and positives, as well as where and when Part A-funded HIV testing occurs • Document that HIV testing activities and methods meet CDC and state requirements • Document the number of referrals for health care and supportive services • Document referrals from key points of entry to EIS programs • Document training and education sessions designed to help individuals navigate and understand the HIV system of care • Establish linkage agreements with testing sites where Part A is not funding testing but is funding referral and access to care, education and system navigation services • Obtain written approval from the Recipient to provide EIS services in points of entry not included in original scope of work

PBC RWHAP Monitoring Standards

Early Intervention Services- Local Standard		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of: • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable clients to navigate the HIV system of care All four components must be present, but Part A funds are to be used for HIV testing only as necessary to supplement, not to supplant, existing funding	Documentation that: • Part A funds are used for HIV testing only where existing federal, state, and local funds are not adequate, and Ryan White funds will supplement and not supplant existing funds for testing • Individuals who test positive are referred for and linked to health care and supportive services • Health education and literacy training is provided that enables clients to navigate the HIV system • EIS is provided at or in coordination with documented key points of entry • EIS services are coordinated with HIV prevention efforts and programs	• Sub-recipient will have a written training plan for EIS staff. • EIS staff will have documentation of completed training plan; which includes, at a minimum, HIV 501 training. • Documentation of the sub-recipient effort to link the client to an initial medical appointment, within 30 days. • Of those clients who attended their initial medical appointment: documentation of the client's attendance (or lack thereof) to a follow-up medical appointment, including completed lab tests. • Of those clients who attended their initial medical appointment: documentation of the client's attendance (or lack thereof) to a follow-up well-visit medical appointment (to assess prescribed medication regimen), including lab test results. This usually occurs within 6 months of initial visit.

Ch 3. Health Insurance Premium & Cost Sharing Assistance (HIPCSA)

Purpose
To establish service standards for Sub-recipients providing Health Insurance Premium & Cost Sharing Assistance through PBC RWHAP.

Policy
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.

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
- Paying cost-sharing on behalf of the client

Program Guidance:
See PCN 18-01: Clarifications Regarding the use of RWHAP Funds for Health Care Coverage Premium and Cost Sharing Assistance

Procedure
Unit of Service Description
1 unit= 1 deductible, co-payment, or monthly premium

Service Specific Criteria & Required Documentation
Summary of Benefits from Coverage

Caps/Limitations
An approved plan released annually

National Monitoring Standards

Health Insurance Premium & Cost Sharing Assistance		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Provision of Health Insurance Premium and Cost-sharing Assistance that provides a cost-effective alternative to ADAP by: • Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low income clients that provide a full range of HIV medications • Paying -co-pays (including co-pays for prescription	• Documentation of an annual cost-benefit analysis illustrating the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays and or deductibles for eligible low income clients, compared to the costs of having the client in the RWHAP • Where funds are covering premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications	• Conduct an annual cost benefit analysis that addresses noted criteria • Where premiums are covered by RWHAP funds, provide proof that the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications • Maintain proof of low-income status • Provide documentation that demonstrates that funds were not used to cover costs of liability risk pools, or social security

eyewear for conditions related to HIV infection) and deductibles on behalf of the client • Providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs	• Where funds are used to cover co-pays for prescription eyewear, documentation including a physician's written statement that the eye condition is related to HIV infection • Assurance that any cost associated with liability risk pools is not being funded by RWHAP • Assurance that RWHAP funds are not being used to cover costs associated with Social Security • Documentation of clients' low income status	• Coordinate with CMS, including entering into appropriate agreements, to ensure that funds are appropriately include in TrOOP or donut hole costs • When funds are used to cover co-pays for prescription eyewear, provide a physician's written statement that the eye condition is related to HIV infection

Ch 4. Home and Community-Based Health Services (HCBHS)

Purpose
To establish service standards for Sub-recipients providing Home and Community-Based Health Services through PBC RWHAP.

Policy
Description
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that 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.

Procedure
Unit of Service Description
1 unit=1 hour of service

Service Specific Criteria & Required Documentation
None

Caps/Limitations
None

National Monitoring Standards

Home and Community-Based Health Services		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Provision of Home and Community-based Health Services, defined as skilled health services furnished in the home of an HIV-infected individual, based on a written plan of care prepared by a case management team that includes appropriate health care professionals. Allowable services include: • Durable medical equipment • Home health aides and personal care services • Day treatment of other partial hospitalization services • Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy) • Routine diagnostic testing • Appropriate mental health, developmental, and rehabilitation services Non-allowable services include: • Inpatient hospital services • Nursing home and other long term care facilities	Documentation that: • All services are provided based on a written care plan signed by a case manager and a clinical health care professional responsible for the individual's HIV care and indicating the need for these services • The care plan specified the types of services needed and the quantity and duration of services • All planned services are allowable within the service category Documentation of services provided that: - Specified the types, dates, and location of the services - Includes the signature of the professional who provided the service at each visit -Indicates that all services are allowable under this service category -Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community based health services • Documentation of appropriate licensure and certifications for individuals providing the services, as required by Palm Beach County and Florida laws	• Ensure that written care plans with appropriate content and signatures are consistently prepared, included in client records, and updated as needed • Establish and maintain a program and client record keeping system to document the types of home services provided, the location of the service, and the signature of the professional who provided the service at each visit • Make available to the Recipient, program files and client records as required for monitoring • Provide assurance that the services are being provided only in an HIV-positive client's home • Maintain, and make available to the Recipient on request, copies of appropriate licenses and certifications for professionals providing services

Ch 5. Medical Case Management Services (MCM)

Purpose
To establish service standards for Sub-recipients providing Medical Case Management Services through PBC RWHAP.

Policy
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 provided under this service category may be provided 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
- 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 activities 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:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes (including Treatment Adherence), whereas those provided under the Non-Medical Case Management service category 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 shall be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit shall be reported under the Outpatient/Ambulatory Health Services category.

***Further information can be found in the PBC RWHAP Supplemental Guide.**

Procedure

Unit of Service Description

1 unit=15 minutes of service

Service Specific Criteria & Required Documentation

None

Caps/Limitations

None

National Monitoring Standards

Medical Case Management		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support for Medical Case Management Services (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication Activities that include at least the following: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Coordination of services required to implement the plan • Continuous client monitoring to assess the efficacy of the plan • Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary Service components that may include: • A range of client-centered services that link clients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, ADAP, PAPs) • Coordination and follow up of medical treatments • Ongoing assessment of the client's and	• Documentation that service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical care team • Documentation that the following activities are being carried out for clients as necessary: - Initial assessment of service needs - Development of a comprehensive, individualized care plan - Coordination of services required to implement the plan - Continuous client monitoring to assess the efficacy of the plan -Periodic re-evaluation and adaptation of the plan at lease every 6 months, during the enrollment of the client • Documentation in program and client records of case management services and encounters, including: -Types of services provided -Types of encounters/communication -Duration and frequency of the encounters • Documentation in client records of services provided, such as: - Client-centered services that ling clients with health care, psychosocial, and other services and assist them to access other public and private programs for which they may be eligible -Coordination and follow up of medical treatments -Ongoing assessment of client's and other key family members' needs and personal support systems	• Provide written assurances and maintain documentation showing that medical case management services are provided by training professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team • Maintain client records that include the required elements for compliance with contractual the RWHAP programmatic requirements, including required case management activities such as services and activities, the type of contact, and the duration and frequency of the encounter

other key family members' needs and personal support systems • Treatment adherence counseling to ensure readiness for, and adherence to complex HIV/AIDS treatments • Client-specific advocacy and/or review of utilization of services	-Treatment adherence counseling -Client-specific advocacy	

Ch 6. Medical Nutrition Therapy (MNT)

Purpose
To establish service standards for Sub-recipients providing Medical Nutrition Therapy through PBC RWHAP.

Policy
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 shall be considered Psychosocial Support Services under PBC RWHAP.

Procedure
Unit of Service Description
1 unit=1 hour of service

Service Specific Criteria & Required Documentation
None

Caps/Limitations
None

National Monitoring Standards

Medical Nutrition Therapy		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support for Medical Nutrition Therapy services including nutritional supplements provided outside of a primary care visit by a licensed registered dietician; may include food provided pursuant to a physician's recommendation and based on a nutritional plan developed by a licensed registered dietician	Documentation of: • Licensure and registration of the dietician as required the State of Florida • Where food is provided to a client under this service category, a client record is maintained that includes a physician's recommendation and a nutritional plan • Required content of the nutritional plan, including: - recommended services and course of medical nutrition therapy to be provided, including types and amounts or nutritional supplements and food - Date service is to be initiated -Planned number and frequency of sessions -The signature of the registered dietician who developed the plan • Services provided, including: - Nutritional supplements and food provided, quantity, and dates -The signature of each registered dietician who rendered service, the date of service - Date of reassessment -Termination date of medical nutrition therapy - Any recommendations for follow up	• Maintain and make available to the Recipient copies of the dietician's license and registration • Document services provided, number of clients served, and quantity of nutritional supplements and food provided to clients • Document in each client record: - Services provided and dates - Nutritional plan as required, including required information and signature - Physician's recommendation for the provision of food

PBC RWHAP Monitoring Standards

Medical Nutrition Therapy- Local Monitoring Standard		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support for Medical Nutrition Therapy services including nutritional supplements provided outside of a primary care visits by a licensed registered dietician; may include food provided pursuant to a physician's recommendation and based on a nutritional plan developed by a licensed registered dietician	Documentation of: • Licensure and registration of the dietician as required the State of Florida • Where food is provided to a client under this service category, a client record is maintained that includes a physician's recommendation and a nutritional plan • Required content of the nutritional plan, including: - recommended services and course of medical nutrition therapy to be provided, including types and amounts or nutritional supplements and food - Date service is to be initiated -Planned number and frequency of sessions -The signature of the registered dietician who developed the plan • Services provided, including: - Nutritional supplements and food provided, quantity, and dates -The signature of each registered dietician who rendered service, the date of service - Date of reassessment -Termination date of medical nutrition therapy - Any recommendations for follow up	2.1 All consumers receiving Medical Nutrition Therapy will be referred by a primary care physician, nurse practitioners, physician's assistants or dentist to a dietitian. 2.2 Consumers will have a comprehensive initial intake and assessment by a qualified dietician. The assessment shall include medical considerations such as; ·actual height and weight, pre-illness body weight, weight trends, goal weight, ideal body weight and % ideal body weight; · lean body mass and fat; · waist and hip circumferences; 2.4 A care plan developed and implemented based on the initial assessment. 2.5 Nutrition monitoring and evaluation by the dietitian shall be conducted to determine the degree to which progress is made toward achieving the goals of the care plan.

Ch 7. Mental Health Services (MHS)

Purpose
To establish service standards for Sub-recipients providing Mental Health Services through PBC RWHAP.

Policy
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 PWH who are eligible to receive PBC RWHAP services.

Procedure
Unit of Service Description
1 unit=1 hour of service

Service Specific Criteria & Required Documentation
None

Caps/Limitations
None

National Monitoring Standards

Mental Health Services		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Funding of Mental Health Services that include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State of Florida to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers	• Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State of Florida • Documentation of the existence of a detailed treatment plan for each eligible client that includes: - The diagnosed mental illness or condition - The treatment modality (group or individual) - Start date for mental health services - Recommended number of sessions - Date for reassessment - Projected treatment end date - Any recommendations for follow up - The signature of the mental health professional rendering service • Documentation of service provided to ensure that: - Services provided are allowable under RWHAP guidelines and contract requirements - Services provided are consistent with the treatment plan	• Obtain and have on file and available for Recipient review appropriate and valid licensure and certification of mental health professionals • Maintain client records that include: - a detailed treatment plan for each eligible client that includes required components and signature -documentation of services provided, dates, and consistency with RWHAP requirements and with individual client treatment plans

PBC RWHAP Monitoring Standards

Mental Health Services- Local Standard		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Funding of Mental Health Services that include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State of Florida to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers	• Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State of Florida • Documentation of the existence of a detailed treatment plan for each eligible client that includes: - The diagnosed mental illness or condition - The treatment modality (group or individual) - Start date for mental health services - Recommended number of sessions - Date for reassessment - Projected treatment end date - Any recommendations for follow up - The signature of the mental health professional rendering service • Documentation of service provided to ensure that: - Services provided are allowable under RWHAP guidelines and contract requirements - Services provided are consistent with the treatment plan	Psychological Assessment 1.1 100% of clients receiving assessment have documentation of a completed referral form. 1.2 100% of assessments include: • Relevant history • Current functioning • Assessment of medical/psychological/ social needs • Mental status • Diagnostic impression based upon DSM IVTR criteria Axis I through IV 1.3 80% of clients have initial screening within 10 business days of referral. If not completed within 10 days, documented attempts must be evident. 1.4 100% of clients that present with imminent risk to self or others have immediate referral, or within 24-48 hours, depending on the practitioner's evaluation of the risk. (i.e. active suicidal plans/ intentions, recent attempt, or psychotic symptoms influencing patient behaviors, presence of violence/ impulsivity, inability to take appropriate care of self) 1.5 100% of clients receive assessment of cultural/language preferences. Initial Treatment Plan: 2.2 100% of agency records have appropriate documentation sent to relevant provider(s) involved in treatment plan. 2.3 100% of agency records document the results of referrals for mental health services. Progress in Treatment Plan: 3.1 100% of client Records document progress towards meeting goals or variance explained. 3.2 50% of desired outcomes should be achieved in accordance with treatment plan. 3.3 100% of client treatment plans are updated (at a minimum) every 12 sessions or every 6 months, whichever occurs first, and/or at discharge. 3.4 100% of progress reports shared with case management agency for clients who have provided consent.

Ch 8. Oral Health Care (OHC)

Purpose
To establish service standards for Sub-recipients providing Oral Health Care through PBC RWHAP.

Policy
Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:

Oral Health Care shall be provided based on the following priorities:

- Elimination of infection, preservation of dentition and restoration of functioning
- Elimination of presenting symptoms, including control of pain and suffering
- Prevention of oral and/or systemic disease where the oral cavity serves as an entry point

Procedure
Sub-recipient shall adhere to the American Dental Association Dental Practice Parameters.

Unit of Service Description
1 unit=1 dental visit

Service Specific Criteria & Required Documentation
None

Caps/Limitations
Maximum of 24 visits per client annually

National Monitoring Standards

Oral Health Care		
Standard	**Performance Measure/Method**	**Provider/ Sub-recipient Responsibility**
Support for Oral Health Services including diagnostic, preventive, and therapeutic dental care that is in compliance with state dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Practice Parameters, is based on an oral health treatment plan, adheres to specified service cap, and is provided by licensed and certified dental professionals	Documentation that: • Oral health services are provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and meet current dental care guidelines • Oral health professionals providing the services have appropriate and valid licensure and certification, based on Florida and Palm Beach County laws • Clinical decisions that are supported by the American Dental Practice Parameters • An oral health treatment plan is developed for each eligible client and signed by the oral health professional rendering the services • Services fall within specified service caps, expressed by dollar amount, type of procedure, limitations of the number of procedures, or a combination of any of the above, as determined by the HIV CARE Council or Recipient	• Maintain a dental record for each client that is signed by the licensed provider and includes a treatment plan, services provided, and any referrals made • Maintain, and provide to Recipient on request, copies of professional licensure and certification

PBC RWHAP Monitoring Standards

Oral Health- Local Standard		
Standard	Performance Measure/Method	Provider/Sub-recipient Responsibility
Support for Oral Health Services including diagnostic, preventive, and therapeutic dental care that is incompliance with state dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Practice Parameters, is based on an oral health treatment plan, adheres to specified service cap, and is provided by licensed and certified dental professionals	Documentation that: • Oral health services are provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and meet current dental care guidelines • Oral health professionals providing the services have appropriate and valid licensure and certification, based on Florida and Palm Beach County laws • Clinical decisions that are supported by the American Dental Practice Parameters • An oral health treatment plan is developed for each eligible client and signed by the oral health professional rendering the services • Services fall within specified service caps, expressed by dollar amount, type of procedure, limitations of the number of procedures, or a combination of any of the above, as determined by the HIV CARE Council or Recipient	• Review Medical/Dental history at least annually • Clients receive oral hygiene education as part of the routine visit and self-management of infections and lesions when necessary • Documentation of current medications, CD4 and Viral Loads at time of visit. • Treatment of oral opportunistic infection is coordinated with the client's medical provider

Ch 9. Outpatient/Ambulatory Health Services (OAHS)

Purpose
To establish service standards for Sub-recipients providing Outpatient/Ambulatory Health Services through PBC RWHAP.

Policy
Description:
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as 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, including audiology and ophthalmology

Program Guidance:
Provision of Outpatient/Ambulatory Health Services must be adherent to HHS Clinical Guidelines for the Treatment of HIV/AIDS (https://aidsinfo.nih.gov/guidelines)

Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

The HIV CARE Council has allocated funding to the OAHS subcategories of OAHS-Primary Care, Laboratory/Diagnostic and Specialty Medical Care. Each of the three subcategories are addressed below separately.

Procedure for OAHS-Primary Care

Service Specific Eligibility Criteria & Required Documentation
None

Caps/Limitations
No caps. No limitations.

Unit of Service Description
1 unit=1 primary care visit

Procedure for Laboratory/Diagnostic Testing

Service Specific Eligibility Criteria & Required Documentation
None

Caps/Limitations
No caps. No Limitations.

Unit of Service Description
1 unit=1 lab test

Procedure for Specialty Medical Care

Service Specific Eligibility Criteria & Required Documentation
Specialty Care Medical Referral Form signed by Primary Care Provider

Caps/Limitations
PBC RWHAP Program Manager must be notified when total amount encumbered for Specialty Medical Care services exceeds $1000 per client/per grant year.

Unallowable expenses for Specialty Medical Care include services for cosmetic purposes only, corrective lenses, or any service provided that does not follow Specialty Medical Care service procedures.

Unit of Service Description
1 unit= 1 specialty medical care visit

Prior to the provision of Specialty Medical Care, a specialty medical care referral form must be completed by the Primary Care Provider electronically through the database management information system including the following:

- Primary Care Provider (PCP) verification that Specialty Medical Care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects

- Specialty Medical Care services are included on the list of conditions on the *Palm Beach County Ryan White Program Allowable Medical Conditions List for Specialty Medical Referrals* form.

- Routine medical diagnostic testing (e.g., Pap smear, mammogram, bone density test, colonoscopy, colorectal cancer screening, prostate cancer screening, and ophthalmologic screening) is allowable as long as such testing follows established medical guidelines, such as U.S. Public Health Service (PHS), American Medical Association, Health Resources and Services Administration (HRSA), or other local guidelines, as a standard of care. Please see the most current, local Ryan White Program Service Delivery Guidelines for more information.

- For Specialty Medical Care services that do not meet all of the above criteria, Sub-recipient may request an override from Recipient.

National Monitoring Standards

Outpatient/Ambulatory Health Services		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Provision of Outpatient and Ambulatory Medical Care, defined as the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with HHS guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.	Documentation of the following: • Care is provided by health care professionals certified in their jurisdictions to prescribe medications in an outpatient setting such as a clinic, medical office, or mobile van • Only allowable services are provided • Services are provided as part of the treatment of HIV infection • Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects • Services are consistent with HHS Guidelines • Service is not being provided in an emergency room, hospital or any other type of inpatient treatment center	• Ensure that client medical records document services provided, the dates and frequency of services provided, that services are for the treatment of HIV infection • Include clinician notes in patient records that are signed by the licensed provider of services • Maintain professional certifications and licensure documents and make them available to the grantee on request
As a part of Outpatient and Ambulatory Medical Care, provision of laboratory tests integral to the treatment of HIV infection and related complications	Documentation that tests are: • Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider • Consistent with medical and laboratory standards • Approved by the Food and Drug Administration (FDA) and/or Certified under the Clinical Laboratory Improvement Amendments (CLIA) Program	Document, include in client medical records, and make available to the grantee on request: • The number of laboratory tests performed • The certification, licenses, or FDA approval of the laboratory from which tests were ordered • The credentials of the individual ordering the tests

PBC RWHAP Monitoring Standards

Outpatient/Ambulatory Health Services- Specialty Medical Care		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Provision of Outpatient and Ambulatory Medical Care, defined as the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with HHS guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.	Documentation of the following: • a written agreement/contract with Specialty Medical Care Providers •Specialty Medical Care service providers are credentialed by Medicaid and/or Medicare. •Specialty Medical Care service providers have entered into a participation agreement under the Medicaid State plan and be qualified to receive payments under such plan, or have received a waiver from this requirement. •Specialty Medical Care services shall not be reimbursed in excess of 150% of the Medicaid rate. •Encumbered services are released if services are not initiated within 90 days of Specialty Medical Care approval. •Specialty Medical Care service reports are received by the PCP prior to Specialty Medical Care service invoice being paid.	• Maintain written agreements/contracts with Specialty Medical Care Providers • Ensure Specialty Medical Care service providers are credentialed by Medicaid and/or Medicare. • Ensure Specialty Medical Care service providers have entered into a participation agreement under the Medicaid State plan and be qualified to receive payments under such plan, or have received a waiver from this requirement. • Ensure that Specialty Medical Care services are not reimbursed in excess of 150% of the Medicaid rate. • Release encumbered services if services are not initiated within 90 days of Specialty Medical Care approval. •Ensure Specialty Medical Care service reports are received by the PCP prior to Specialty Medical Care service invoice being paid.

Section V: Support Services Guidelines

Ch 1. Emergency Financial Assistance (EFA)

Purpose
To establish service standards for Sub-recipients providing Emergency Financial Assistance through PBC RWHAP.

Policy
Description:
Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist the PBC RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, and medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:
The Emergency Financial Assistance service category may assist with short-term assistance for medications. LPAP funds are not to be used for emergency or short-term financial assistance. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client shall not be funded through emergency financial assistance.

Procedure
Subcategory A: Essential utilities, housing, food, transportation, etc.
Unit of Service Description
1 unit=1 emergency assistance

Service Specific Criteria & Required Documentation
Documented need for assistance based on income/expense ratio

Caps/Limitations
Up to 12 accesses per grant year for no more than a combined total of $1,000.

Subcategory B: Medication
Unit of Service Description
1 unit=1 emergency assistance

Service Specific Criteria & Required Documentation
Letter of Medical Necessity for Chronic Opioid Medication

Caps/Limitations
Dispensing of one (1) emergency medication not exceeding a thirty (30) day supply to a client during any 12-month period.

National Monitoring Standards

Emergency Financial Assistance		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support for Emergency Financial Assistance (EFA) for essential services including utilities, housing, food (including groceries, food vouchers, and food stamps), or medications, provided to clients with limited frequency and for limited periods of time through either: • Short-term payments to agencies • Establishment of voucher programs Note: Direct cash payments to clients are not permitted	Documentation of services and payments to verify that: • EFA to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the Recipient • Assistance is provided only for the following essential services: utilities, housing, food (including groceries, food vouchers, and food stamps), or medications • Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to the clients • Emergency funds are allocated, tracked, and reported by type of assistance • Ryan White is the payer of last resort	• Maintain client records that document for each client: - Client eligibility and need for EFA - Types of EFA provided - Dates (s) EFA was provided -Method of providing EFA • Maintain and make available to the Recipient program documentation of assistance provided, including: - Number of clients and amount expended for each type of EFA -Summary of number of EFA services received by client -Methods used to provide EFA (e.g. payments to agencies, vouchers) • Provide assurance to the Recipient that all EFA: -Was for allowable types of assistance -Was used only in cases where RYHAP was the payer of last resort -Met Recipient-specified limitations on amount and frequency of assistance to an individual client -Was provided through allowable payment methods

PBC RWHAP Monitoring Standards

Emergency Financial Assistance- Local Monitoring Standards		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support for Emergency Financial Assistance (EFA) for essential services including utilities, housing, food (including groceries, food vouchers, and food stamps), or medications, provided to clients with limited frequency and for limited periods of time through either: • Short-term payments to agencies • Establishment of voucher programs Note: Direct cash payments to clients are not permitted	Documentation of services and payments to verify that: • EFA to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the Recipient • Assistance is provided only for the following essential services: utilities, housing, food (including groceries, food vouchers, and food stamps), or medications • Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to the clients • Emergency funds are allocated, tracked, and reported by type of assistance • Ryan White is the payer of last resort	● Dispensing of one (1) emergency medication not exceeding a thirty (30) day supply to a client during any 12-month period. ● Medications dispensed shall be included on the most recently published Florida Medicaid PDL Preferred Drug List.* ● Medications defined by Florida Medicaid PDL as “Clinical PA Required”, “Cystic Fib Diag Auto PA”, or “Requires Med Cert 3” shall require submission and approval of an override request prior to dispensing. ● One (1) additional dispensing of an emergency medication not exceeding a thirty (30) day supply during any 12 month period may be permitted in instances where a client has applied, and been denied access to the medication from all other medication assistance programs for which the client may be eligible (ADAP, pharmaceutical manufacturer patient assistance program, etc.). Documentation of medication access denial must be provided, and shall require submission and approval of an override

		request prior to dispensing. ● Dispensing of any medication under Emergency Financial Assistance may not exceed a sixty (60) day supply during any 12 month period. ● Any emergency medication needs not specified in this service standard shall require submission and approval of an override request prior to dispensing. Override requests shall not be submitted as exception to policy (e.g. more than a sixty (60) day supply during any 12-month period). *Florida Medicaid PDL https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

Ch 2. Food Bank/Home Delivered Meals (FBHDM)

Purpose
To establish service standards for Sub-recipients providing Food Bank/Home Delivered Meals through PBC RWHAP

Policy
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.

Procedure
Subcategory A: Food vouchers
Unit of Service Description
1 unit=1 voucher

Service Specific Criteria & Required Documentation
At or below 150% FPL
Nutritional Assessment (annually)
Must apply for and maintain enrollment in Food Stamps, when applicable

Caps/Limitations
Limit of $50 equivalent, per client per month

Subcategory B: Nutritional Supplements
Unit of Service Description
1 unit=1 prescription

Service Specific Criteria & Required Documentation
Requires a prescription from a medical provider

Caps/Limitations
None

National Monitoring Standards

Food Bank/Home Delivered Meals		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Funding for Food Bank/Home Delivered Meals that may include: • The provision of actual food items • Provision of hot meals • A voucher program to purchase food May also include the provision of non-food items that are limited to: • Personal Hygiene products • Household cleaning supplies • Water filtration/purification systems in communities where issues with water purity exist Appropriate licensure/certification for food banks and home delivered meals where required under State of Florida and Palm Beach County regulations No funds used for: • Permanent water filtration systems for water entering the house • Household appliances • Pet foods • Other non-essential products	Documentation that: • Services supported are limited to food bank, home-delivered meals, and/or food voucher program • Types of non-food items provided are allowable • If water filtration/purification systems are provided, community has water purity issues Assurances of: • Compliance with federal, state and local regulations including any required licensure or certification for the provision of food banks and/or home-delivered meals • Use of funds only for allowable essential non-food items Documentation of actual services provided, client eligibility, number of clients served, and level of services to these clients	• Maintain and make available to Recipient documentation of: - Services provided by type of service, number of clients served, and levels of service - Amount and use of funds for purchase of non-food items, including use of funds only for allowable non-food items - Compliance with all federal, state, and local laws regarding the provision of food bank, home-delivered meals and food voucher programs, including any required licensure and/or certifications • Provide assurance that RWHAP funds were used only for allowable purposes and RWHAP funding was payer of last resort

Ch 3. Housing Services (HS)

Purpose
To establish service standards for Sub-recipients providing Housing Services through PBC RWHAP.

Policy
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, including 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 may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing services also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these services.

Program Guidance:
Sub-recipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

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

Housing shall be prioritized based on the Housing Waitlist rank in client database.

Procedure
Unit of Service Description
1 unit=1 day of service

Service Specific Criteria & Required Documentation
Housing plan, updated every 2 weeks

Caps/Limitations
Up to 6 months of housing services

National Monitoring Standards

Housing Services		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support for Housing Services that involve the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care Funds received under the RWHAP may be used for the following housing expenditures: • Housing referral services defined as assessment, search, placement, and advocacy services must be provided by case managers or other professional (s) who possess a comprehensive knowledge of local, state, and federal housing programs and how these programs can be accessed; or • Short-term or emergency housing defined as necessary to gain or maintain access to medical care and must be related to either: -Housing services that include some type of medical or supportive service: including, but not limited to , residential substance treatment or mental health services (not including facilities classified as an Institution for Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or -Housing services that do not provide direct medical or supportive services, but are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment; necessity of housing for purposes of medical care must be certified or documented. • Sub-recipients must provide an individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services. • Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-	Documentation that funds are used only for allowable purposes: • The provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing -related referral services including housing assessment, search, placement, advocacy, and the fees associated with them. • Housing related referrals are provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs For all housing, regardless of whether or not the service includes some type of medical or supportive services. • Each client receives assistance designed to help him/her obtain stable long-term housing, through a strategy to identify, relocate, and/or ensure the individual or family is moved to or capable of maintaining a stable long-term living situation. • Housing services are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment. • Mechanisms are in place to allow newly identified clients access to housing services. • Policies and procedures to provide individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services. • No funds are used for direct payments to recipients of services for rent or mortgages.	• Document: Services provided including number of clients served, duration of housing services, types of housing provided and housing referral services • Ensure staff providing housing services are case managers or other professionals who possess a comprehensive knowledge of local, state, and federal housing programs and how to access those programs. • Maintain client records that document: - Client eligibility determination - Housing services, including referral services provided - Individualized housing plans for all clients that receive short-term, transitional, and emergency housing services • Mechanisms are in place to allow newly identified clients access to housing services. • Develop and maintain housing policies and procedures that are consistent with this Housing Policy -Assistance provided to clients to help them obtain stable long-term housing Provide documentation and assurance that no RWHAP funds are used to provide direct payments to clients for rent or mortgages

term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long term, and stable living situation. • Housing funds cannot be in the form of direct cash payments to recipients or services and cannot be used for mortgage payments. Note: Established duration limits must be adhered to.		

PBC RWHAP Monitoring Standards

Housing Services- Local Monitoring Standard		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support for Housing Services that involve the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care Funds received under the RWHAP may be used for the following housing expenditures: • Housing referral services defined as assessment, search, placement, and advocacy services must be provided by case managers or other professional (s) who possess a comprehensive knowledge of local, state, and federal housing programs and how these programs can be accessed; or • Short-term or emergency hosing defined as necessary to gain or maintain access to medical care and must be related to either: -Housing services that include some type of medical or supportive service: including, but not limited to , residential substance treatment or mental health services (not including facilities classified as an Institution for Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or -Housing services that do not provide direct medical or supportive services, but are essential for an individual or family to gain or maintain access and compliance	Documentation that funds are used only for allowable purposes: • The provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing -related referral services including housing assessment, search, placement, advocacy, and the fees associated with them. • Housing related referrals are provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs For all housing, regardless of whether or not the service includes some type of medical or supportive services. • Each client receives assistance designed to health him/her obtain stable long-term housing, through a strategy to identify, relocate, and/or ensure the individual or family is moved to or capable of maintaining a stable long-term living situation. • Housing services are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment. • Mechanisms are in place to allow newly identified clients access to	Referring agency will complete client initial assessment to identify resources needed. Clients will have initial financial assessment completed for housing needs . Referring agency and client must develop initial Emergency Housing Plan, to include specific housing goals for clients' which include referral and/or counseling to help with permanent housing, and/or other funding source, with copy offered to client. - Plan developed within 5 business days of initial assessment. Assessments will have a review/update every two weeks by referring agency; including financial assessment. Clients provide documentation to support achieving Emergency Housing Plan goals, within 30 days, to remain in the program. Sub-recipient will designate a representative for participation in the local homelessness planning processes

with HIV-related medical care and treatment; necessity of housing for purposes of medical care must be certified or documented. • Sub-recipients must provide an individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services. • Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable lining situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to , or capable of maintaining, a long term, stable living situation. • Housing funds cannot be in the form of direct cash payments to recipients or services and cannot be used for mortgage payments. Note: Established duration limits must be adhered to.	housing services. • Policies and procedures to provide individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services. • No funds are used for direct payments to recipients of services for rent or mortgages.	

Ch 4. Legal Services (LS)

Purpose
To establish service standards for Sub-recipients providing Legal Services through PBC RWHAP.

Policy
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 HRSA RWHAP-eligible PWH and involving legal matters related to or arising from their HIV, 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 PBC RWHAP
    - Preparation of healthcare power of attorney, durable powers of attorney, and 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 PBC RWHAP.
See 45 CFR § 75.459

Procedure
Unit of Service Description
1 unit=1 hour of service

Service Specific Criteria & Required Documentation
None

Caps/Limitations
None

National Monitoring Standards

Legal Services		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Funding for Legal Services provided for an HIV-infected person to address legal matters directly necessitated by the individual's HIV status Such services include, but are not limited to: • Preparation of Powers of Attorney and Living Wills • Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under RWHAP • Permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counsel regarding (1) the drafting of wills or delegating powers of attorney, (2) preparation of or custody options for legal dependents including standby guardianship, joint custody or adoption. Excludes: -Criminal defense -Class-action suits unless related to access to services eligible for funding under the RWHAP	Documentation that funds are used only for allowable legal services, which involve legal matter directly necessitated by an individual's HIV status, such as: -Preparation of Powers of Attorney and Living Wills -Services designed to ensure access to eligible benefits - Permanency planning Assurance that program activities do not include any criminal defense or class-action suits unrelated to access to services eligible for funding under the RWHAP	• Document, and make available to the Recipient upon request, services provided, including specific types of legal services provided • Provide assurance that: - Funds are being used only for legal services directly necessitated by an individual's HIV status - RWHAP served as the payer of last resort • Document in each client file: - Client eligibility determination -A description of how the legal service is necessitated by the individual's HIV status - Types of services provided -Hours spent in the provision of such services

Other Professional Services (Legal)		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Funding for Legal Services provided for an HIV-infected person to address legal matters directly necessitated by the individual's HIV status Such services include, but are not limited to: • Preparation of Powers of Attorney and Living Wills • Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under RWHAP • Permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counsel regarding (1) the drafting of wills or delegating powers of attorney, (2) preparation of or custody options for legal dependents including standby guardianship, joint custody or adoption. Excludes: -Criminal defense -Class-action suits unless related to access to services eligible for funding under the RWHAP	Documentation that funds are used only for allowable legal services, which involve legal matter directly necessitated by an individual's HIV status, such as: -Preparation of Powers of Attorney and Living Wills -Services designed to ensure access to eligible benefits - Permanency planning Assurance that program activities do not include any criminal defense or class-action suits unrelated to access to services eligible for funding under the RWHAP	1. Competent provision of legal services to HIV/AIDS community and dependents. 1.1 Show evidence of State of Florida license to practice law (as applicable). 1.2 Training of paralegals and other support staff occurs for programmatic staff (those working with HIV/AIDS population). 1.3 Minimum training requirement (AIDS 101 for support staff, AIDS 104 for attorneys and paralegals). 2. Reasonable response time to telephone inquiries/referrals. 2.1 Procedures in place to route calls/referrals to available staff. 2.2 Grievance procedures in place when client feels calls are not returned in a timely manner. 3. Records display intake documentation. 3.1 100% of records show intake form and outcome or resolution. 3.2 Notification of outcome for resolution is provided to referring agency, if applicable. 4. Clients or caretakers receive disposition or resolution of legal issue. 4.1 100% of legal services document progress toward resolution of presenting issue. 4.2 Desired outcomes achieved in at least 50% of legal services. 4.3 With client's consent, progress report shared with case management agency (Florida Law statute), if applicable.

Ch 5. Medical Transportation Services (MTS)

Purpose
To establish service standards for Sub-recipients providing Medical Transportation Services through PBC RWHAP.

Policy
Description:
Medical Transportation is the provision of non-emergency 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
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but shall 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

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

Procedure
Unit of Service Description
1 unit=1 trip/voucher

Service Specific Criteria & Required Documentation
At or below 150% FPL

Caps/Limitations
None

National Monitoring Standards

Medical Transportation		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Funding for Medical Transportation Services that enable an eligible individual to access HIV-related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens May be provided through: • Contracts with providers of transportation services • Voucher or token systems • Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed) • Purchase or lease of organizational vehicles for client transportation programs, provided the Recipient receives prior approval for the purchase of a vehicle	Documentation that: • Medical transportation services are used only to enable an eligible individual to access HIV-related health and support services • That services are provided through one of the following methods: - A contract or some other local procurement mechanism with a provider of transportation services - A voucher or token system that allows for tracking the distribution of the vouchers or tokens - A system of mileage reimbursement that does not exceed the federal per-mile reimbursement rates -A system of volunteer drivers, where insurance and other liability issues are addressed - Purchase or lease of organizational vehicles for client transportation, with prior approval from HIV/HAB for the purchase	• Maintain program files that document: - The level of services/number of trips provided -The reason for each trip and its relation to accessing health and support services - Trip origin and destination - Client eligibility determination -The cost per trip - The method used to meet the transportation need • Maintain documentation showing that the provider is meeting stated contract requirements with regard to methods of providing transportation: - Reimbursement methods do not involve cash payments to service recipients - Mileage reimbursement does not exceed the federal reimbursement rate - Use of volunteer drivers appropriately addresses insurance and other liability issues • Collection and maintenance of data documenting that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services • Obtain Recipient approval prior to purchasing or leasing a vehicle(s)

Ch 6. Non-Medical Case Management Services (NMCM)

Purpose
To establish service standards for Sub-recipients providing Non-Medical Case Management services through PBC RWHAP.

Policy
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 (including Treatment Adherence). Non-Medical Case Management may not analyze the services to enhance client care toward improving health outcomes.

***Further information can be found in the PBC RWHAP Supplemental Guide.**

Procedure
Unit of Service Description
1 unit=15 minutes of service

Service Specific Criteria & Required Documentation
None

Caps/Limitations
None

National Monitoring Standards

Non-Medical Case Management		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support for Case Management (Non-medical) Services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs of which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Transitional case management for incarcerated persons as they prepare to exit the correctional system Note: Does not involve coordination and follow up of medical treatments	Documentation that: • Scope of activity includes advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services • Where benefits/entitlement counseling and referral services are provided, they assist clients in obtaining access to both public and private programs, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services • Services cover all types of encounters and communications (e.g., face-to-face, telephone contact, other) Where transitional case management for incarcerated persons is provided, assurance that such services are provided either as part of discharge planning or for individuals who are in the correctional system for a brief period	Maintain client records that include the required elements as detailed by the Recipient, including: • Date of encounter • Type of encounter • Duration of encounter • Key activities, including benefits/entitlement counseling and referral services Provide assurances that any transitional case management for incarcerated persons meets contract requirements

Ch 7. Psychosocial Support Services (PSS)

Purpose
To establish service standards for Sub-recipients providing Psychosocial Support Services through PBC RWHAP.

Policy
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist eligible people with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- 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:
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.

Procedure
Unit of Service Description
1 unit=15 minutes of service

Service Specific Criteria & Required Documentation
None

Caps/Limitations
None

National Monitoring Standards

Psychosocial Support Services		
Standard	**Performance Measure/Method**	**Provider/Sub-recipient Responsibility**
Support for Psychosocial Support Services that may include: • Support and counseling activities • Child abuse and neglect counseling • HIV support groups • Pastoral care/counseling • Caregiver support • Bereavement counseling • Nutrition counseling provided by a non-registered dietitian Note: Funds under this service category may not be used to provide nutritional supplements Pastoral care/counseling supported under this service category to be: • Provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider) • Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available • Available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation	• Documentation that psychosocial services funds are used only to support eligible activities, including: o Support and counseling activities o Child abuse and neglect counseling o HIV support groups o Pastoral care/counseling o Caregiver support o Bereavement counseling o Nutrition counseling provided by a non-registered dietitian • Documentation that pastoral care/counseling services meet all stated requirements: o Provided by an institutional pastoral care program o Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available o Available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation • Assurance that no funds under this service category are used for the provision of nutritional supplements	• Document the provision of psychosocial support services, including: o Types and level of activities provided o Client eligibility determination • Maintain documentation demonstrating that: o Funds are used only for allowable services o No funds are used for provision of nutritional supplements o Any pastoral care/counseling services meet all stated requirements

Section VI: References

Ch 1. Glossary

Below are terms used most frequently in HRSA's Ryan White HIV/AIDS Program (RWHAP).

A

Administrative or Fiscal Agent
Entity that functions to assist the Ryan White HIV/AIDS Program recipient or planning body in carrying out administrative activities (e.g., disbursing program funds, developing reimbursement and accounting systems, developing funding announcements, monitoring contracts).

Affordable Care Act (ACA)
Federal law comprised of expanded health insurance coverage and health care delivery innovations designed to achieve better health outcomes by increasing the number of insured Americans, reducing care costs, and improving the overall American health care system. Enacted in 2010 as the Patient Protection and Affordable Care Act.

Agency for Healthcare Research and Quality (AHRQ)
Federal agency within HHS that supports research designed to improve the outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services.

AIDS Drug Assistance Program (ADAP)
Administered by States and authorized under Part B of the Ryan White HIV/AIDS Treatment Extension Act. Provides FDA-approved medications to low-income individuals with HIV who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured Ryan White HIV/AIDS Program clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program at least match those offered through ADAP.

ADAP Data Report (ADR)
Reporting requirement for ADAPs to provide client-level data on individuals served, services being delivered, and costs associated with these services.

AIDS
Acquired Immune Deficiency Syndrome. A disease caused by the human immunodeficiency virus (HIV).

AIDS Education and Training Center (AETC)
Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs are authorized under Part F of the Ryan White HIV/AIDS Program.

AIDS Service Organization (ASO)
An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease.

Annual Gross Income
A measure of income. There are several ways to measure an individual's Annual Gross Income. For example, these forms of income could be used by the provider for the purposes of imposition of charges:

- Gross Income: the total amount of income earned from all sources during the calendar year before taxes.
- Adjusted Gross Income: gross income less deductions.

Antiretroviral Therapy
An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV that is designed to reduce viral load to undetectable levels.
Applicable Services
Any RWHAP service with a distinct fee typically charged in the local market. In the broader healthcare community this distinct fee is often referred to as a usual, customary, and reasonable (UCR) fee.

C
Cap on Charges
The limitation on aggregate charges imposed during the calendar year based on patient's annual gross income. All fees must be waived once a RWHAP patient reaches their cap for that calendar year.
Capacity
Core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services. Capacity development activities shall increase access to the HIV/AIDS service system and reduce disparities in care among underserved people with HIV (PWH) in the EMA.
CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act)
Now referred to as the Ryan White HIV/AIDS Program, this was the name of the original federal legislation (link is external) created to address the unmet health care and service needs of people with HIV Disease (PWH) disease and their families. The legislation was enacted in 1990 and reauthorized in 1996 and 2000. The legislation was subsequently reauthorized as the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and later as the Ryan White HIV/AIDS Treatment Extension Act of 2009.
CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
This advisory committee, often referred to as the CHAC, advises the Secretary, HHS; the Director, CDC; and the Administrator, HRSA, regarding objectives, strategies, policies, and priorities for HIV, Viral Hepatitis, and STD prevention and treatment efforts.
Centers for Disease Control and Prevention (CDC)
Federal agency within HHS that administers disease prevention programs including HIV/AIDS prevention.
Centers for Medicare and Medicaid Services (CMS)
Federal agency within HHS that administers the Medicaid, Medicare, the Children's Health Insurance Program (CHIP) and the Health Insurance Marketplace.
Chief Elected Official (CEO)
The official recipient of Part A or Part B Ryan White HIV/AIDS Program funds. For Part A, this is usually a city mayor, county executive, or chair of the county board of supervisors. For Part B, this is usually the governor. The CEO is ultimately responsible for administering all aspects of their Part's RWHAP Act funds and ensuring that all legal requirements are met.
Client Level Data (CLD)
Information collected on each client eligible for and receiving RWHAP core medical services or support services. The data elements reported per client are determined by the specific RWHAP services that the agency is funded to provide.
Community-based Organization (CBO)
An organization that provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

Community Based Dental Partnership Program (CBDPP)
A program under the Ryan White HIV/AIDS Program (Part F) that delivers HIV/AIDS dental care while simultaneously training dental professionals in these areas in order to expand community capacity to deliver HIV oral health care.

Community Forum or Public Meeting
A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion. Similar to but less formal than a focus group, it usually includes a larger group; participants are often self-selected (i.e., not randomly selected to attend).

Co-morbidity
A disease or condition, such as hepatitis, mental illness or substance abuse, co-existing with HIV disease.

Comprehensive Planning
The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PWH.

Community Health Centers
See Health Centers.

Cone of Silence
A prohibition on any non-written communication regarding an RFP between any respondent or respondent's representative and any County Commissioner

Consortium/HIV Care Consortium
A regional or statewide planning entity established by many State recipient under Part B of the Ryan White HIV/AIDS Program to plan and sometimes administer Part B services. An association of health care and support service agencies serving PWHA under Part B.

Continuous Quality Improvement
An ongoing process that involves organization members in monitoring and evaluating programs to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care by identifying opportunities for improvement.

Continuum of Care
The extent to which a person living with HIV disease is engaged in HIV/AIDS care and is realizing the full advantages of care and treatment—from initial diagnosis and engagement in care to full viral suppression. Generally referred to as the HIV Care Continuum.

Core Medical Services
Essential, direct, health care services for HIV/AIDS care specified in the Ryan White legislation. Recipient/Sub-recipient expenditures are limited to core medical services, support services, and administrative expenses.

Cultural Competence
The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

D

Data Terms
For definitions of terms, see data dictionaries for the Ryan White Services Report (RSR) (link is external) and the ADAP Data Report (ADR) (link is external).

Documentation
Papers and documents required from clients, as defined by the recipient, in order to assure all RWHAP statutory requirements are met.

E

Early Intervention Services (EIS)
Activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Parts A and B of the Ryan White HIV/AIDS Program, includes outreach, counseling and testing, information and referral services. Under Part C Ryan White HIV/AIDS Program, also includes comprehensive primary medical care for individuals living with HIV/AIDS.

Eligible Metropolitan Area (EMA)
Geographic areas highly-impacted by HIV/AIDS that are eligible to receive Ryan White HIV/AIDS Program Part A funds To be an eligible EMA, an area must have reported more than 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000. See also Transitional Grant Area, TGA.

Eligible Scope
A method of data collection based on a client's ability to receive federally funded RWHAP services using established recipient criteria.

Epidemiologic Profile
A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area. Specific to HIV planning, a description of the burden of HIV in the population of an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, PWH, and persons at higher risk for infection.

Epidemiology
The branch of medical science that studies the incidence, distribution, and control of disease in a population.

eUCI (encrypted Unique Client Identifier)
An alphanumeric code that distinguishes one RWHAP client from all others and is the same for the client across all provider settings.

F

Family-Centered Care
A model in which systems of care under Ryan White Part D are designed to address the needs of PWHA and affected family members as a unit, providing or arranging for a full range of services. Family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated caregivers.

Federal Poverty Level (FPL)
A measure of income issued every year by HHS. Federal poverty levels are commonly used to determine eligibility for certain programs and benefits such as Medicaid, Food Stamps, the Children’s Health Insurance Program (CHIP), and RWHAP.

Fee-for-Service
The method of billing for health services whereby a physician or other health service provider charges the payer (whether it be the patient or his or her health insurance plan) separately for each patient encounter or service rendered.

Fee Schedule
A complete listing of billable services, those with UCR fees, and their associated fees based on locally prevailing rates or charges. A fee schedule is used by healthcare providers to identify which services they bill for and for how much. A fee schedule is not a schedule of charges. A fee schedule is not required by the RWHAP legislation, but it may be useful as the basis for a

schedule of charges. Having one in place is considered a best practice and, for those multi-funded clinics, is a requirement for HRSA Bureau of Primary Health Care (BPHC) grant recipients.

Financial Status Report (FSR - Form 269)

A report that is required to be submitted within 90 days after the end of the budget period that serves as documentation of the financial status of grants according to the official accounting records of the recipient organization.

Food and Drug Administration (FDA)

Federal agency within HHS responsible for ensuring the safety and effectiveness of drugs, biologics, vaccines, and medical devices used (among others) in the diagnosis, treatment, and prevention of HIV infection, AIDS, and AIDS-related opportunistic infections. The FDA also works with the blood banking industry to safeguard the nation's blood supply.

G

Grant Contract Management System

An electronic data system that RWHAP recipients use to manage their Sub-recipient contracts.

H

Health Centers

Community-based and patient-directed organizations funded by HRSA that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing.

Health Resources & Services Administration (HRSA)

The agency of the U.S. Department of Health and Human Services that administers various primary care programs for the medically underserved, including the Ryan White HIV/AIDS Program.

HRSA HIV/AIDS Bureau (HAB)

The bureau within HRSA of the U.S. Department of Health and Human Services (HHS) that is responsible for administering the Ryan White HIV/AIDS Program. See the HRSA HAB Program Administration fact sheet (link is external).

HIV Care Continuum

The stages of HIV care, from initial diagnosis to achieving the goal of viral suppression. The effectiveness of HIV testing and care in a given jurisdiction is typically depicted as the proportion of individuals living with HIV who are engaged at each stage.

HIV Disease

Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

HIV-related Charges

Those charges a RWHAP recipient imposes on the patient plus any other out of-pocket charges related to their HIV care (as determined by their provider) that a patient incurs and reports to their RWHAP recipient/provider. These charges can be from any provider as long as the service is a RWHAP allowable service.

Housing Opportunities for People With AIDS (HOPWA)

A program administered by the U.S. Department of Housing and Urban Development (HUD) that provides funding to support housing for PWHA and their families.

HUD (U.S. Department of Housing and Urban Development)

The Federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for People with AIDS (HOPWA).

I

Imposition of Charges
All activities, policies, and procedures related to assessing RWHAP patient charges as outlined in legislation.

Incidence
The number of new cases of a disease that occur during a specified time period.

Incidence Rate
The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 persons. AIDS incidence rates are often expressed this way.

Intergovernmental Agreement (IGA)
A written agreement between a governmental agency and an outside agency that provides services.

L

Lead Agency
The agency within a Part B consortium that is responsible for contract administration; also called a fiscal agent (an incorporated consortium sometimes serves as the lead agency).

M

Medicaid Spend-down
A process whereby an individual who meets the Medicaid medical eligibility criteria, but has income that exceeds the financial eligibility ceiling, may "spend down" to eligibility level. The individual accomplishes spend-down by deducting accrued medically related expenses from countable income. Most State Medicaid programs offer an optional category of eligibility, the "medically needy" eligibility category, for these individuals.

Minority AIDS Initiative (MAI)
A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people with HIV/AIDS within communities of color. Enacted to address the disproportionate impact of the disease in such communities. Formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

Multiply Diagnosed
A person having multiple morbidities (e.g., hepatitis and HIV, substance abuse and HIV infection) (see co-morbidity).

N

Needs Assessment
A process of collecting information about the needs of PWH (both those receiving care and those not in care), identifying current resources (Ryan White HIV/AIDS Program and other) available to meet those needs, and determining what gaps in care exist.

Nominal Charge
A fee greater than zero.

Notice of Funding Opportunity (NOFO)
An open and competitive process for selecting providers of services.

O

Office of Management and Budget (OMB)

The office within the executive branch of the Federal government that prepares the President's annual budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulations.

Opportunistic Infection

An infection or cancer that occurs in people with weak immune systems due to HIV, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's sarcoma, Pneumocystis jiroveci pneumonia, toxoplasmosis, and cytomegalovirus are all examples of such infections.

P

Patient Assistance Programs (PAPs)

Programs operated by pharmaceutical companies and foundations that provide medicines at little or no cost to eligible patients.

Part A

The part of the Ryan White HIV/AIDS Program that provides emergency assistance to localities disproportionately affected by the HIV/AIDS epidemic.

Part B

The part of the Ryan White HIV/AIDS Program that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PWHA and their families.

Part C

The part of the Ryan White HIV/AIDS Program that supports outpatient primary medical care and early intervention services (EIS) to PWH through grants to public and private non-profit organizations. Part C also funds planning grants to prepare programs to provide EIS services.

Part D

The part of the Ryan White HIV/AIDS Program that supports family-centered, comprehensive care to women, infants, children, and youth living with HIV.

Part F: AIDS Education and Training Centers (AETC)

National and regional centers providing education and training for primary care professionals and other AIDS-related personnel.

Part F: Dental Programs

The part of the Ryan White HIV/AIDS Program that provides additional funding for oral health care for people with HIV through the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program.

Part F: SPNS: Special Projects of National Significance

The part of the Ryan White HIV/AIDS Program that funds demonstration and evaluation of innovative models of care delivery for hard-to-reach populations.

Part F : Minority AIDS Initiative

The Minority AIDS Initiative provides funding to evaluate and address the impact of HIV/AIDS on disproportionately affected minority populations.

People with HIV (PWH)

Descriptive term for persons living with HIV disease.

Planning Council/Planning Body

There are various types of planning groups. For Part A of the RWHAP, a planning council is a body appointed or established by the Chief Elected Official with responsibility to assess needs, establish a plan for the delivery of HIV care in the area, and establish priorities for the use of Part

A funds. Part B planning bodies conduct similar tasks but do not establish service dollar allocations. In addition, jurisdictions directly funded by CDC are responsible for convening planning bodies to address HIV prevention, care and treatment issues. Many jurisdictions facilitate collaboration through joint care/prevention planning bodies and/or shared planning tasks.

Planning Process

Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.

PrEP

Pre-exposure prophylaxis is a prevention method for people at higher risk for HIV exposure and involves taking an antiretroviral pill every day to greatly reduce, if not eliminate, the risk of becoming infected with HIV if exposed to the virus.

Prevalence

The total number of persons in a defined population living with a specific disease or condition at a given time (compared to incidence, which is the number of new cases).

Prevalence Rate

The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

Primary Health Care Service

Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client living with HIV. Examples include medical, subspecialty care, dental, nutrition, mental health, or substance use disorder treatment services; medical case management; pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; and counseling and testing.

Priorities & Allocations Process (P&A)

A decision-making process utilized by the P&A Committee of the HIV CARE Council to establish priorities among service categories and develop funding allocation recommendations addressing locally identified needs.

Program Income

Gross income earned by the Sub-recipient that is directly generated by a supported activity or earned as a result of the RWHAP service provision during the contract year. For purposes of the RWHAP, program income includes, but is not limited to, income from fees for services performed (i.e. fees paid by clients based on a sliding fee schedule, or other third parties). Direct payments include charges imposed by Sub-recipients for RWHAP Part A services as required under Section 2605 (e) of the RWHAP legislation, such as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges. Additionally, income a Sub-recipient earns as the result of a benefit made possible by receipt of the RWHAP funds. Program income does not include rebates, credits, discounts, and interest earned on any of them.

Prophylaxis

Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has previously been brought under control (secondary prophylaxis).

Provider (or service provider)

The agency that provides direct services to clients (and their families) or the recipient. A provider may receive funds as a recipient (such as under RWHAP Parts C and D) or through a contractual relationship with a recipient funded directly by RWHAP. Also see Sub-recipient.

Q

Quality

The degree to which a health or social service meets or exceeds established professional standards and user expectations.

Quality Assurance (QA)

The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.

Quality Improvement (QI)

Also called Continuous Quality Improvement (CQI). An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care.

R

Recipient

An organization that receives RWHAP funds directly from. Recipients may provide direct services and/or may contract with Sub-recipients for services. Replaces the term "Grantee." See also Recipient/Sub-recipient.

Recipient-provider

An organization that receives RWHAP funds directly from HRSA HAB and provides direct client services. Replaces the term “grantee-provider.”

Recipient of record (or recipient)

An organization receiving financial assistance directly from an HHS- awarding agency to carry out a project or program. A recipient also may be a recipient-provider if it provides direct services in addition to administering its grant. Replaces the term “grantee of record.”

Reflectiveness

The extent to which the demographics of the planning body's membership look like the demographics of the epidemic in the service area.

Representative

Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

Request for Proposal (RFP)

A public solicitation for proposals for providing HIV/AIDS core medical and support services for Palm Beach County residents.

Resource Allocation

The Part A planning council responsibility to assign Ryan White HIV/AIDS Program amounts or percentages to established priorities across specific service categories, geographic areas, populations, or subpopulations.

Resource Inventory

An inventory of the financial resources available in a jurisdiction to meet the HIV prevention, care, and treatment needs of its population as well as resource gaps. The inventory also details the CDC-funded high impact prevention services and the HRSA-funded core medical and support services.

Ryan White HIV/AIDS Program Services Report (RSR)

Data collection and reporting system for reporting information on programs and clients served (Client Level Data).

S

Schedule of Charges

Fees imposed on the RWHAP patient for services based on the patient's annual gross income. A schedule of charges may take the form of a flat rate or a varying rate (e.g. sliding fee scale). The schedule of charges is how you know what amount of money to charge a patient. The schedule of charges applies to uninsured patients with incomes above 100% FPL, and may be applied to insured patients as determined by RWHAP recipients' policies and procedures. When applied to insured patients, recipients shall consider how their policy will be applied uniformly to all insured patients, rather than on a case-by-case basis.

Section 340B Drug Discount Program

A program administered by the HRSA's Office of Pharmacy Affairs that was established by Section 340B of the Veteran's Health Care Act of 1992, which limits the cost of drugs to Federal purchasers and to certain recipients of federal agencies.

Seroprevalence

The number of persons in a defined population who test HIV-positive based on HIV testing of blood specimens. (Seroprevalence is often presented either as a percent of the total specimens tested or as a rate per 100,000 persons tested.)

Service Gaps

HIV prevention and care services for persons at risk for HIV and PWH that do not exist in the jurisdiction.

Sexually Transmitted Disease (STD)

Socio-demographics

Demographic (e.g. race, age, gender identity, sex) and socioeconomic data (e.g. income, education, health insurance status) characteristics of individuals and communities. Also known as: SES, demographic data.

Special Projects of National Significance (SPNS)

The part of the Ryan White HIV/AIDS Program under Part F that funds demonstration and evaluation of innovative models of care delivery for hard-to-reach populations.

Statewide Coordinated Statement of Need (SCSN)

The process of identifying the needs of persons at risk for HIV infection and people with HIV (those receiving care and those not receiving care); identifying current resources available to meet those needs, and determining what gaps in HIV prevention and care services exist. The SCSN is a culminating report which consists of information gathered through needs assessments conducted by three separate entities: RWHAP Part A Recipients, RWHAP Part B Recipients, and CDC funded recipients. Required component of the Integrated HIV Prevention and Care Plan.

Sub-Grantee/Sub-recipient

A governmental or private nonprofit agency receiving HRSA funds through a contract originating from the Palm Beach County Community Services Department.

Sub-recipient/Sub-Grantee

The legal entity that receives Ryan White HIV/AIDS Program funds from a recipient and is accountable to the recipient for the use of the funds provided. Sub-recipients may provide direct client services or administrative services directly to a recipient. Sub-recipient replaces the term "Provider (or service provider)."

Substance Abuse and Mental Health Services Administration (SAMHSA)

Federal agency within HHS that administers programs in substance abuse and mental health.

Support Services
Services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV/AIDS. Recipient/Sub-recipient expenditures are limited to core medical services, support services, and administrative expenses.
Surveillance
An ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases (e.g., Centers for Disease Control and Prevention surveillance system for AIDS cases).
Surveillance Report
A report providing information on the number of reported cases of a disease such as AIDS, nationally and for specific sub-populations.

T
Prioritized Population
A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.
Technical Assistance (TA)
The delivery of practical program and technical support to the Ryan White community. TA is to assist Recipients/Sub-recipients, planning bodies, and affected communities in designing, implementing, and evaluating Ryan White-supported planning and primary care service delivery systems.
Transitional Grant Area (TGA)
Geographic areas highly-impacted by HIV/AIDS that are eligible to receive Ryan White HIV/AIDS Program Part A funds To be an eligible TGA, an area must have reported at least 1,000 but fewer than 2,000 new AIDS cases in the most recent 5 years and a population of at least 50,000. See also Eligible Metropolitan Area, EMA.
Transmission Category
A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include, for example, men who have sex with men, injection drug use, heterosexual contact, and perinatal transmission.

U
Unmet Need
The unmet need for primary health services among individuals who know their HIV status but are not receiving primary health care.
UCR
Usual, customary, and reasonable, as in services for which there is a usual, customary, and reasonable fee associated. Such services are found on a fee schedule.

V
Viral Load
In relation to HIV, the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.

W

Waiver

A waiver of the imposition of charges requirement can only be requested by RWHAP recipients operating as free clinics (e.g. healthcare for the homeless clinics). Only a handful of RWHAP recipients are operating as free clinics; therefore, other RWHAP recipients/Sub-recipients shall be charging patients over 100% FPL for applicable services – even if it is only $1.Organizations that receive funding from RWHAP and other Federal funding sources (i.e., facilities operated directly by the Indian Health Service or by Tribes through a contract with the Indian Health Service, Community Health Centers) must follow the requirements imposed by each Federal program. To the extent that services under the RWHAP are provided and attributed to the RWHAP, RWHAP statutory requirements on imposition of charges must be followed.

X

XML (Extensible Markup Language)

A standard, simple, and widely adopted method of formatting text and data so that it can be exchanged across all of the different computer platforms, languages, and applications.

Ch 2. Acronyms

ACA - Affordable Care Act

ADAP- AIDS Drug Assistance Program

AETC – AIDS Education and Training Centers

AHCA- Agency for Health Care Administration

AICP- AIDS Insurance Continuation Program

AITRP - AIDS International Training and Research Program, FIC

ART – Anti-Retroviral Treatment

ARTAS - Anti-Retroviral Treatment and Access to Services

ASO – AIDS Services Organization

ATIS -HIV/AIDS Treatment Information Service

B/START - Behavioral Science Track Award for Rapid Transition, NIMH & NIDA

BCC: The Palm Beach County Board of County Commissioners

CAB - Community Advisory Board

CAMCODA - Center on AIDS and Other Medical Consequences of Drug Abuse

CAPS - Center for AIDS Prevention Studies

CARF: The Committee on Accreditation of Rehabilitation Organizations

CBC - Congressional Black Caucus

CBO - Community-Based Organization

CDC - Centers for Disease Control and Prevention

CFAR - Center for AIDS Research

CMS- Children Medical Services

CMS- Center for Medicare and Medicaid Services

CMV - Cytomegalovirus

CMV - Cytomegalovirus

CNS - Central Nervous System

CPP- Community Planning Partnership

CPCRA - Community Program for Clinical Research on AIDS

CSF - Cerebrospinal Fluid

CSN - Coordinator Statement of Need

CTL - Cytotoxic T Lymphocyte

CW - CAREWare

DHHS - Department of Health and Human Services

DIS - Disease Intervention Specialist

DOH- Department of Health

DNA - Deoxyribonucleic Acid

DRG - Division of Research Grants, NIH (now the Center for Scientific Review)

EBV - Epstein-Barr Virus

EHB – Electronic Hand Book (HRSA reporting system)

EIIHA - Early Identification of Individuals with HIV/AIDS

EIS - Early Intervention Services

EMA - Eligible Metropolitan Area

ETI - Expanded Testing Initiative

FDOH - Florida Department of Health

FIRCA - Fogarty International Research Collaboration Award, FIC

FLAETC- Florida AIDS Education Treatment Center

FPL – Federal Poverty Level

FQHC – Federally Qualified Healthcare Center

FY - Fiscal Year

GCRC - General Clinical Research Center

GIS – Geographic Information System

HAART – Highly Active Anti-Retroviral Therapy

HAB – HIV/AIDS Bureau

HAPC - HIV/AIDS Program Coordinator

HBCU - Historically Black Colleges and Universities

HCD - Health Care District

HCSEF- Health Council of Southeast Florida

HHV-8 -Human Herpesvirus-8

HIVIG - HIV Immunoglobulin

HMS – Health Management System

HPV - Human Papillomavirus

HRSA – Health Resources & Services Administration, a subsidiary of the US Department of Health and Human Services

IDU- Injection Drug User

IHS - Indian Health Service

IVIG- Intravenous Immunoglobulin

JCAHO: The Joint Commission for the Accreditation of Healthcare Organizations

JCV - JC Virus

MAC - Mycobacterium Avium Complex

MAI- Minority AIDS Initiative

MCT - Mother-to-Child Transmission

MOE – Maintenance of Effort

MSM - Men who have Sex with Men

NAFEO - National Association for Equal Opportunity in Higher Education

NHAS - National HIV/AIDS Strategy

NOE - Notice of Eligibility

OAR - Office of AIDS Research, NIH

OARAC - Office of AIDS Research Advisory Council

OI - Opportunistic Infection

P&A - Priorities & Allocations Committee, of the HIV CARE Council

PBCHD – Palm Beach County Health Department

PBCSAC – Palm Beach County Substance Abuse Coalition

PBMC - Peripheral Blood Mononuclear Cell

PCN – Policy Clarification Notice (HRSA)

PIR- Parity, Inclusion and Representation

PWH/A - Person(s) Living with HIV/AIDS Disease

PML - Progressive Multifocal Leukoencephalopathy

PWA/PLWA - Person With AIDS: A person living with AIDS

QIP – Quality Improvement Plan

RARE - Rapid Assessment Response Evaluation

RCMI - Research Center in Minority Institution

RDR – Ryan White Program Data Report

RFP – Request for Proposals

RNA - Ribonucleic Acid

RSR – Ryan White Services Report

SAMHSA – Substance Abuse and Mental Health Services Administration

SCID - Severe Combined Immunodeficiency

SI - Synctia-Inducing

SMART - Specific, Measurable, Achievable, Realistic and Time Sensitive

SRA - Scientific Review Administration

STD – Sexually Transmitted Disease

STI - Structured Treatment Interruption

STI – Sexually Transmitted Infection

TB- Tuberculosis

TGA – Transitional Grant Area

TOPWA- Targeted Outreach for Pregnant Women Act

UOB – Unobligated Balance

VA - Veterans Administration

WHO -World Health Organization

WICY – Women, Infant, Children and Youth

ZDV - Zidovudine

Section VII. Appendix

Appendix A- PBC RWHAP Client Eligibility Determination Table

Palm Beach County Ryan White HIV/AIDS Program
Client Eligibility Determination & Recertification
Required Documentation Table

Eligibility Requirement	Initial Eligibility Determination & Annual/12-Month Recertification	Recertification (Every 6-Month Period following initial & annual certifications)
HIV Status	Documentation is ONLY required for initial eligibility determination	No documentation is required
Income	Documentation is required	Self-attestation of no change is acceptable OR Self-attestation of change (documentation is required)
Residency	Documentation is required	Self-attestation of no change is acceptable OR Self-attestation of change (documentation is required)
Insurance Status / Third Party Payer	Sub-recipient must verify if applicant is enrolled in other health care coverage and document status in client file.	Sub-recipient must verify if applicant is enrolled in, or eligible for, other health care coverage and document status in client file. Self-attestation of no change is acceptable OR Self-attestation of change (documentation is required)

Appendix B- PBC RWHAP Self-Attestation Form

Palm Beach County Ryan White HIV/AIDS Program

Six-Month Self-Attestation Eligibility Form

The Health Resources & Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) requires Sub-recipient agencies to recertify clients' eligibility status every six months following initial and annual recertification in order to continue RWHAP funded services. Please complete this form and submit it to your Sub-recipient agency to maintain your eligibility status.

Client Name:		**Client PE Identification Number:**
Phone:		**E-mail:**
Address► please provide your current address		
Since your initial certification or annual re-certification six months ago, have you moved/changed residence?	☐ No, I have not moved and my residence has remained the same ☐ Yes, I have moved and/or my residence has changed*	
**If your current address has changed, please provide documentation to assist your Sub-recipient agency in determining if the change affects eligibility for PBC RWHAP services.*		
Living Arrangement		
Since your initial certification or annual re-certification six months ago, has your living arrangement changed? ☐ No, my living arrangement has remained the same ☐ Yes, my living arrangement has changed*	☐ Stable/Permanent (own home, renting, HOPWA funded housing assistance, Section 8 housing, public housing, etc.) ☐ Temporary (transitional housing, temporarily living with family or friends, hotel or motel paid without a voucher, etc.) ☐ Unstable (emergency shelter, hotel or motel paid with a voucher, homeless, prison, jail, etc.)	
**If your current living arrangement has changed, additional information may be needed and you may be contacted by your Sub-recipient agency*		
Household Income *(Includes income of spouse and dependents, if applicable)*		

Since your initial certification or annual re-certification six months ago, has your income or household size changed?	☐ No, my/our income and household size has remained the same ☐ Yes, my/our income OR household size has changed* Household Size _____ Household Income _____ Monthly OR Annually (circle one)

**If your current household income has changed, please provide documentation to assist your Sub-recipient agency in determining if the change affects eligibility for PBC RWHAP services.*

Insurance Status

Since your initial certification or annual re-certification six months ago, has your insurance status changed? ☐ No, my/our insurance status has remained the same ☐ Yes, my/our insurance status has changed*	☐ Medicaid ☐ Child Health Insurance Program (CHIP) ☐ Medicare (A, B, C, or D) ☐ ACA/Marketplace Health Plan ☐ Employer-Sponsored Health Insurance ☐ Other Private Insurance ☐ No Insurance

**If your current insurance status has changed, please provide documentation to assist your Sub-recipient agency in determining if the change affects eligibility for PBC RWHAP services.*

I certify and attest that my signature on this Palm Beach County Ryan White Part A Program Six-Month Self-Attestation Eligibility Form indicates the information provided is true, accurate and complete to the best of my knowledge. I understand that providing false information may disqualify me from Palm Beach County Ryan White Part A services. Palm Beach County Ryan White Part A cannot pay for services that have been paid or can reasonably be paid by any state, federal or private entity that provides health benefits.

Client Signature:	**Date:**

*****In person attestations must be signed by the client. *****
*****Attestations not made in person (phone, email, mail, etc.) must include the name, signature, and agency name of the staff member completing the form. *****

Staff Signature:	**Date:**

Staff Name:	**Sub-recipient Agency:**	**Phone #:**

Appendix C- PBC RWHAP Allowable Eligibility Documentation List

PBC RWHAP Allowable Eligibility Documentation List	
Proof of HIV	
Western Blot or Immunofluorescence Assay (IFA).	A detectable (quantitative) HIV viral load (undetectable viral load tests are NOT proof of HIV)
A positive qualitative HIV NAT (DNA or RNA) or HIV-1 p24 antigen test	An HIV nucleotide sequence (genotype)
If client is an exposed infant (up to 12 months), document mother's HIV status	STARS Report
Certified medical record documenting HIV diagnosis (ICD-10: B20; ICD-9: 042)	Signed letter from a licensed medical provider (MD, DO, PA, NP) attesting to HIV diagnosis
Viral resistance test result	4th Generation (Ag/Ab) test result
Proof of Palm Beach County Residency	
Unemployment documentation with street address	Recently postmarked letter mailed to client at street address
Current and valid Health Care District card	Current and valid license or photo ID
Receipt of payment for rent with name, address, and signature of landlord	Mortgage or rent agreement with name and address (the entire document is not required- signature page and page with client name and address are required)
Letter from person with whom client resides	Letter from homeless shelter or social service agency
Utility bill with name and street address	Documentation of homelessness with client signature & date
Prison records (if recently released)	PBC Insurance Verification form (for clients who cannot get paystubs)
Recent School records	Bank statement with name and street address
Property tax receipt or W-2 form for previous year	Current voter/vehicle registration card.
Declaration of Domicile (Section 222.17, Florida Statutes).	Any acceptable Proof of Income documentation with street address
Proof of Income at or below 400% FPL	
Pay Stubs (enough stubs to determine an average annual income)	TPQY (not older than 90 days for proof of no income or annually for proof of income)
Self-Employment documentation (1040 Schedule SE or C)	Retirement/Disability Income (SSI, SSDI, other)
Letter of Support (if no income explain)	Military/Veteran Pension or VA Benefits
1040 or W2 form (with TPQY and, if no income, a Letter of Support)	Unemployment Letter (website print screen for current status and payment history)
Self-Tracking Form or DCF Work Calendar	Alimony/Child Support/Survivor Benefits
SEQY (if no income- required annually, or as necessary)	SSA.gov printout
TANF/Section 8 benefit award/assistance letter	Other governmental letters of Notification of Benefits (SNAP, WIC, LIS, Worker's Comp, etc.)
Verification/Screening for Other Payer Sources	
Medicaid (**copy of card is not sufficient**, must be a current Medicaid check from FLMISS or other source/Community Partners verification)	Current and valid Health Care District card
FLMMIS Screen	Medicaid Prescreen (myflorida.com/accessflorida/)
Private Insurance	Medicare (Part A/B/C/D)
Affordable Care Act (ACA) Insurance	Indian Health Service (IHS)
Veteran's Administration (VA)	Children's Health Insurance Program (CHIP)
Insurance Documentation from Employer	Patient Assistance Programs (PAP's)
PBC Insurance Verification form	Patient Advocate Foundation (PAF)/Patient Access Network (PAN) Foundation
PBC RWHAP will allow an active, current (less than 6 months old) Notice of Eligibility from a RW HIV/AIDS Program Part A or Part B/ADAP within the state of Florida as acceptable source documentation for PBC RWHAP eligibility so long as the NOE contains sufficient information from which an eligibility determination can be made (current address, income/household size/FPL, 3rd party payer source, etc.). If the information contained in the NOE is insufficient (i.e. address outside of PBC), additional documentation must be provided from this list.	

Appendix D- PBC RWHAP Incident Report

Palm Beach County Ryan White HIV/AIDS Program
Incident Notification Form

Agency: _____

Date Incident Occurred: _____

Person Completing Form: _____

Date of Report: _____

Email (*Optional*)**:** _____ **Phone #:**_____

Method of Communication: (Please check the appropriate box)

- ❒ Drop Off
- ❒ Standard Mail
- ❒ Provide Enterprise-Secure Transmission
- ❒ Certified Mail

Incidents Reported: (Please check the appropriate box)

- *Timeline to notify Funder - Incidents related to Children shall be notified between 2-4 hours.*
  - ❒ Client injury/accident requiring medical attention or hospitalization that could pose an Agency liability
  - ❒ Allegation of neglect, physical, mental and sexual abuse of a client by an Agency staff
  - ❒ Incidents that may portray the Agency in a negative manner (service delivery, safety and/or fiscal)

- *Timeline to notify Funder - Incidents related to Adults shall be notified between 4-8 hours.*
  - ❒ Client injury/ accident requiring medical attention or hospitalization that could pose an Agency liability
  - ❒ Allegation of neglect, physical, mental and sexual abuse of a client by an Agency staff
  - ❒ Incidents that may portray the Agency in a negative manner (service delivery, safety and/or fiscal)

- *Timeline to notify Funder- Programmatic Incidents (within 14 business days)*
  - ❒ Resignation/Termination of CEO, President, or CFO
  - ❒ Resignation/Termination of key Ryan White funded staff
  - ❒ Ryan White funded staff vacancy over 30 days
  - ❒ Change in AGENCY'S name
  - ❒ Loss of License
  - ❒ Loss of funding from another Funder that could impact services
  - ❒ Temporary interruption of service delivery (i.e. natural and unnatural disasters)
  - ❒ Other (Issues that impact service delivery to Ryan White clients)
    Specify: _____

Summary of incident: (Do not include the name of client or staff involved in incident)

_____

_____

_____

_____

Will there be an investigation?

❒ Yes
❒ No
❒ NA

_____ _____

Individual Completing Report: Print Name **Position /Title**

_____ _____

Individual Completing Report: Signature **Date**

Appendix E- PBC RWHAP PE User Confidentiality Agreement

Provide Enterprise
User Confidentiality Security Agreement
Palm Beach County Department of Community Services
Ryan White Part A Program Office

I the undersigned acknowledge that violation of the Health Insurance Portability and Accountability Act may result in prosecution, civil liability, or civil penalty, and may subject me to disciplinary action, including possible termination of employment, by my employer.

I understand that the purpose of this agreement is to emphasize that all client information contained in any of the Palm Beach County Ryan White Provide Enterprise system related to client services systems is confidential.

I understand my professional responsibilities, and that I am to report suspected or known security violations to Palm Beach County Community Services Department.

I understand that access to confidential information is governed by State and Federal laws. Client confidential information includes medical, social and financial data.

Client data collected by interview, observation or review of documents must be in a setting which protects the client's privacy.

I further understand and acknowledge the following:

1. Registered user ID's and/or passwords are not to be disclosed.
2. Information, electronic or paper-based, is not to be obtained for my own or another person's personal use.
3. Client services information systems, data and information technology resources shall be used only for official business purposes.
4. Copyright law prohibits the unauthorized use or duplication of software.

User Name (print): _____

User Signature: _____

Date Signed: _____

Supervisor Name (print): _____

Supervisor Signature: _____

Date Signed: _____

Appendix F- PBC RWHAP Letter of Medical Necessity for Opioid Medications

Palm Beach County Ryan White Part A Program
Letter of Medical Necessity/Chronic Opioid Medication

Date: _____

As the health care practitioner treating _____, and
Patient Name

in accordance with **Section 456, Florida Statutes**[1] and **F.A.C. 64B8-9.013**[2], it is my clinical opinion that the opioid medication below be prescribed.

Medication Name: _____

Strength/Dosage: _____

Directions/SIG: _____

Duration of Therapy: _____

The patient's diagnosis for this medication is_____. This diagnosis is related to the patient's HIV/AIDS status, complication of HIV or HIV-related co-morbidity because
_____
_____
_____

- I have documented that non-opioid pain medications have been used and have failed, or were not tolerated by the patient. It is my professional judgement that an opioid is the best medication for treating this patient's chronic pain.
- I have discussed the risk of opioid dependency with the patient.
- I have discussed other modalities for the treatment of pain with the patient.
- To my knowledge, the patient is not being prescribed other medications that can cause serious adverse events when taken with the opioid medication I am prescribing.
- I have consulted the Florida PDMP (E-FORSE) prior to prescribing the opioid medication.

I attest the above conditions have been met and are fully documented in the patient's medical record.

Sincerely,

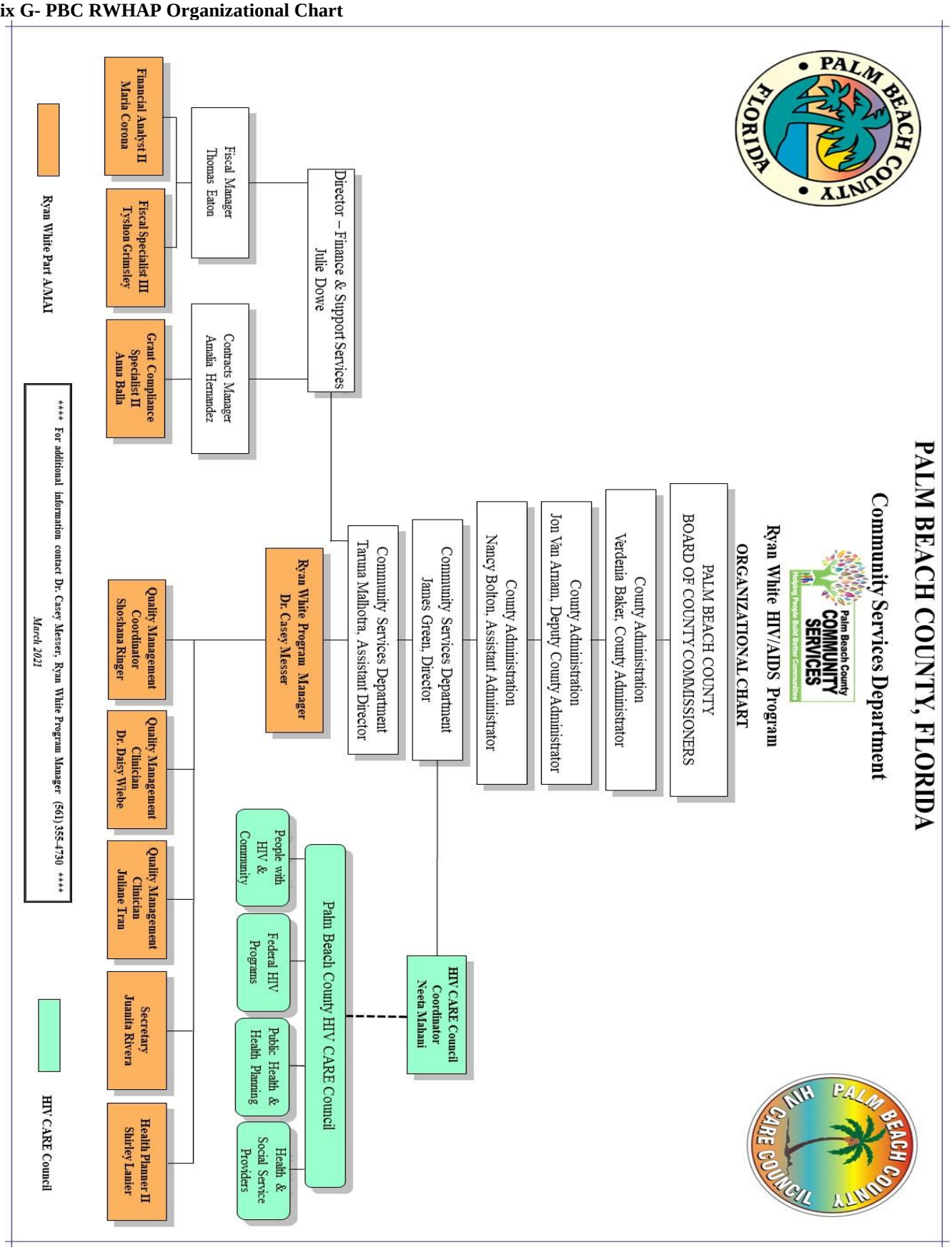
_____

_____
Print Name with Practitioner Degree(s)

Please note: All questions should be directed to the Ryan White Program Recipient, at (561) 355-4730.

[1]Florida Statute Section 456.44 Controlled Substance Prescribing
[2] Florida Administrative Code 64B8-9.013 Standards for the Use of Controlled Substances for the Treatment of Acute Pain. Specific Authority Florida Statute 458.309 and 458.331.
Created and Approved by LPAP 10/20/2020 CC 10/22/2020

Appendix G- PBC RWHAP Organizational Chart



PALM BEACH COUNTY
RYAN WHITE HIV/AIDS PROGRAM
Subrecipient Services Matrix
Grant Year 2021

SUBRECIPIENT/PROVIDER	AIDS Pharmaceutical Assistance	Early Intervention Services	Medical Case Management (including Treatment Adherence)	Outpatient/Ambulatory Health Services (including Lab Diagnostic Testing)	Emergency Financial Assistance-Emergency Medications	Food Bank/Nutritional Supplements	Medical Transportation	Non-Medical Case Management	Health Insurance Premium and Cost-Sharing Assistance	Mental Health Services	Emergency Financial Assistance	Food Bank/Home Delivered Meals	Housing	Oral Health Care	Psychosocial Support Counseling (MAI only)	Legal Services	Specialty Outpatient Medical Care	Medical Nutritional Therapy	Referral for Healthcare/Support Services (Part B Only)
	SERVICE CATEGORY																		
AIDS Healthcare Foundation (AHF)	•	•	•	•	•	•	•	•											
Compass, Inc.		•	•				•	•	•	•	•	•	•						
Florida Department of Health (Part A & B)																			
C.L. Brumbach Health Center (Belle Glade)		•	•	•		•	•			•								•	•
Delray Beach Health Center		•	•	•		•	•			•								•	•
Northeast Health Center (Riviera Beach)		•												•					
West Palm Beach Health Center		•	•	•		•	•			•								•	•
FoundCare, Inc.																			
Belle Glade		•	•				•	•	•	•		•			•				
Boynton Beach		•	•				•	•	•	•		•			•				
North Palm Beach				•															
Palm Springs		•	•	•			•	•	•	•		•		•	•				
Health Council of Southeast Florida		•	•				•	•	•						•		•		
Legal Aid Society of Palm Beach County								•								•			
Midway Specialty Care Center				•				•											
Monarch Health Services, Inc.		•																	
The Poverello Center, Inc.												•							

PBC RWHAP Subrecipient Service List (2021-2022)

AIDS Healthcare Foundation (AHF)

AIDS Pharmaceutical Assistance, Early Intervention Services (EIS), Medical Case Management, including Treatment Adherence, Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Emergency Financial Assistance/Emergency Medication, Food Bank/Nutritional Supplements, Medical Transportation, Non-Medical Case Management

Location(s): 1. 200 Congress Park Drive, Delray Beach, FL 33445
2. 1411 North Flagler Drive, West Palm Beach, FL 33401
Phone: 1. (561) 279-0991
2. (561) 284-8182
Fax: 1. (561) 279-0539

Program Contact: Kristen Harrington
Email: Kristen.Harrington@ahf.org
Phone: (561) 350-2196

Fiscal Contact: Brad Mester
Email: Brad.Mester@ahf.org
Phone: (954) 522-3132

Quality Management Contact: Kristen Harrington
Email: Kristen.Harrington@ahf.org
Phone: (561) 350-2196

Compass, Inc.

Early Intervention Services (EIS), Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Mental Health Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Housing, Medical Transportation, Non-Medical Case Management

Location(s): 201 N. Dixie Highway, Lake Worth, FL 33460
Phone: (561) 533-9699
Fax: (561) 318-6671

Program Contact: Lysette Pérez
Email: lysette@compassglcc.com
Phone: (561)533-9699 ext. 4007

Fiscal Contact: Julie Seaver or Crista Mockenhaupt
Email: julie@compassglcc.com or Crista@compassglcc.com
Phone: (561)533-9699 ext. 4038

Quality Management Contact: Neka Mackay or Lysette Pérez
Email: neka@compassglcc.com or lysette@compassglcc.com
Phone: (561)533-9699 ext. 4003 or 4007

Florida Department of Health, Palm Beach County

Early Intervention Services (EIS), Oral Health Care

Appointment Line: (561) 625-5180
Location(s):

1. 851 Avenue P, Riviera Beach, FL 33404
   Northeast Health Center, (561) 803-7300
   Dental Clinic
2. 1250 Southwinds Dr, Lantana, FL 33462
   Lantana/Lake Worth Health Center, (561) 547-6800
   Maternity, Family Planning, STD Clinic, PrEP
3. 225 S. Congress Avenue, Delray Beach, FL 33445
   Delray Beach Health Center, (561) 274-3100
   STD Clinic, PrEP, Maternity, Family Planning
4. 345 S. Congress Avenue, Delray Beach, FL 33445
   Delray Beach Health Center, (561) 274-3100
   IDC
5. 38754 State Road 80, Belle Glade, FL 33430
   C.L. Brumback Health Center, (561) 983-9220
   IDC, STD Clinic, PrEP, Maternity, Family Planning
6. 1150 45th Street, West Palm Beach, FL 33407
   West Palm Beach Health Center, (561) 514-5300
   IDC, STD Clinic, PrEP, Maternity, Family Planning
7. 5985 10th Ave, Greenacres, FL 33463
   WIC Greenacres Center, (561) 357-6000
   WIC

Program Contact: Robert Scott
Email: Robert.Scott@flhealth.gov
Phone: (561) 804-7947

Fiscal Contact: Liliana Vasquez
Email: Liliana.Vasquez@flhealth.gov
Phone: (561) 530-6885

Quality Management Contact: Kathryn Mathieu
Email: Kathryn.Mathieu@flhealth.gov
Phone: (561) 514-5322

FoundCare, Inc.

Early Intervention Services (EIS), Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Food Bank/Home Delivered Meals, Medical Transportation, Non-Medical Case Management, Psychosocial Support Counseling (MAI only)

Location(s):
(1) 2330 S. Congress Avenue, Palm Springs, FL 33406
(2) 1901 South Congress Ave Suite 100 Boynton Beach, FL 33426
(3) 840 US Highway 1 North Palm Beach FL 33408
(4) 1500 NW Ave. L Suite A, Belle Glade, FL 33430

Phone:
(1) (561) 472-2466 (Palm Springs)
(2) (561) 274-6400 (Boynton Beach)
(3) (561) 776-8300 (North Palm Beach)
(4) (561) 996-7059 (Belle Glade)

Fax: (1) (561) 304-0472
(2) (561) 274-3912
(3) (561) 776-0727
(4) (561) 996-1567

Program Contact: Tiffany Coutee
Email: tcoutee@foundcare.org
Phone: (561) 472-2466 X111

Fiscal Contact: Hannah Burson
Email: hburson@foundcare.org
Phone: (561) 472-9160 X211

Quality Management Contact: Tiffany Coutee
Email: tcoutee@foundcare.org
Phone: (561) 472-2466 X111

Legal Aid Society of Palm Beach County
Legal Services, Non-Medical Case Management

Location(s): 423 Fern Street, Suite 200, West Palm Beach, FL 33401
Phone: (561)655-8944
Fax: (561)655-5269

Program Contact: Sandra Powery Moses
Email: smoses@legalaidpbc.org
Phone: (561)822-9821 and (561)383-1530

Fiscal Contact: Shane Ramsaroop
Email: sramsaroop@legalaidpbc.org
Phone: (561)822-9765

Quality Management Contact: Laura Rivera
Email: lrivera@legalaidpbc.org
Phone: (561)721-6096

Midway Specialty Care Center

Outpatient/Ambulatory Health Services including Lab Diagnostic Testing, Non-Medical Case Management

Location(s): 1515 North Flagler Drive, Suite 200, West Palm Beach, FL 33401
Phone: (561) 249-2279
Fax: (561) 720-2970

Program Contact: Jenn Kuretski, DNP, APRN, FNP-C, AAHIVS
Email: jkuretski@midwaycare.org
Phone: (561) 249-2279

Fiscal Contact: Kathyrn Hayden
Email: khayden@midwaycare.org
Phone: (772) 742-9276

Quality Management Contact: Geoff Downie
Email: gdownie@midwaycare.org
Phone: (954) 495-7141

Monarch Health Services, Inc.

Early Intervention Services (EIS)

Location(s): 2580 Metrocentre Blvd., Ste 1
Phone: (561) 523-4589
Fax: (561) 491-2602

Program Contact: Stephanie Thomas
Email: sthomas@monarchealth.org
Phone: (786)449-9683

Fiscal Contact: Stephanie Thomas
Email: sthomas@monarchealth.org
Phone: (786)449-9683

Quality Management Contact: Stephanie Thomas
Email: sthomas@monarchealth.org
Phone: (786)449-9683

The Poverello Center, Inc.

Food Bank/Home Delivered Meals

Location(s): Grocery and Gift Card Home Deliveries throughout Palm Beach County, Administrative Offices at 2056 N Dixie Hwy, Wilton Manors, FL 33305

Program Contact: Shanel Pamphile
Email: spamphile@poverello.org for intake: intake@poverello.org
Phone: (954) 361-9242

Fiscal Contact: Jose Castillo
Email: jcastillo@poverello.org
Phone: (954) 256-8134

Quality Management Contact: Santiago Barney
Email: sbarney@poverello.org
Phone: (954) 449-6357

Treasure Coast Health Council, Inc. d/b/a Health Council of Southeast Florida

Early Intervention Services (EIS), Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence, Specialty Outpatient Medical Care, Medical Transportation, Non-Medical Case Management, Psychosocial Support Counseling (MAI only)

Location(s): 600 Sand Tree Drive, Suite 101, Palm Beach Gardens, FL 33403
Phone: (561) 844-4220
Fax: (561) 844-3310

Program Contact: Anil Pandya, COO
Email: apandya@hcsef.org
Phone: Extension 2400

Fiscal Contact: Anne Costello, CFO
Email: acostello@hcsef.org
Phone: Extension 2000

Quality Management Contact: Anil Pandya, COO
Email: apandya@hcsef.org
Phone: Extension 2400